



February 18, 2020

Brittany Ingraham, Senior Buyer

Department of Administration, Purchasing Division

2019 Washington Street, East

Charleston, WV 25305-0130

RECEIVED
2020 FEB 18 AM 8:29
WV PURCHASING
DIVISION

RE: Response to DHHR's Request for Proposal (RFP) for Mountain Health Trust Solicitation
No. CRFP 0511 BMS2000000002

Dear Ms. Ingraham,

UniCare Health Plan of West Virginia, Inc. (UniCare), Respondent to this RFP, is pleased to submit our response to the West Virginia Department of Health and Human Resources (DHHR) Mountain Health Trust (MHT) Managed Care Procurement Request for Proposal (RFP) No. CRFP 0511 BMS2000000002. As a West Virginia MHT and Health Bridge (WVHB) incumbent Managed Care Organization (MCO), we look forward to the opportunity to continue serving MHT and WVHB members and further expanding our services to the West Virginia Children's Health Insurance Program (WVCHIP) members. We will continue to draw on our local experience as a collaborative State partner and Medicaid thought leader to serve our Medicaid members and future CHIP members.

Our sole focus on West Virginia's health programs has been at the heart of what we do since our founding 17 years ago. Our local experience has helped us develop our MHT programs and services specifically for our members, while simultaneously addressing DHHR goals and

objectives and the unique West Virginia landscape. Our local focus and knowledge, paired with administrative advantages from our ultimate parent company, Anthem, Inc. (Anthem), and the ability to leverage and share ideas and programs with our affiliated health plans solidifies UniCare's optimal position to serve Medicaid and WVCHIP members.

Meeting DHHR's Goals

The solutions and capabilities we have developed are based on our deep understanding of our members' unique needs and challenges, input from our extensive provider network, and the guidance received from our strong community collaborations. Through these solutions and capabilities, we help the Bureau for Medical Services (BMS) and DHHR achieve their goals, empower providers, and together make our communities stronger.

Throughout our proposal, we highlight the solutions and capabilities we bring to support DHHR's goals, and showcase those ties with messaging and icons related to key concepts. We will use these icons throughout our proposal to highlight the solutions we are implementing to meet DHHR's objectives and how we will continue to go above and beyond contract requirements.



Experienced and Local Staff

Our proposed project team is grounded in the exceptional experience and talent of our key staff, who are experienced in all facets of managed care. Based in our Charleston, West Virginia office, our leadership team maintains full accountability and autonomy for making service delivery and administrative decisions at the local level.

We bring a long-established infrastructure of seasoned, key local staff and senior leadership already in place, who live and work in West Virginia, in the same neighborhoods as our members and providers.

We are hiring additional key and support staff who will enable us to not only continue to meet, but to exceed, our commitment to the Service Provider Agreement. We continually refine our staffing plan to meet the evolving needs of our members, providers, and communities, and to continuously fulfill our commitment to DHHR. ***We are increasing our team by over 65 new employees.*** For example, we have already begun hiring to build out our Population Health team, which includes 15 new positions (ten of whom are strategically based in communities).

It is important to us that our physical presence extends



beyond Charleston. To support our staff across the State, we plan to open a satellite office in Morgantown. Our Morgantown office will allow us to broaden our impact across the State and make a positive impact on the Morgantown economy.

Charleston Call Center

We are establishing a West Virginia-based call center, staffed with experienced representatives who have the skill set and local knowledge to address the more complex needs of our members and providers. Our call center will be comprised of 12 employees and located in our Charleston,

West Virginia office, alongside the rest of our health plan staff. The team will have immediate access to the health plan staff most appropriate to address the needs of our members and providers, such as our local Care management and Care Coordination teams, Operations department, Clinical staff, and Provider Relations team. These call center representatives will also be familiar with the local community, including the barriers members may be facing and the local resources available. As West Virginians serving West Virginians, this local knowledge will help make sure our members and providers receive the highest level of service and embraces our philosophy that health care is local.

Focused on Improving the Comprehensive System of Care

We believe in setting the bar high and continuously striving for better outcomes, better health, and better service. Our proposal incorporates a person-centered model to address West Virginia's public health challenges.

Whole Person Health

UniCare's Whole Person Health model is informed by predictive analytics, which look at the needs of the UniCare population as a whole (health, well-being, and disease prevention) and identifies the distribution of health needs across sub-populations — those who may need additional supports both through clinical intervention (provider-facing) and care management supports (UniCare). Through thoughtful consideration and development of strategies that are specific to



West Virginia, we have developed an approach that is holistic, with teams across our organization working together to develop programs and initiatives designed to meet the needs of our communities, our providers (in the delivery and management of care), and our members.

Our Whole Person Health model deploys both member and provider-facing staff in our Prevent, Engage, and Care strategy. These staff work within our communities and care delivery system to develop a holistic understanding of our members, their health conditions, their state of well-being, and their physical and social environments. These teams develop both community- and population-level strategies, using analytics to identify opportunities and incorporating feedback from key stakeholders to design interventions for both clinical and social determinants of health (SDOH) initiatives.

Identifying and Addressing Social Determinants of Health

Addressing SDOH in partnership with providers and community organizations is an integral part of our care model that improves health and reduces health disparities in West Virginia. Our No Wrong Door approach assures each member has access to the coordinated array of treatment and services they might need, when they need it, including physical health, behavioral health, SUDs, vision, dental, and the day-to-day social support needs that are foundational to supporting overall health and well-being.

We capture SDOH data for care management and population health opportunities through ICD-10 codes, Z-codes submitted on provider claims, new member welcome calls, initial health assessments (initial screenings), and interactions with our community-based team(s) and other methods. SDOH needs are often identified through initial screenings and Community Resource Link, and we have refined our screenings to specifically address SDOH needs and concerns.

Developing Programs to Address Social Determinants of Health

We have long demonstrated our commitment to partnering at a local level to address SDOH, focusing on the unique and evolving needs of members as well as investments in programming and capacity to support the communities in which our members live. Our plans to develop additional SDOH programs are both a continuation of our in-progress and successful programs we have implemented in West Virginia, as well as the design and launch of new programs. In many cases, such as our work with Kanawha County Emergency Ambulance Authority, our programs involve a community-focused approach, and we have continually sought partnerships with local stakeholders to not only build upon evidence-based practices, but to also think outside the box. Examples of some new offerings that demonstrate our SDOH focus center around employment, food security, housing security, education, social cohesion, and environmental needs.

Kanawha County Emergency Ambulance Authority

Launched in 2018, this paramedicine outreach visitation initiative supports our community-based care management model through engagement of hard-to-reach, high-cost Medicaid members. These members are often affected by multiple SDOH factors, such as environmental needs, transportation restrictions, and financial limitations. Using our analytics, we identify members who may benefit from care management, but have been non-responsive to outreach. Community Paramedics complete feet-on-the-street outreach, conducting assessments and connecting members to available community resources, health education, and immediate care needs. They may also conduct safety checks of the member's home. ***Since implementation, 40% of members we contacted agreed to complete the assessment, and 74% of those members completed the care management program.***

Quality Focused

Everything we do is based on quality. Our Quality Assessment and Performance Improvement program, led by an experienced local team, encompasses the full spectrum of physical health, behavioral health, and social supports available to our members. Our quality program is embedded across, and integrates data from, all functions of our organizational operations to reflect our holistic approach to member health and well-being. We work diligently to sustain our NCQA accreditation, which we have held since 2006. Our most recent renewal was in 2018 and is valid until September 2021. Our accreditation level is currently Commendable. In 2017, UniCare additionally received NCQA's Multicultural Health Care Distinction, and we are the only West Virginia MCO with that distinction.



Value-Added Services Offerings

UniCare proposes 22 Value-Added Services (VAS) to support our West Virginia members and their families. We expanded our VAS to support the needs of WVCHIP members and to address West Virginia's top health priorities, such as decreasing obesity and improving key chronic diseases. To develop VAS, we listen to members' priorities, monitor outcome data, review local trends, and collaborate with DHHR to make sure our VAS complement, but never duplicate, existing programs. Our VAS are easy to access and are trackable to monitor effectiveness.

UniCare's Unique Value-Added Services Meet Members' SDOH Needs

 Maternal & Child Benefits	 Physical Activity & Healthy Weight	 Whole Person Health	 Community & Social Supports
▪ Fresh Fruit and Veggies Program* ▪ Preventive Dental Care for Pregnant Members ▪ Mail Order Diapers* ▪ Safe Sleep Kit* ▪ Convertible Car Seat or Portable Crib ▪ Electric Breast Pump Accessory Kit	▪ Summer Camp Memberships ▪ Youth Club Memberships* ▪ Fitness Coach Program ▪ WW® (formerly known as Weight Watchers®) Memberships	▪ SUD Recovery Support Program* ▪ Healthy Rewards Program ▪ Oral Care Essentials* ▪ Build Your Own Personal Hygiene Box* ▪ Feminine Care Collection* ▪ Healthy Lifestyle Aids*	▪ No-Cost Laptop Benefit* ▪ \$100 Gas Card* ▪ Family Activity Coupon book* ▪ Online Well-Being program* ▪ Lifeline Smart Phone Benefit ▪ Community Resource Link

*New Value-Added Services

A Thought Leader in West Virginia Medicaid

When we see an opportunity for improvement, we create solutions. We will continue to support DHHR with innovative solutions that result in high-quality outcomes of which the State can be proud.

Tackling the Opioid Epidemic

UniCare has developed new solutions and supports existing community programs that benefit MHT members and impact

West Virginia's rate of overdose deaths. We view our Medication Assisted Treatment (MAT) and neonatal abstinence syndrome initiatives as critical preventive strategies that make meaningful changes on this local crisis.

We brought the Project ECHO® (Extension for Community Healthcare Outcomes) model to West Virginia in June 2017. Through collaborations with three academic medical centers, including West Virginia University School of Medicine, the ECHO model uses videoconferencing to conduct virtual clinics, mentoring, and patient case presentations between

Decreasing Opioid Overdoses

We realized a 32% decline in opioid overdose in 2019 compared to 2018 and a 53% decline since 2017.

academic medical centers, specialists, and community providers who are MAT-certified or interested in becoming MAT-certified.

Prenatal Care as a Continued Focus

Early engagement in prenatal care is a key strategy to positively impact low birth weight, preterm birth, and infant

mortality. We employ multiple strategies to identify members who are pregnant to enroll them into our comprehensive perinatal program. Once we identify members who are pregnant, we quickly assess obstetric (OB) risk and initiate care management services, including perinatal education to mitigate risks to healthy birth outcomes. We also assist members to schedule a prenatal care visit within 14 calendar days of the date we learn of a pregnancy. All UniCare members who meet our High-risk Obstetrics criteria are referred to our OB Care Management program.

Early and sustained member engagement is critical for improving birth outcomes. In addition to care management supports for prenatal members identified as high-risk, UniCare offers a continuum of supports through our Taking Care of Baby and Me® (TCOBAM) program. TCOBAM provides targeted health outreach to our members who are pregnant to encourage them to act as self-advocates in their health, and the health of their babies, by seeking early and continuous prenatal care.

Increasing Access to Long-acting Reversible Contraceptives

UniCare is a leader in promoting access to long-acting reversible contraceptives (LARC) to reduce adverse health outcomes associated with unintended pregnancies. We have strong ties with local organizations to promote our common purpose of achieving State goals and fulfilling our responsibilities to provide access to family planning services. UniCare's former Medical Director, Dr. Tracy Dlott, founded and led the State's LARC workgroup, which is responsible

Improving Timeliness of Prenatal Care
Between 2017 and 2019, UniCare's Timeliness of Prenatal Care HEDIS results rose steadily, exceeding the 75th percentile.

for coordinating access to both immediate postpartum LARC and outpatient LARC services.

Immediate postpartum LARC services are available at all three teaching hospitals in West Virginia. We will continue to lead the workgroup as we plan to implement access in the smaller community hospitals through education and support. The workgroup also facilitates training for PCPs to provide LARC services instead of having to refer their patients to OB/GYN providers to access outpatient LARC services.

Digital Enhancements Paving the Way for UniCare Members

By July 1, 2020, members will have access to a mobile application (app) that will provide the same information and functionality available on our member portal. The mobile app is being developed for both iOS and Android™ users and will take advantage of technology available on these mobile devices, including GPS, and biometric security.

In 2021, UniCare will implement Sydney, a next-generation member engagement platform that uses Artificial Intelligence (AI) and data science to deliver a customized mobile and web experience tailored to each member's needs. Maintaining all of the features and functionality available to members with the current app, Sydney is the next evolution of mobile app — capitalizing on the latest technology and finding new ways to engage members in their own health, wherever they are. Sydney brings together easy-to-use care finder tools, clear benefit details, and wellness improvement programs in one simple mobile solution. Sydney leverages AI and data science to unlock the power of Anthem's data to drive a personalized, intuitive experience for each one of our members. Today, Anthem has more data than any other carrier and it doubles every 73 days. The use of this data coupled with innovation makes health care smarter, easier, and more accessible than ever before. AI and personalized data helps us

intervene earlier to lower members' risk of disease and improve their health. Each time a member interacts with their health care, data is consumed and risk is identified.

President's Panel

UniCare proactively monitors our performance to identify emerging risks and systemic patterns to address them early and minimize any downstream impacts. UniCare's President's Panel is charged with identifying and mitigating complex challenges and systemic problems. Our cross-functional approach involves the highest levels of health plan leadership, Quality Management (QM), and other key functional areas. We prioritize issues that have an impact on members and/or providers to find cross-functional solutions. The President's Panel will use a data-driven approach to inform its monthly meetings and leverage QM methodology to implement changes. We have developed a policy and procedure to govern the collection of complaints, system shortcomings, and near-misses so they can be tracked and trended for root cause analysis. We also use a heat map of operational areas for regular status updates and risk identification.

High-quality Care and Member Satisfaction Are the Result of Our Long-standing Partnerships

For the past 17 years, we have been in our West Virginia communities, creating and nurturing relationships with like-minded people at organizations that share a common goal of improving the health and lives of West Virginians. We value our relationships and work to develop community collaborations, helping to create the best possible outcomes for UniCare members. We will continue to grow our outreach, engagement, and community support initiatives.

We are an organization that truly cares for our members and drives change and



From 2018 to present, UniCare and its philanthropic arm, the UniCare Foundation, have invested more than \$1 million dollars in West Virginia to support community organizations and expand access to health programs.

innovation to provide the highest quality programs and services in West Virginia. We are excited to continue to work with DHHR to build on our experience and collaboration.

Should you have any questions regarding our proposal or capability, please contact me by telephone at (304) 347-2474 or email at Tadd.Haynes@anthem.com. Our technical and cost proposals were prepared simply and economically; DHHR templates were used for our in-line response to the RFP. Specifically in Attachment 6, we have adhered to the direction outlined in GE001 and GE002.

Sincerely,

Tadd Haynes, Chief Executive Officer
UniCare Health Plan of West Virginia, Inc.

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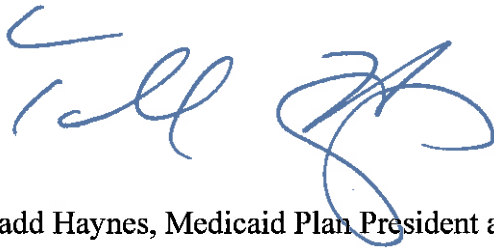
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A handwritten signature in blue ink, appearing to read 'Tadd Haynes', with a stylized flourish at the end.

Tadd Haynes, Medicaid Plan President and Chief Executive Officer
UniCare Health Plan of West Virginia, Inc.

TITLE PAGE

RFP subject: West Virginia Department for Health and Human Resources Mountain Health Trust (MHT) Managed Care Procurement Request for Proposal, Technical Proposal

Number: CRFP 0511 BMS2000000002

Vendor's name: UniCare Health Plan of West Virginia, Inc.

Business address: 200 Association Drive, Suite 200, Charleston, WV 25311

Telephone number: (888) 611-9958

Fax number: (877) 833-5729

Name of contact person: Tadd Haynes

Email address: Tadd.Haynes@anthem.com

Vendor signature: 

Date: February 18, 2020

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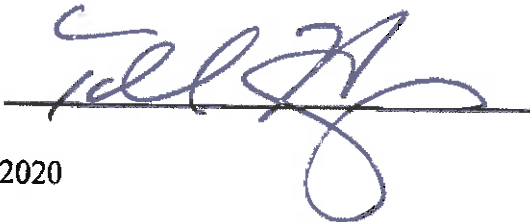
Business address: 200 Association Drive, Suite 200, Charleston, WV 25311

Telephone number: (888) 611-9558

Fax number: (877) 833-5729

Name of contact person: Tadd Haynes

Email address: Tadd.Haynes@anthem.com

Vendor signature: 

Date: February 18, 2020

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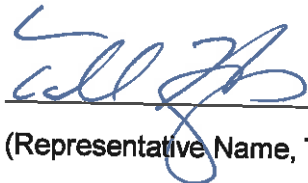
6.8 Availability of Information

Proposal submissions become public and are available for review after opening pursuant to West Virginia Code §5A-3-11(h) (<http://www.wvlegislature.gov/wvcode/code.cfm?chap=05a&art=3>). All other information associated with the RFP, including but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3.d (https://www.state.wv.us/admin/purchase/rule_148-01.pdf).

By signing below, I certify that I have reviewed this Request for Proposal in its entirety; understand the requirements, terms and conditions, and other information contained herein; that I am submitting this proposal for review and consideration; that I am authorized by the bidder to execute this bid or any documents related thereto on bidder's behalf; that I am authorized to bind the bidder in a contractual relationship; and that, to the best of my knowledge, the bidder has properly registered with any State agency that may require registration.

UniCare Health Plan of West Virginia, Inc.

(Company)

 Medicaid Plan President

(Representative Name, Title)

Contract Phone: (888) 611-9958/Fax Number: (877) 833-5729

(Contact Phone/Fax Number)

2/17/20

(Date)

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP 0511 BMS2000000002

Instructions: Please acknowledge receipt of all addenda issued with this solicitation by completing this addendum acknowledgment form. Check the box next to each addendum received and sign below. Failure to acknowledge addenda may result in bid disqualification.

Acknowledgment: I hereby acknowledge receipt of the following addenda and have made the necessary revisions to my proposal, plans and/or specification, etc.

Addendum Numbers Received:

(Check the box next to each addendum received)

☒ Addendum No. 1	☒ Addendum No. 6
☒ Addendum No. 2	☐ Addendum No. 7
☒ Addendum No. 3	☐ Addendum No. 8
☒ Addendum No. 4	☐ Addendum No. 9
☒ Addendum No. 5	☐ Addendum No. 10

I understand that failure to confirm the receipt of addenda may be cause for rejection of this bid. I further understand that that any verbal representation made or assumed to be made during any oral discussion held between Vendor's representatives and any state personnel is not binding. Only the information issued in writing and added to the specifications by an official addendum is binding.

UNICARE HEALTH PLAN OF MN, Inc

Company
[Signature]

Authorized Signature
2/13/20

Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.

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UNICARE HEALTH PLAN OF WV, Inc
Company
[Signature]
Authorized Signature
2/13/20
Date

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

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #1 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-18	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	2

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Vendor name: UniCare Health Plan of West Virginia, Inc.
Address: 200 Association Drive, Suite 200, Charleston, WV 25311
Telephone Number: (888) 611-9958

FOR INFORMATION CONTACT THE BUYER

April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X

FEIN # 84-1620480

DATE

2/17/20

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum #1 is issued to clarify the location, date, and time of the mandatory pre-bid meeting.

THE MANDATORY PRE-BID MEETING WILL BE HELD AT:

ONE DAVIS SQUARE
SUITE 100E, CR 134
CHARLESTON WV 25301

ON JANUARY 8, 2020, AT 10:00 AM EST

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

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2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

	Purchasing Division 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	State of West Virginia Request for Proposal 34 — Service - Prof

Proc Folder: 643604 Doc Description: Addendum #1 RFP for Mountain Health Trust (MHT) Managed Care Proc Type: Central Master Agreement			
Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-18	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	2

BID RECEIVING LOCATION			
BID CLERK DEPARTMENT OF ADMINISTRATION PURCHASING DIVISION 2019 WASHINGTON ST E CHARLESTON WV 25305 US			

VENDOR
Vendor Name, Address and Telephone Number: Vendor name: UniCare Health Plan of West Virginia, Inc. Address: 200 Association Drive, Suite 200, Charleston, WV 25311 Telephone Number: (888) 611-9558

FOR INFORMATION CONTACT THE BUYER		
April E Battle (304) 558-0067 april.e.battle@wv.gov		
Signature X 	FEIN # 84-1620480	DATE 1/24/20
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BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV25301-3709	CHARLESTON	WV 25301-3709
US		US	

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MHT MCO FY2021

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HEALTH AND HUMAN RESOURCES		HEALTH AND HUMAN RESOURCES	
BUREAU FOR MEDICAL SERVICES		BUREAU FOR MEDICAL SERVICES	
350 CAPITOL ST, RM 251		350 CAPITOL ST, RM 251	
CHARLESTON	WV25301-3709	CHARLESTON	WV 25301-3709
US		US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

BMS2000000002	Document Phase Final	Document Description Addendum #1 RFP for Mountain Health Trust (MHT) Managed Care	Page 4 of 4
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ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions



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

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #2 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-23	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	3

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Vendor name: UniCare Health Plan of West Virginia, Inc.
Address: 200 Association Drive, Suite 200, Charleston, WV 25311
Telephone Number: (888) 611-9958

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X

FEIN # 84-1620480

DATE

2/17/20

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum No. 2 - issued to change the buyer and contact information for the CRFP.

Contact Information: Brittany Ingraham, Senior Buyer
 Email: Brittany.E.Ingraham@wv.gov
 Phone number: 304-558-0067

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
 MHT MCO FY2021

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

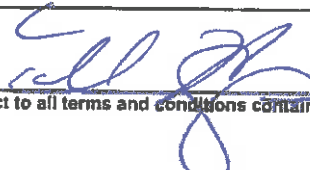
Extended Description :
 MHT MCO FY2022

	Purchasing Division 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	State of West Virginia Request for Proposal 34 -- Service - Prof

Proc Folder: 643604			
Doc Description: Addendum #2 RFP for Mountain Health Trust (MHT) Managed Care			
Proc Type: Central Master Agreement			
Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-23	2020-02-12 13:30.00	CRFP 0511 BMS2000000002	3

BID RECEIVING LOCATION		
BID CLERK DEPARTMENT OF ADMINISTRATION PURCHASING DIVISION 2019 WASHINGTON ST E CHARLESTON WV 25305 US		

VENDOR
Vendor Name, Address and Telephone Number: Vendor name: UniCare Health Plan of West Virginia, Inc. Address: 200 Association Drive, Suite 200, Charleston, WV 25311 Telephone Number: (888) 611-9558

FOR INFORMATION CONTACT THE BUYER		
Brittany E Ingraham (304) 558-2157 brittany.e.ingraham@wv.gov		
Signature X 	FEIN # 84-1620480	DATE 1/24/20
All offers subject to all terms and conditions contained in this solicitation		

ADDITIONAL INFORMATION:

Addendum No. 2 - issued to change the buyer and contact information for the CRFP.

Contact Information: Brittany Ingraham, Senior Buyer
 Email: Brittany.E.Ingraham@wv.gov
 Phone number: 304-558-0067

No other changes.

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

BMS2000000002	Document Phase Final	Document Description Addendum #2 RFP for Mountain Health Trust (MHT) Managed Care	Page 4 of 4
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ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions



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

State of West Virginia
Request for Proposal
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Proc Folder: 643604

Doc Description: Addendum #3 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-23	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	4

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Vendor name: UniCare Health Plan of West Virginia, Inc.
Address: 200 Association Drive, Suite 200, Charleston, WV 25311
Telephone Number: (888) 611-9958

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X

FEIN # 84-1620480

DATE

2/17/20

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum No. 3 - issued to correct attached documentation previously provided on Addendum No. 2 since the wrong solicitation number was listed at the top of the page.

Buyer Contact Information:
 Brittany Ingraham, Senior Buyer
 Email: Brittany.E.Ingraham@wv.gov
 Phone number: 304-558-0067

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
 MHT MCO FY2021

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
 MHT MCO FY2022



Purchasing Division
2019 Washington Street East
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State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #3 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-23	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	4

BID RECEIVING LOCATION

BID CLERK

DEPARTMENT OF ADMINISTRATION

PURCHASING DIVISION

2019 WASHINGTON ST E

CHARLESTON

WV 25305

US

VENDOR

Vendor Name, Address and Telephone Number:

Vendor name: UniCare Health Plan of West Virginia, Inc.

Address: 200 Association Drive, Suite 200, Charleston, WV 25311

Telephone Number: (888) 611-9558

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham

(304) 558-2157

brittany.e.ingraham@wv.gov

Signature X

FEIN # 84-1620480

DATE

1/24/20

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ADDITIONAL INFORMATION:

Addendum No. 3 - issued to correct attached documentation previously provided on Addendum No. 2 since the wrong solicitation number was listed at the top of the page.

Buyer Contact Information:

Brittany Ingraham, Senior Buyer
Email: Brittany.E.Ingraham@wv.gov
Phone number: 304-558-0067

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS		
Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

	Document Phase	Document Description	Page 4
BMS2000000002	Final	Addendum #3 RFP for Mountain Health Trust (MHT) Managed Care	of 4

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions



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

State of West Virginia
Request for Proposal
34 - Service - Prof

Proc Folder: 643604

Doc Description: Addendum #4 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2020-01-08	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	5

BID RECEIVING LOCATION

BID CLERK

DEPARTMENT OF ADMINISTRATION

PURCHASING DIVISION

2019 WASHINGTON ST E

CHARLESTON

WV 25305

US

VENDOR

Vendor Name, Address and Telephone Number:

Vendor name: UniCare Health Plan of West Virginia, Inc.

Address: 200 Association Drive, Suite 200, Charleston, WV 25311

Telephone Number: (888) 611-9958

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham

(304) 558-2157

brittany.e.ingraham@wv.gov

Signature X

FEIN # 84-1620480

DATE

2/17/20

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum No. 4 - issued to provide the pre-bid meeting sign-in sheets.

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

	Purchasing Division 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	State of West Virginia Request for Proposal 34 – Service - Prof

Proc Folder: 643604			
Doc Description: Addendum #4 RFP for Mountain Health Trust (MHT) Managed Care			
Proc Type: Central Master Agreement			
Date Issued	Solicitation Closes	Solicitation No	Version
2020-01-08	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	5

BID RECEIVING LOCATION	
BID CLERK DEPARTMENT OF ADMINISTRATION PURCHASING DIVISION 2019 WASHINGTON ST E CHARLESTON WV 25305 US	

VENDOR
Vendor Name, Address and Telephone Number: Vendor name: UniCare Health Plan of West Virginia, Inc. Address: 200 Association Drive, Suite 200, Charleston, WV 25311 Telephone Number: (888) 611-9558

FOR INFORMATION CONTACT THE BUYER		
Brittany E Ingraham (304) 558-2157 brittany.e.ingraham@wv.gov		
Signature X 	FEIN # 84-1620480	DATE 1/24/20
All offers subject to all terms and conditions contained in this solicitation		

ADDITIONAL INFORMATION:

Addendum No. 4 - issued to provide the pre-bid meeting sign-in sheets.

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO	SHIP TO
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US	PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17

	Document Phase	Document Description	Page 4
BMS2000300002	Final	Addendum #4 RFP for Mountain Health Trust (MHT) Managed Care	of 4

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions



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

State of West Virginia
Request for Proposal
34 - Service - Prof

Proc Folder: 643604

Doc Description: Addendum #5 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date issued	Solicitation Closes	Solicitation No	Version
2020-02-05	2020-02-18 13:30:00	CRFP 0511 BMS2000000002	6

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

Vendor name: UniCare Health Plan of West Virginia, Inc.
Address: 200 Association Drive, Suite 200, Charleston, WV 25311
Telephone Number: (888) 611-9958

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X

FEIN # 84-1620480

DATE

2/17/20

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum No. 5 - The purpose of this addendum is to:

1. Modify the bid opening date as follows:

Bid opening WAS 02/12/2020 at 1:30 PM ET

Bid opening IS NOW 02/18/2020 at 1:30 PM ET

2. Provide a Change Log

3. Provide Vendor Questions and Agency Responses

4. Attach Appendix 7_SFYZ1 Service Provider Agreement

5. Attach Appendix 8_CHIP Provider Listing

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022



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

State of West Virginia
Request for Proposal
34 — Service - Prof

Proc Folder: 643604

Doc Description: Addendum #5 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2020-02-05	2020-02-18 13:30:00	CRFP 0511 BMS2000000002	6

BID RECEIVING LOCATION

BID CLERK
DEPARTMENT OF ADMINISTRATION
PURCHASING DIVISION
2019 WASHINGTON ST E
CHARLESTON WV 25305
US

VENDOR

Vendor Name, Address and Telephone Number:

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham
(304) 558-2157
brittany.e.ingraham@wv.gov

Signature X

FEIN #

DATE

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum No. 5 - The purpose of this addendum is to:

1. Modify the bid opening date as follows:

Bid opening WAS 02/12/2020 at 1:30 PM ET

Bid opening IS NOW 02/18/2020 at 1:30 PM ET

2. Provide a Change Log

3. Provide Vendor Questions and Agency Responses

4. Attach Appendix 7_SF Y21 Service Provider Agreement

5. Attach Appendix 8_CHIP Provider Listing

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
3	MHT MCO FY2023				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2023

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024				

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid Meeting	2020-01-08
2	Questions Due	2020-01-17



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

State of West Virginia
Request for Proposal
34 -- Service - Prof

Proc Folder: 643604

Doc Description: Addendum #6 RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2020-02-07	2020-02-18 13:30:00	CRFP 0511 BMS2000000002	7

BID RECEIVING LOCATION

BID CLERK

DEPARTMENT OF ADMINISTRATION

PURCHASING DIVISION

2019 WASHINGTON ST E

CHARLESTON

WV 25305

US

VENDOR

Vendor Name, Address and Telephone Number:

Vendor name: UniCare Health Plan of West Virginia, Inc.

Address: 200 Association Drive, Suite 200, Charleston, WV 25311

Telephone Number: (888) 611-9958

FOR INFORMATION CONTACT THE BUYER

Brittany E Ingraham

(304) 558-2157

brittany.e.ingraham@wv.gov

Signature X

FEIN # 84-1620480

DATE

2/17/20

All offers subject to all terms and conditions contained in this solicitation

ADDITIONAL INFORMATION:

Addendum No. 6 - The purpose of this addendum is to:

1. Provide Agency responses to additional Vendor questions.

Bid Opening will remain 02/18/2020 at 1:30 PM ET

No other changes.

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
1	MHT MCO FY2021	0.00000			

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

INVOICE TO		SHIP TO	
PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV25301-3709 US		PROCUREMENT OFFICER - 304-356-4861 HEALTH AND HUMAN RESOURCES BUREAU FOR MEDICAL SERVICES 350 CAPITOL ST, RM 251 CHARLESTON WV 25301-3709 US	

Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
2	MHT MCO FY2022	0.00000			

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2022

	Purchasing Division 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	State of West Virginia Request for Proposal 34 – Service - Prof

Proc Folder: 643604			
Doc Description: Addendum #6 RFP for Mountain Health Trust (MHT) Managed Care			
Proc Type: Central Master Agreement			
Date issued	Solicitation Closes	Solicitation No	Version
2020-02-07	2020-02-18 13:30.00	CRFP 0511 BMS2000000002	7

BID RECEIVING LOCATION		
BID CLERK DEPARTMENT OF ADMINISTRATION PURCHASING DIVISION 2019 WASHINGTON ST E CHARLESTON WV 25305 US		

VENDOR
Vendor Name, Address and Telephone Number:

FOR INFORMATION CONTACT THE BUYER		
Brittany E Ingraham (304) 558-2157 brittany.e.ingraham@wv.gov		
Signature X	FEIN #	DATE
All offers subject to all terms and conditions contained in this solicitation		

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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
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Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :

MHT MCO FY2021

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Line	Comm Ln Desc	Qty	Unit Issue	Unit Price	Total Price
4	MHT MCO FY2024	0.00000			

Comm Code	Manufacturer	Specification	Model #
85000000			

Extended Description :
MHT MCO FY2024

SCHEDULE OF EVENTS

Line	Event	Event Date
1	Pre-bid meeting	2020-01-08
2	Questions Due	2020-01-17

ATTACHMENT 3: VENDOR QUALIFICATIONS & EXPERIENCE

1. Organization Overview

This section of the Vendor's Technical Proposal should include an overview of the Vendor and any subcontractor(s), excluding direct-care providers. The Vendor should provide their response as part of their bid in accordance with the template(s) below. Unless otherwise stated, requested documentation must be provided to the Department as part of the bid submission.

1.1 Vendor Overview

Provide all relevant information regarding the general profile of the Vendor. The Vendor should provide their response as part of their bid in accordance with the template below.

The Vendor is NOT to change any of the pre-filled cells in the following tables.

Table 5: Vendor Overview

Vendor Overview	
Corporate (Legal) Name	UNICARE Health Plan of West Virginia, Inc. (UniCare)
Name of Parent Company (If Applicable)	UNICARE National Services, Inc. is UniCare's direct parent. Anthem Holding Corp. is UniCare's indirect parent. Anthem, Inc. is UniCare's ultimate parent company.
Tax Identification Number	84-1620480
Industry (North American Industry Classification System [NAICS])	524114
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	UniCare Health Plan of West Virginia, Inc.'s direct parent, UNICARE National Services, Inc., is a private company, as is its indirect parent, Anthem Holding Corp. UniCare Health Plan of West Virginia, Inc.'s ultimate parent, Anthem, Inc., is a publicly traded company.
Number of Full-Time Employees	Our organization has 123 full-time employees dedicated to our West Virginia operations.
Last Fiscal Year Company Revenue	\$490,020,613
Last Fiscal Year Company Net Income	\$21,358,786
% of Revenue From State Government Clients in the United States	100%
Number of Years in Business	17 years
Number of Years Vendor Has Been Providing the Type of Services Specified in the RFP	UniCare has provided Medicaid managed care services in West Virginia for 17 years, since our incorporation in 2003. West Virginia is our sole customer, and the Mountain Health Trust contract is the only focus of our organization.

Vendor Overview	
Number of Employees Providing the Type of Services Specified in the RFP	UniCare has 123 current full-time employees.
Headquarters in the United States	UniCare's headquarters is in Charleston, West Virginia. All operations will be administered or overseen from this location.
Headquarters Mailing Address	200 Association Drive, Suite 200, Charleston, WV 25311
Street Address	200 Association Drive, Suite 200, Charleston, WV 25311
Telephone Number	888-611-9958
Fax Number	877-833-5729
Locations in the United States	Our Charleston, West Virginia, headquarters is UniCare's sole office location. Our care management and member services team members live and work throughout the State.
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: same as above Mailing Address: Street Address: Telephone Number: Fax Number:
Name of Contact Person for Bid	Tadd Haynes, Medicaid Plan President, is the contact person for this bid. In our organization, the role of Medicaid Plan President is identical in function and authority to Chief Executive Officer (CEO) and will be referred to as CEO for the purposes of this proposal.

- The Vendor should provide a list of all counties for which the Vendor intends to serve members, and indicate whether the Vendor has received approval from the Department of Insurance to serve Medicaid and WVCHIP members in each county. *All counties must be served under the contract resulting from this solicitation.*

Under the Mountain Health Trust and West Virginia Health Bridge (West Virginia Medicaid) programs, UniCare currently serves and intends to continue serving members in all 55 West Virginia counties. UniCare has met the Certificate of Authority (COA) requirements outlined by the West Virginia Offices of the Insurance Commissioner, receiving approval to serve Medicaid members in each county through our continuous licensure as a Health Maintenance Organization in good standing since 2003 when we began our operations.

- The Vendor should describe the business type of the Vendor and its parent company, as applicable.

UniCare Health Plan of West Virginia, Inc. is a for-profit, private domestic West Virginia corporation. UniCare Health Plan of West Virginia, Inc. is a wholly-owned direct subsidiary of UNICARE National Services, Inc., a domestic for-profit corporation. UNICARE National Services, Inc. is a wholly-owned direct subsidiary of Anthem, Inc., a for-profit, publicly traded corporation traded under the symbol ANTM on the New York Stock Exchange.

- The Vendor should provide the number of current Medicaid and CHIP members in other states, by state, and describe any experience managing services for members in other Medicaid programs or other lines of business within West Virginia.

Our sole focus on West Virginia's state-sponsored health programs has been at the heart of our mission since our founding 17 years ago. UniCare is the largest Medicaid Managed Care Organization (MCO) in West Virginia. We exclusively serve more than 153,000 Medicaid members in the Mountain Health Trust and West Virginia Health Bridge programs, and we are fully prepared to serve incoming CHIP members as part of the new Service Provider Agreement (SPA). UniCare has no other line of business in West Virginia.



As part of the Anthem family of companies, our affiliates have managed services for state-sponsored health programs since 1991, currently serving more than 7.5 million members in Medicaid, CHIP, and other state-sponsored programs in 23 additional markets nationwide, with 17 of those markets featuring CHIP programs (please refer to Table 3.1-1, which provides market-by-market detail of our organization's membership and years of experience).¹

¹ Anthem, Inc., UniCare's ultimate parent company, recently completed the acquisition of Medicaid managed care plans in Nebraska and Missouri, which brings our total Medicaid footprint through affiliated health plans to more than 7.5 million Medicaid members in 23 states and the District of Columbia.

Table 3.1-1. Our Organization's Medicaid Membership and Experience Nationwide
(**Bold Text Indicates Markets Where the Affiliate Is a Prime Managed Care Organization**)

Medicaid Market	TANF Membership	CHIP Membership	Medicaid Expansion (ACA) Membership	SSI-ABD Membership	Other Membership	Total Medicaid Membership	Total Years of Experience
Arkansas	n/a	n/a	n/a	n/a	14,996	14,996	2 years
California	1,018,606	n/a	325,205	144,788	407	1,163,801	29 years
Colorado	n/a	*	*	*	*	312,428	1 year
District of Columbia	43,687	3,041	3,589	n/a	n/a	46,728	2 years
Florida	368,338	53,975	n/a	71,067	9,920	503,300	17 years
Georgia	348,163	31,893	n/a	n/a	13,538	393,594	14 years
Indiana	205,965	13,384	178,426	56,596	178,426	454,371	13 years
Iowa	285,737	36,899	95,283	61,517	1	384,154	3 years
Kentucky	116,713	3,623	64,736	12,048	n/a	132,384	6 years
Louisiana	204,694	17,655	92,105	22,134	23,690	268,173	8 years
Maryland	179,691	35,599	45,264	14,965	45,264	275,519	20 years
Minnesota	325,673	n/a	62,964	3,231	n/a	328,904	1 year
Missouri	194,257	11,091	n/a	n/a	13,771	219,119	21 years
Nebraska	54,998	12,000	n/a	13,150	3,102	83,250	3 years
Nevada	184,829	8,919	71,514	n/a	n/a	193,748	13 years
New Jersey	82,661	16,114	52,580	27,817	52,580	179,172	24 years
New York	379,289	45,600		30,716		455,605	28 years
South Carolina	122,962	n/a	n/a	10,168	n/a	133,130	11 years
Tennessee	331,875	n/a	n/a	72,661	n/a	404,536	13 years
Texas	547,740	68,874	n/a	155,495	n/a	771,769	23 years
Virginia	305,036	28,931	75,649	67,732	n/a	401,699	23 years
Washington	153,480	5,298	75,802	12,187	25,547	196,512	7 years
West Virginia	83,081	n/a	55,071	16,116	n/a	154,268	17 years
Wisconsin	89,989	n/a	n/a	6,261	n/a	96,250	14 years
All Markets	More than 5.6 Million	More than 392,000	More than 1.1 Million	More than 798,000	More than 693,000	More than 7.5 Million	313 years combined

*In Colorado, our organization, as part of a joint venture, is responsible solely for the provision of behavioral health (BH) services, which comprises CHIP, Medicaid Expansion, and ABD member populations. Membership totals are not reported by individual population.

Local Experience Serving Medicaid & Medicaid Expansion Members

For 17 years, UniCare has built a strong history of progressively deeper experience serving West Virginia Medicaid. We have been a partner to the West Virginia Department of Health and Human Resources (DHHR) as a Mountain Health Trust MCO since 2003, when the program expanded for the first time to serve the entire state. Additionally, in 2015, we began serving Medicaid expansion members through the West Virginia Health Bridge (WVHB) program. Currently, we serve more than 153,000 members, including more than 83,000 TANF members, more than 16,000 Supplemental Security Income (SSI) members, and more than WVHB 55,000 members.

UniCare and Affiliates Medicaid Highlights

In 2019, UniCare and our affiliated health plans coordinated the delivery of more than 398,000 babies nationwide or approximately 33,000 babies per month.

UniCare and our affiliated health plans coordinate care for approximately 4 million children and adolescents under the age of 19.

Over 59% of our national service area is in rural counties.

UniCare and our affiliated health plans serve more than 43,000 members in Opioid Reduction programs.

Almost 58% of the total population served by UniCare and our affiliated health plans are engaged with providers participating in Value-Based Payment programs.

As a current WVHB and Mountain Health Trust provider, collaborative State partner, and Medicaid thought leader, we will continue to draw on both our local experience and affiliate health plans' knowledge to continue to serve our Medicaid members and our future CHIP members.

West Virginia Initiatives and Innovations



UniCare continues to focus on the needs of West Virginians in a myriad of ways through initiatives and innovations, detailed next and in the corresponding Care Management responses, such as collaboration with community resources through our partnership with Mission West Virginia's Teaching Health Instead of Nagging Kids (THINK) program to develop programs to address members' biopsychological needs (CM043) and through our partnership in 2020 with the Think Kids Health and Hunger Project (CM053), which includes launching our Social Determinants of Health (SDOH) Provider Incentive Program (PIP) — (CM045-CM053). We engage with

our local communities through our participation with organizations like the West Virginia Perinatal Partnership on a long-acting reversible contraceptives (LARC) program task force and through our attendance of quarterly meetings of the Office of Maternal, Child, and Family Health (OMCFH) Pediatric Medical Advisory Board (CM062). We also focus on our members' cultural diversity through our Cultural Competency Plan, and we have plans to improve our members' lives who live in more rural areas of our state with initiatives to address food insecurity in rural communities through contributions to a mobile food pantry (CM053), as well as initiatives to address the opioid crisis by improving outreach to members in rural areas through our partnership with the West Virginia Balance of State Continuum of Care's Program Leadership (CM043).

- **Preventive Health Education Programs.** In 2018, UniCare funded a staff position to support Mission West Virginia's THINK program. This program leverages evidenced-based curriculum to increase student knowledge in areas critical to maintaining good health among youth, including pregnancy prevention, sexually transmitted infections prevention, communication skills, family success, employment readiness, organization, social media, and personal safety. Additionally, each student completes a needs assessment to determine personal barriers, including housing, food, transportation, clothing, sexual activity, relationship safety (including parental safety), alcohol and drug use, and future goals. Resources and referral are made based on need of each student with the aim of preparing them for a future with a decreased risk of adult poverty. After six months, 353 middle and high school students completed the courses, and 394 students were assessed for social needs.
- **Expanded Approach to SDOH Assessments.** In 2020, we have partnered with Think Kids Health and Hunger Project to support their mission of growing generations of West Virginia's kids to their healthiest potential. This program includes two components. The first, currently underway, is to

collect and analyze provider surveys assessing provider involvement in assessment of patient SDOH needs. The second component is a UniCare-convened Food Insecurity Summit of providers discussing, planning, and coordinating efforts to address food insecurity and to increase provider participation in capturing and addressing childhood hunger. One way we will be increasing provider participation is through the launch of our SDOH PIP that supports providers in methodically identifying and connecting members with resources that help address SDOH barriers. Through incentivizing providers to proactively evaluate member social barriers, we will be able to systematically identify members with positive screens and alert staff to engage these members and link them with additional resources.

▪ **Community Engagement.** We expand and invest in partnerships with local organizations and quality providers. For example, since 2015, we have had great success working with the West Virginia Perinatal Partnership on a LARC program task force, with the goal of improving birth outcomes by reducing unplanned pregnancies, teen pregnancies, and substance-exposed babies. As another example, we participate in the Quarterly OMCFH Pediatric Medical Advisory Board Meeting. This advisory board includes public health personnel, private medical providers, MCOs, and school personnel from across West Virginia. The Pediatric Medical Advisory Board participates in HealthCheck policy development and advises the West Virginia Title V agency about health and medical service needs within local communities.



From 2018 to present, UniCare and its philanthropic arm, the UniCare Foundation, have invested more than \$1 million dollars in West Virginia to support community organizations and expand access to health programs.

▪ **Cultural Diversity.** We focus on cultural diversity and how various perspectives influence the way each member engages with the health care system. Our Cultural Competency Plan aims to advance

health equity, improve quality, and help eliminate health care disparities across West Virginia by implementing culturally and linguistically appropriate services.

- **Service to Rural Communities.** West Virginia's counties are 61.82% rural and UniCare realizes additional outreach is needed to serve these members. We have initiatives focused on our rural members through addressing issues such as food insecurity through our contributions to the United Way of Central West Virginia's Mobile Food Pantry aiding residents in Clay County who had their last grocery store close in the summer of 2019, as well as expanding outreach to surrounding rural communities in Boone, Kanawha, Logan, and Putnam counties. To address the opioid epidemic and make sure members in rural areas get the assistance they need, we have entered into a partnership with West Virginia Balance of State Continuum of Care on two key initiatives impacting all West Virginians. We will join some of our UniCare opioid programming — such as Project ECHO® (Extension for Community Healthcare Outcomes), quality Medication Assisted Treatment (MAT) services, and PreManage for overdose monitoring — with West Virginia Balance of State Continuum of Care's State Opioid Response program. This opioid program will boost their current Street Outreach team, access to housing, and supportive services, paired with a Peer Recovery Support Specialist focused on the most rural areas of the State.

- **CHIP Specific Initiatives.**

- **Youth Vaping Epidemic.** UniCare is partnering with the American Heart Association to establish a community dialogue in Kanawha County on the epidemic of youth vaping. UniCare will provide sponsorship support to this initiative, which involves convening stakeholders to discuss how the community can address e-cigarettes, including policy and systems changes to prevent and reduce vaping among teens. These dialogues will bring together regional and local leaders to raise

awareness, create synergistic relationships that generate momentum, and develop plans that will reverse the course of smoking and vaping.

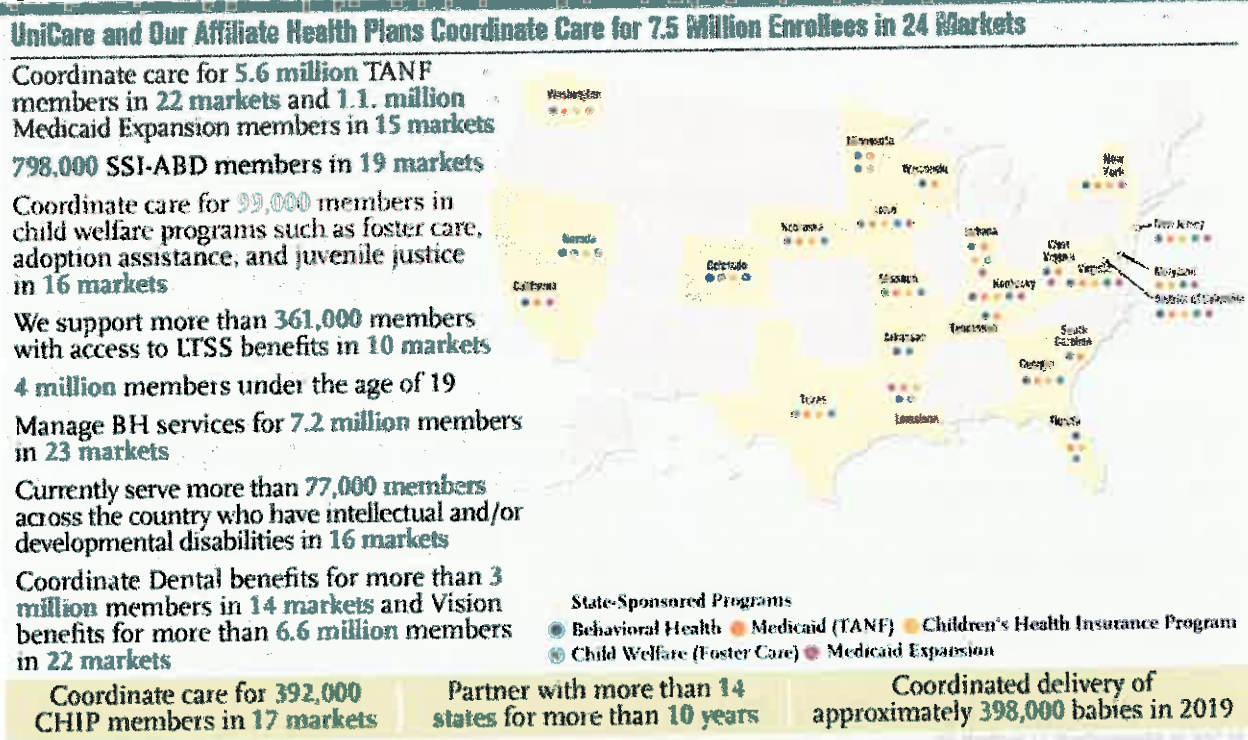
- **Positive Action Program.** UniCare is partnering with Boys and Girls Clubs to provide trauma-informed training to staff members to help respond to youth with behavioral challenges and anti-social behaviors. UniCare will sponsor training in the use of the evidence-based *Positive Action* program, and other strategies, for at least 24 full and part-time staff members across the state. Goals for the program include:
 - Provide staff training in working with opioid addicted families; Engage at least 400 youth per year with the Positive Action curriculum.
 - Utilize the skills of a licensed social worker, provide specialized individual or group sessions for 175 youth and parents/caregivers who are presenting problematic behaviors that could indicate they are struggling with opioid or other substance use problems in their homes.
 - Provide access to a certified counselor at the Clubs for 100 youth and parents/caregivers with the aim of helping them cope with the most traumatic elements in their lives.
 - Pilot a parent engagement initiative at a minimum of one site providing small group classes and support to 25 adults.

Nationwide Medicaid and CHIP Experience

UniCare is part of one of the nation's leading health benefits organizations — Anthem, Inc. Through its health plan subsidiaries, our ultimate parent company, Anthem, Inc., delivers health benefit solutions to more than 41 million members via a broad portfolio of integrated health care plans including more than 7.5 million members in Medicaid in 24 markets (shown in Figure 3.1-1). Our affiliate health plans serve more than 392,000 CHIP members in 17 markets, with more than 59% of the national service area in rural

counties, including in West Virginia. We and our affiliates serve approximately four million children and adolescents under the age of 19 through CHIP, Medicaid, and other government-sponsored programs. Beginning with the first health plan in California in 1991 to the most recently implemented plan in the District of Columbia, our affiliates have been serving the Medicaid population for more than 29 years and our organizational commitment to State partners, providers, members, and communities has never wavered.

Figure 3.1-1. With Our Affiliate Health Plans, We Coordinate Care for 7.5 Million Medicaid Members



We will continue to benefit from the national presence, best practices, and depth of experience across Medicaid and other state-sponsored programs through Anthem and our affiliate health plans. These affiliate health plans have coordinated a wide variety of benefits, including acute, behavioral, CHIP, and long-term services and supports benefits for Medicaid and other state-sponsored health programs for more than 29 years. Furthermore, our organization has been a pioneer and innovator in providing integrated

care solutions for individuals with specialized care and service needs: children, including those in foster care and who are medically frail; members who are dually eligible for Medicare and Medicaid; frail adult populations residing in nursing facilities and the community; those with intellectual or developmental disabilities; members with serious mental illness; and those with substance use disorders.

Twenty-one of our affiliates are prime contractor MCOs with contracts of *similar scope* to UniCare by providing full service managed care, including benefit administration, care management, community and stakeholder engagement, member services, enrollment and disenrollment, network development, provider services, quality, claims and encounters, program integrity, and information management systems.

Seventeen of these prime MCO affiliate markets have total Medicaid membership of similar or greater size to UniCare and of those, 15 markets include CHIP populations. Further details can be seen in Figure 3.1-2.

Figure 3.1-2. UniCare's and its Affiliates' Medicaid Managed Care History and Experience

UniCare's and its Affiliates' Medicaid Managed Care History and Experience														
State/Market	Covered Populations						Covered Services						Years of Medicaid Experience	Medicaid Membership (Q4 2019)
	TANF	CHIP	ABD/SPD/SSI	Medicaid Expansion	HIV/AIDS	Foster Care	PH	BH/SUD	Rx/PBM	Dental	Transport	Vision		
Arkansas						*	*	*	*			*	2	14,996
California	*		*	*	*		*	*	*		*	*	29	1,163,801
Colorado		*	*	*	*	*		*					1	313,000
District of Columbia	*	*		*	*	*	*	*	*	*	*	*	2	46,728
Florida	*	*	*		*	*	*	*	*		*	*	17	503,300
Georgia	*	*			*	*	*	*	*	*	*	*	14	393,594
Indiana	*	*	*	*	*	*	*	*	*	*	*	*	13	454,371
Iowa	*	*	*	*	*	*	*	*	*		*	*	3	384,154
Kentucky	*	*	*	*	*	*	*	*	*	*	*	*	6	132,384
Louisiana	*	*	*	*	*	*	*	*	*	*	*	*	8	268,173
Maryland	*	*	*	*		*	*		*	*	*	*	20	275,519
Minnesota	*		*	*	*	*	*	*		*	*		1	328,904
Missouri	*	*			*	*	*	*		*	*	*	21	219,119
Nebraska	*	*	*		*	*	*	*	*		*	*	3	83,250
Nevada	*	*		*			*	*	*			*	13	193,748
New Jersey	*	*	*	*	*	*	*	*	*	*		*	24	179,172
New York	*	*	*	*	*		*	*	*	*	*	*	28	455,605
South Carolina	*		*		*		*	*	*			*	11	133,130
Tennessee	*		*		*		*	*				*	13	404,536
Texas	*	*	*			*	*	*	*	*	*	*	23	771,769
Virginia	*	*	*	*		*	*	*	*	*	*	*	23	401,699
West Virginia	*		*	*			*	*		*		*	17	154,268
Wisconsin	*		*		*		*	*		*		*	14	96,250
Washington	*	*	*	*	*		*	*	*			*	7	196,512
Total	22	17	19	15	18	16	23	23	18	14	15	22	313	7,567,982

Medicaid Successes Modeled by Our Affiliates

UniCare, and our members by extension, benefit from our affiliates' extensive national experience. We share the best of our West Virginia experience and innovations throughout our organization for implementation in our affiliate plans. Similarly, we can and do identify and leverage best practices, lessons learned, and innovative programming our affiliates have piloted or implemented in other states.

An example of leveraging this experience, to meet DHHR's goal of enhancing access to services, UniCare is implementing a telemedicine approach supporting access to care. We are accomplishing this through our LiveHealth Online (LHO) solution, which provides members with real-time, online access to West Virginia-licensed, board-certified physicians through two-way audio-video technology. UniCare's affiliates in California, Iowa, Louisiana, Nevada, Texas, and Washington have implemented LHO for their Medicaid programs. Our California market has seen positive outcomes through its use in reduction of member emergency room (ER) and urgent care visits, with over 760 members having utilized LHO since inception in September 2018, for a total of 810 LHO visits. Based on LHO patient responses to post-visit surveys, ***19% of LHO patients said they would have gone to the emergency room if LHO had not been available to them***, and 42% said they would have sought care at an urgent care center. Our affiliate's Medicaid members are highly satisfied with LHO. Patient feedback survey information indicates ***ratings 4.9 out of 5 points (with 5 points meaning extremely satisfied) for both LHO and the LHO provider***. Our affiliate's record of success gives UniCare a wealth of knowledge and experience to mine for innovations and best practices to bring to our members.

Affiliates' Experience Serving CHIP Members

As a local, West Virginia health plan with access to national resources, we adapt both innovations and proven solutions from our affiliates to West Virginia's unique health care landscape. Our organization's access to experience serving 392,000 CHIP members across our affiliated health plans has helped us to build familiarity with these members' needs, and it positions us well to expand our services to CHIP members in West Virginia. CHIP members have unique needs different from those of the other populations we serve — they tend to be in good health, and so our solutions need to focus on what keeps them healthy.

Our affiliates' experience serving CHIP members provides us with a roadmap of possible solutions to apply locally — preventive health programs, education, and removing barriers to care, among others — and their successes are evident in their quality results. As described in Table 3.1-2, our affiliate health plans score well on HEDIS® measures, with many measures in the 90th or higher percentile.

Table 3.1-2. Affiliates' Successes with CHIP

CHIP Market	HEDIS Measures in the 90 th Percentile
Kentucky	- Childhood Immunization Status: DTAP, IPV, HEPB, PNEUMO, ROTA, Combo 1, Combo 3 - Well-child Visits in the First 15 Months of Life (6+ Visits)
Georgia	- Immunizations for Adolescents — MENIN, Combo 1 - Cervical Cancer Screening - Asthma Medication Ratio — Total - Annual Dental Visit — ADV 11–14
Indiana	- Medication Management for People With Asthma - Non-recommended Cervical Cancer Screening in Adolescent Females - Use of Multiple Concurrent Antipsychotics in Children & Adolescents — Ages 1 to 5
Iowa	- Immunizations for Adolescents — MENIN - Follow-up After ER Visit Alcohol and Other Drug Abuse or Dependence — 7 Days and 30 Days for Ages 13–17 - Non-recommended Cervical Cancer Screening in Adolescent Females
Louisiana	- Immunizations for Adolescents — MENIN - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment — Initiation and Engagement for Ages 13–17
Maryland	Immunizations for Adolescents — MENIN
Nevada	Immunizations for Adolescents — MENIN
New York	- Lead Screening in Children - Cervical Cancer Screening - Chlamydia Screening in Women (16–20) - Follow-up After Hospitalization For Mental Illness — Seven Days Total - Metabolic Monitoring for Children and Adolescents on Antipsychotics — Ages 6–11, 12–17, and Total - Children's and Adolescents' Access To PCP — 25 Months to 6 Years, 7 to 11 Years, and 12–19 Years - Well-child Visits in the Third, Fourth, Fifth, and Sixth Year of Life - Adolescent Well-care Visits
Texas	- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — Counseling for Physical Activity 12–17 years - Childhood Immunization Status — HEPA - Immunizations for Adolescents — MENIN - Use of Multiple Concurrent Antipsychotics in Children & Adolescents (Ages 1 to 5) - Adolescent Well-care Visits
Virginia	- Childhood Immunization Status — DTAP, MMR, VZ - Immunizations for Adolescents — TDAP - Asthma Medication Ratio — Total - Non-recommended Cervical Cancer Screening in Adolescent Females
Washington	- Non-recommended Cervical Cancer Screening in Adolescent Females - Use of Multiple Concurrent Antipsychotics in Children and Adolescents — Ages 6 to 11

CHIP Successes Modeled by our Affiliates Nationwide

Iowa. Our Iowa affiliate is a prime contractor MCO, serving populations and coordinating scope of services similar to the ones we serve in West Virginia, with membership including 285,737 TANF members, 61,517 ABD members, and 36,899 CHIP members. They have recently piloted programs aimed at reducing risk from SDOH, particularly as they apply to children's health and well-being. In September 2019, they began a partnership with an elementary school on a program aimed at asthma mitigation and addressing nutritional issues. Additionally, they invested \$115,000 in grant funding to create a Housing Stability and Homelessness Diversion Fund.

As a way to connect with local communities, particularly families, our Iowa affiliate partners with Brenton Skating Plaza to host an Annual Day of Giving as part of Martin Luther King, Jr. Day celebrations. This event harnesses the generosity of our affiliate's members, offering free admission and skate rental with the donation of gently used warm clothing. In addition to providing an opportunity for families to be active and social in their communities, it gives our affiliate's child and adolescent members a fun day off school while encouraging them to get involved in service to their local community.

Maryland. Our Maryland affiliate is a prime contractor MCO, serving populations and coordinating scope of services similar to the ones we serve in West Virginia, with membership including 179,691 TANF members, 14,965 ABD members, and 35,599 CHIP members. Our affiliate demonstrates their commitment to their child members through participation in the Baltimore City Health Department Lead Collaborative, and they are the only MCO to do so. This program's mission is to serve children under age seven through environmental and medical home visits, both in-home and telephonic. The trained staff who conduct these visits provide health education on topics critical to children's health, including lead, nutrition, child supervision, good housekeeping, and clinic compliance.

Additionally, our affiliate shares data with the Baltimore City Health Department to help identify children with uncontrolled asthma who would benefit from home assessments, education, and case management referrals. Our affiliate provides care management and home assessments for these children, and also supplies kits to reduce asthma triggers in their homes.

Texas. Our Texas affiliate is a prime contractor MCO, serving populations and coordinating scope of services similar to the ones we serve in West Virginia, with membership including 547,740 TANF members, 155,495 ABD members, and 68,874 CHIP members. Their provided services include physical and behavioral health, long-term care, long-term services and supports (LTSS), dental, vision, pharmacy, and non-emergency medical transportation. This similarity makes the experience they share with us very valuable, especially their extensive experience serving children, adolescents, and young adults under the age of 19 living in rural areas. They help inspire us with the knowledge and expertise to deliver timely access to high-quality, appropriate health care services for our incoming CHIP members.

Our Texas affiliate uses a member-centered approach that improves satisfaction and outcomes for all their members, but is particularly suited to individuals with the most complex health care needs. Our affiliate has continued to expand its managed care model since 1996, including programs tailored towards child members and members living in rural areas: STAR+PLUS, STAR Kids, the Medicaid Rural Service Area, CHIP Perinate, and the Medicaid Child Obesity Prevention Pilot. As they carve in new populations and adapt to evolving circumstances, they expand and invest in partnerships with local organizations and high-quality providers, emphasizing transition planning and continuity of care by implementing a care system centered on member experience. We will draw on the lessons they have learned as we welcome CHIP members under the new SPA.

Florida. Our Florida affiliate is a prime contractor MCO operating smaller individual contracts similar in size and scope to UniCare. It serves populations similar to the ones we serve in West Virginia, with overall membership including 368,338 TANF members, 71,067 ABD members, and 53,975 CHIP members. Our Florida affiliate operates a CHIP contract providing physical and behavioral health, and pharmacy services to their members. Our affiliate has tailored its programs and initiatives to meet the needs of their youth membership. As we have noted earlier, youth members tend to be among our healthier populations: More than 82% of our Florida affiliate's CHIP members do not have a diagnosed condition, 17% are diagnosed with a manageable condition such as asthma or ADHD, and less than 1% are targeted for complex case management. As a result, many of our affiliate's initiatives focus on prevention and wellness to keep children healthy.

For those with more complex conditions, our affiliate teams up with providers, schools, and other government entities and community organizations to develop a care plan that addresses members' needs across all domains. To further support families with the resources and tools to build healthy, active lifestyles, our affiliate offers a suite of Enhanced Benefits, which we have looked to as we develop the Value-Added Services (VAS) offered in this proposal (please see Attachment 6, question 13 for complete details). These VAS focus on key areas, based on feedback from our system partners, members, and their families.

Implementation Experience

As proud West Virginians living and working in our local communities, our local knowledge, expertise, network, and community relationships provide a solid foundation for implementing any new requirements for West Virginia Mountain Health Trust (MHT). As an incumbent health plan, we are meeting or exceeding current contract requirements and stand ready to implement any new SPA requirements and those for the CHIP population by July 1, 2020, as agreed upon with DHHR. We began preparing for implementation in 2019 and have remained engaged in the planning process. Our local West Virginia team is directing and overseeing this implementation process for new requirements and carving in the CHIP program, while strategically drawing on support resources from our national Anthem implementation team. Throughout our nearly 17-year incumbency serving Medicaid members in West Virginia, we have implemented numerous service requirements and are well prepared to meet all readiness review and implementation requirements. We will adhere to DHHR's expectations and requirements as described throughout this RFP.

Our local West Virginia team is leading and managing this implementation process with the support from a dedicated team from our national Implementation Management Office (IMO). Since 1999, our IMO has successfully executed more than 250 implementations, including those of similar or greater size and scope for our 17 affiliate health plans with CHIP members, and has not missed a readiness review nor member operational start day.

As we carve in new populations and adapt our programs to the changing health care landscape, we will collaborate with DHHR, members, providers, and other partners to tailor our programs, systems, and services to meet specific needs, concerns, and goals. UniCare has a long history of engaging stakeholders across the State under our current contract and we will continue to do so as we launch the additional innovative programs

and services included in our proposal. We have been actively engaging stakeholders to collaboratively listen and learn the best approaches to program design and implementation for West Virginians.

- The Vendor should provide the following information in accordance with 42 CFR § 455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104>):
 - The name and address of any person (individual or corporation) with an ownership or control interest in the Vendor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

UniCare Health Plan of West Virginia, Inc. is a wholly-owned direct subsidiary of UNICARE National Services, Inc. UNICARE National Services, Inc. is a wholly-owned direct subsidiary of Anthem Holding Corp. Anthem Holding Corp. is a wholly-owned direct subsidiary of Anthem, Inc. Therefore, both Anthem Holding Corp. and Anthem, Inc. are 100% indirect owners of UniCare Health Plans of West Virginia, Inc. Table 3.1-3 as follows gives addresses and relevant ownership details for these entities.

Table 3.1-3. Addresses and Ownership Details for Individuals or Corporations with Ownership or Control Interest in UniCare

Entity or Individual Name (Officers and Directors of UniCare Health Plan of West Virginia, Inc.)	Address	Tax ID	Ownership in UniCare Health Plan of West Virginia, Inc.
UniCare Health Plan of West Virginia, Inc.	200 Association Drive, Suite 200, Charleston, WV 25311	84-1620480	N/A
Michael Tadd Haynes, President and Medicaid Plan President	200 Association Drive, Charleston, WV 25311*	N/A	N/A
Jorge A. Cortina, Director	200 Association Drive, Charleston, WV 25311*	N/A	N/A
Kristen Louise Metzger, Director and Executive Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Ronald William Penczek, Director and Chief Financial Officer	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Jack Louis Young, Director	4425 Corporation Lane, Virginia Beach, VA 23462*	N/A	N/A
Kathleen Susan Kiefer, Secretary	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Vincent Edward Scher, Treasurer	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Eric Kenneth Noble, Assistant Treasurer	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Stephen Douglas Beebe, Assistant Secretary	4361 Irwin Simpson Road, Mason, OH 45040*	N/A	N/A

Entity or Individual Name (Officers and Directors of UniCare Health Plan of West Virginia, Inc.)	Address	Tax ID	Ownership in UniCare Health Plan of West Virginia, Inc.
UNICARE National Services, Inc.	1209 Orange Street, Wilmington, DE 19801	95-4633507	100% direct
Anthem Holding Corp.	220 Virginia Avenue, Indianapolis, IN 46204	61-1459939	100% indirect
Anthem, Inc.	Primary: 220 Virginia Avenue, Indianapolis, IN 46204 Additional locations: Anthem, Inc. and its subsidiaries have 81 offices where they serve Medicaid members. See Table 3.1-4.	35-2145715	100% indirect
BlackRock, Inc.	Primary: 40 East 52 nd Street, New York, NY 10022 Additional locations: BlackRock has 70 offices in 30 countries. U.S. locations are in: Newport Beach, CA; Palo Alto, CA; San Francisco, CA; Santa Monica, CA; Denver, CO; Greenwich, CT; Boca Raton, FL; Miami, FL; Ponte Vedra Beach, FL; Atlanta, GA; Chicago, IL; Boston, MA; Bloomfield Hills, MI; Princeton, NJ; New York, NY; Charlotte, NC; Philadelphia, PA; Pittsburgh, PA; Dallas, TX; Houston, TX; Seattle, WA Non-U.S. locations can be found at: https://www.blackrock.com/corporate/about-us/contacts-locations	32-0174431	8.97% indirect (8.97% direct of Anthem, Inc.)
The Vanguard Group, Inc.	Primary: P.O. Box 2600, Valley Forge, PA 19482 Additional locations: The Vanguard Group, Inc. has four locations in the United States and 14 international offices in 11 countries. U.S. locations are in: Scottsdale, AZ; Washington, D.C.; Charlotte, NC; and Valley Forge, PA	23-1945930	7.78% indirect (7.78% direct of Anthem, Inc.)

** For officers and directors of UniCare Health Plan of West Virginia, Inc., addresses provided reflect business addresses of the individuals. Pursuant to DHHR's response to Q066, personal addresses will be made available to DHHR upon request post award.*

Shares of Anthem, Inc.'s (Anthem's) common stock are publicly traded on the New York Stock Exchange under the symbol ANTM. As such, Anthem common stock may be acquired in the ordinary course of business through open market purchases. Per Securities and Exchange Commission (SEC) filings, as of September 30, 2019, Anthem is aware of BlackRock, Inc. and The Vanguard Group, Inc., noted in Table 3.1-3, that own beneficially 5% or more of the outstanding shares of Anthem's common stock and, therefore, indirectly beneficially own shares of UniCare Health Plans of West Virginia, Inc. It

should be noted that beneficial ownership is determined in accordance with the SEC's rules and regulations.

Anthem, Inc. has many wholly-owned subsidiaries across the nation that provide services exclusively to Medicaid members. Table 3.1-4 provides business addresses, in other states as applicable where subsidiaries serve Medicaid members.

Table 3.1-4. Business Addresses of Anthem Subsidiaries and Affiliates Serving Medicaid Members

Address	City	State	ZIP
650 S Shackelford Road, Suite 440	Little Rock	AR	72211
5250 North Palm Avenue, Suite 421	Fresno	CA	93704
425 East Colorado Street, Suite 600	Glendale	CA	91205
406 East Colorado Street	Glendale	CA	91205
2000 Corporate Center Drive, Building 7	Newbury Park	CA	91320
2868 Prospect Park Drive, Suite 100	Rancho Cordova	CA	95670
11030 White Rock Road	Rancho Cordova	CA	95670
9655 Granite Ridge Drive, Suite 600	San Diego	CA	92123
120 South Via Merida	Thousand Oaks	CA	91362
4553 La Tienda Drive	Thousand Oaks	CA	91362
3330 West Mineral King	Visalia	CA	93292
21555 Oxnard Street	Woodland Hills	CA	91367
7150 Campus Drive	Colorado Springs	CO	80920
700 Broadway	Denver	CO	80273
1125 17 th Street, Suite 1000	Denver	CO	80202
108 Leigus Road	Wallingford	CT	06492
609 H Street, NE, Suite 200	Washington	DC	20002
2290 Lucien Way	Maitland	FL	32751
9250 West Flagler Street, Suite 600	Miami	FL	33174
1000 South Pine Island, Suite 900	Plantation	FL	33324
4200 West Cypress Street, Suite 900	Tampa	FL	33607
4170 Ashford Dunwoody Road, Suite 100	Atlanta	GA	30319
3350 Peachtree Road	Atlanta	GA	30326
621 Northwest Frontage Road, Suite 310	Augusta	GA	30907
6087 Technology Parkway	Midland	GA	31820
8001 Chatham Center Drive	Savannah	GA	31405
4800 Westown Parkway	West Des Moines	IA	50266
7509 Eagle Crest Boulevard	Evansville	IN	47715
220 Virginia Avenue	Indianapolis	IN	46204
13550 Triton Park Boulevard	Louisville	KY	40223
10000 Perkins Rowe, Suite 510	Baton Rouge	LA	70810
3850 North Causeway Boulevard, Suite 600	Metairie	LA	70002
7550 Teague Road, Suite 500	Hanover	MD	21076
3000 Ames Crossing Road, Suite 100	Eagan	MN	55121
800 Market Street, 27 th Floor	St. Louis	MO	63101
10040 Regency Circle, Suite 100	Omaha	NE	68114
4000 Centre Green Way, Suite 350	Cary	NC	27513

Address	City	State	ZIP
11000 Weston Parkway, Suite 200	Cary	NC	27513
14120 Ballantyne Corporate Place, Suite 225	Charlotte	NC	28277
101 Wood Avenue South, Suite 800	Iselin	NJ	08830
9133 West Russell Road	Las Vegas	NV	89148
11 Corporate Woods Boulevard	Albany	NY	12211
32-31 Steinway	Astoria	NY	11103
2411 Grand Concourse	Bronx	NY	10468
968 Southern Boulevard	Bronx	NY	10459
241 37 th Street, 4 th Floor	Brooklyn	NY	11232
2875 West 8 th Street	Brooklyn	NY	11224
364 Knickerbocker Avenue	Brooklyn	NY	11237
471 5 th Avenue	Brooklyn	NY	11215
815 59 th Street	Brooklyn	NY	11220
2009 Church Avenue	Brooklyn	NY	11226
257 West Genesee Street, 6 th Floor	Buffalo	NY	14202
3913 104 th Street	Corona	NY	11368
13656 39 th Avenue	Flushing	NY	11354
91 North Franklin Street	Hempstead	NY	11550
95-40 Roosevelt Avenue	Jackson Heights	NY	11372
9 Pine Street (aka 14 Wall Street), 14 th Floor	New York	NY	10005
221 Sherman Avenue	New York	NY	10034
139 Centre Street	New York	NY	10013
153-17 Jamaica Avenue	Queens	NY	11432
11603 Liberty Avenue	South Richmond Hill	NY	11419
32 Richmond Terrace	Staten Island	NY	10301
37 Thurber Boulevard, Suite 108	Smithfield	RI	02917
4101 Percival Road	Columbia	SC	29229
7130 Goodlett Farms Parkway	Cordova	TN	38016
9041 Executive Park Drive, OFC 18, Suite 250	Knoxville	TN	37923
22 Century Boulevard, Suite 220	Nashville	TN	37214
823 Congress Avenue, Suite 400	Austin	TX	78701
7430 Remcon Circle, Building C, Suite 120	El Paso	TX	79912
2505 North Highway 360, Suite 300	Grand Prairie	TX	75050
3800 Buffalo Speedway, Suite 400	Houston	TX	77098
5959 Corporate Drive, Suite 3500	Houston	TX	77036
3223 South Loop 289, Suite 110	Lubbock	TX	79423
12500 San Pedro, Suite 400	San Antonio	TX	78216
5800 Northampton Boulevard	Norfolk	VA	23502
10701 Parkridge Boulevard, Suite 100	Reston	VA	20191
2015 Staples Mill Road	Richmond	VA	23230
1300 Amerigroup Way	Virginia Beach	VA	23464
1330 Amerigroup Way	Virginia Beach	VA	23464
4425 Corporation Lane	Virginia Beach	VA	23462
4433 Corporation Lane	Virginia Beach	VA	23462
705 5 th Avenue South, Suite 300	Seattle	WA	98104
216 Pinnacle Way, Suite 260	Eau Claire	WI	54701
N17 W24222 Riverwood Drive	Waukesha	WI	53188
200 Association Drive, Suite 200	Charleston	WV	25311

- Tax identification number for a corporation with an ownership or control interest in the Vendor or in a subcontractor in which the Vendor has a five (5) percent or more interest.

Information on corporations with an ownership or control interest in UniCare is provided in Table 3.1-

3. UniCare does not have ownership interest in a subcontractor.

- Whether the person (individual or corporation) with ownership or control interest in the Vendor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

UNICARE National Services, Inc. is a wholly-owned direct subsidiary of its direct parent, Anthem Holding Corp. Anthem Holding Corp. is a wholly-owned direct subsidiary of its direct parent, Anthem, Inc.

- The name of any other organization in which a person with ownership or control interest in the Vendor also has an ownership or control interest.

Anthem, Inc. has ownership, control interest, or otherwise conducts managed care business through the following subsidiaries and their affiliates as reflected in Table 3.1-5.

Table 3.1-5. Anthem's Ownership, Control Interest, or Managed Care Business Through Subsidiaries and Affiliates

American Imaging Management, Inc.	CareMore, LLC	Living Complete Technologies, Inc.
America's 1st Choice of South Carolina, Inc.	CCHA, LLC	Matthew Thornton Health Plan, Inc.
America's Health Management Services, Inc.	Cerulean Companies, Inc.	MCS Holdings, Inc.
AMERIGROUP Community Care of New Mexico, Inc.	Claim Management Services, Inc.	Memphis Supportive Care Partnership, LLC
AMERIGROUP Corporation	Community Care Health Plan of Louisiana, Inc.	Meridian Resource Company, LLC
Amerigroup Delaware, Inc.	Community Care Health Plan of Nevada, Inc.	Missouri Care, Incorporated
Amerigroup District of Columbia, Inc.	Community Insurance Company	Momentum Health Partners, LLC
Amerigroup Health Plan of Louisiana, Inc.	CompCare Health Services Insurance Corporation	Nash Holding Company, LLC
Amerigroup Insurance Company	Crossroads Acquisition Corp.	National Account Service Company, LLC
Amerigroup Iowa, Inc.	DBG Holdings, Inc.	National Government Services, Inc.
Amerigroup IPA of New York, LLC	DeCare Analytics, LLC	National Telehealth Network, LLC
Amerigroup Kansas, Inc.	DeCare Dental Health International, LLC	New England Research Institutes, Inc.
AMERIGROUP Maryland, Inc.	DeCare Dental Insurance Ireland, Ltd.	NGS Federal, LLC
Amerigroup Mississippi, Inc.	DeCare Dental Networks, LLC	Optimum Healthcare, Inc.

AMERIGROUP New Jersey, Inc.	DeCare Dental, LLC	Park Square Holdings, Inc.
AMERIGROUP Ohio, Inc.	DeCare Operations Ireland, Limited	Park Square I, Inc.
Amerigroup Oklahoma Inc.	Delivery Network, LLC	Park Square II, Inc.
Amerigroup Partnership Plan, LLC	Designated Agent Company, Inc.	Pasteur Medical Bird Road, LLC
Amerigroup Pennsylvania, Inc.	EasyScripts Cutler Bay, LLC	Pasteur Medical Center, LLC
AMERIGROUP Tennessee, Inc.	EasyScripts Hialeah, LLC	Pasteur Medical Cutler Bay, LLC
AMERIGROUP Texas, Inc.	EasyScripts Westchester, LLC	Pasteur Medical Group, LLC
AMERIGROUP Washington, Inc.	EasyScripts, LLC	Pasteur Medical Hialeah Gardens, LLC
AMGP Georgia Managed Care Company, Inc.	EHC Benefits Agency, Inc.	Pasteur Medical Holdings, LLC
AMH Health Plans of Maine, Inc.	Empire HealthChoice Assurance, Inc.	Pasteur Medical Kendall, LLC
AMH Health, LLC	Empire HealthChoice HMO, Inc.	Pasteur Medical Management, LLC
Angel Care Health Networks, LLC	Federal Government Solutions, LLC	Pasteur Medical Miami Gardens, LLC
Anthem Blue Cross Life and Health Insurance Company	Freedom Health, Inc.	Pasteur Medical North Miami Beach, LLC
Anthem Financial, Inc.	GeriNet Physician Services, Inc.	Pasteur Medical Partners, LLC
Anthem Health Plans of Kentucky, Inc.	Global TPA, LLC	Physicians Immediate Care LLC
Anthem Health Plans of Maine, Inc.	Golden West Health Plan, Inc.	Preferred Diagnostic Imaging, LLC
Anthem Health Plans of New Hampshire, Inc.	Greater Georgia Life Insurance Company	PriMed Management Consulting Services, Inc.
Anthem Health Plans of Virginia, Inc.	GRID Dental Corporation	Resolution Health, Inc.
Anthem Health Plans, Inc.	Health Core, Inc.	RightCHOICE Managed Care, Inc.
Anthem Holding Corp.	Health Management Corporation	Rocky Mountain Hospital and Medical Service, Inc.
Anthem Innovation Israel, Ltd.	Health Ventures Partner, L.L.C.	SellCore, Inc.
Anthem Insurance Companies, Inc.	HealthKeepers, Inc.	Simply Healthcare Plans, Inc.
Anthem Kentucky Managed Care Plan, Inc.	HealthLink HMO, Inc.	Pursuant Health, Inc.
Anthem Life & Disability Insurance Company	HealthLink Insurance Company	Southeast Services, Inc.
Anthem Life Insurance Company	HealthLink, Inc.	State Sponsored Services, Inc.
Anthem Partnership Holding Company, LLC	HealthPlus HP, LLC	The Anthem Companies of California, Inc.
Anthem Services Company, LLC	HealthSun Health Plans, Inc.	The Anthem Companies, Inc.
Anthem Southeast, Inc.	HealthSun Holdings, LLC	TrustSolutions, LLC
Anthem UM Services, Inc.	HealthSun Management, LLC	UNICARE Health Plan of West Virginia, Inc.
Anthem Workers' Compensation, LLC	HealthSun Physicians Network I, LLC	UNICARE Illinois Services, Inc.
APC PASSE, LLC	HealthSun Physicians Network, LLC	UniCare Life & Health Insurance Company
Applied Pathways LLC	Healthy Alliance Life Insurance Company	UNICARE National Services, Inc.
Arcus Enterprises, Inc.	HEP AP Holdings, Inc.	UniCare Specialty Services, Inc.
Aspire Health, Inc.	Highland Acquisition Holdings, LLC	Valus, Inc.
Associated Group, Inc.	Highland Holdeo, Inc.	WellCare of Nebraska, Inc.
ATH Holding Company, LLC	Highland Intermediate Holdings, LLC	Wellmax Health Medical Centers, LLC
Availity, L.L.C.	Highland Investor Holdings, LLC	Wellmax Health Physicians Network, LLC

BCS Financial Corporation	Highway to Health, Inc.	WellPoint Acquisition, LLC
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	HMO Colorado, Inc.	WellPoint California Services, Inc.
Blue Cross Blue Shield of Wisconsin	HMO Missouri, Inc.	WellPoint Dental Services, Inc.
Blue Cross of California	Imaging Management Holdings, LLC	WellPoint Health Solutions, Inc.
Blue Cross of California Partnership Plan, Inc.	IngenioRx, Inc.	WellPoint Holding Corp.
CareMarket, Inc.	Legato Health Technologies LLP	WellPoint Information Technology Services, Inc.
CareMore Health Plan	Legato Health Technologies Philippines, Inc.	WellPoint Insurance Services, Inc.
CareMore Health Plan of Arizona, Inc.	Legato Holdings I, Inc.	WellPoint Military Care Corporation
CareMore Health Plan of Nevada	Legato Holdings II, LLC	Wisconsin Collaborative Insurance Company
CareMore Health Plan of Texas, Inc.	Linkwell Health, Inc.	WPMI, LLC
CareMore Health System		

Additionally, two institutional investors, BlackRock, Inc. and The Vanguard Group, Inc., own shares in Anthem, Inc. Each has filed a Form 13F and/or Schedule 13G with the SEC to identify its holdings as an institutional investment manager and noted that the share purchases were acquired and are held in the ordinary course of business and were not acquired and are not held for the purpose of or with the effect of changing or influencing the control of the issuer of the securities. Therefore, as independent institutional investment managers with no direct relationship to our company and the fact that they have acquired Anthem, Inc. shares for investment purposes, we do not know and are unable to discover whether they own interest in any other disclosing entities, fiscal agents, or managed care entities.

- The Vendor should complete the Disclosure of Interested Parties to Contract Form, located at (http://www.state.wv.us/admin/purchase/VRC/Ethics_DisclosureInterestedParties_2018.pdf).

UniCare has completed the Disclosure of Interested Parties to Contract Form as located at the indicated URL. We have included the completed form with this proposal under the tab titled Disclosure of Interested Parties to Contract.

- Please describe if the Vendor has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) accreditation status, and indicate: if NCQA-accredited, its current NCQA accreditation status and its accreditation term effective dates; and if not accredited, a

statement describing whether and when NCQA accreditation status was ever denied. NCQA accreditation is required within nine (9) months of the contract effective date.

UniCare has held NCQA Health Plan accreditation since 2006, and we currently hold Commendable status. Our most recent renewal was on 9/5/2018, and it is valid until 9/5/2021. We will maintain NCQA accreditation for the life of the Contract. In addition, our organization's BH program is accredited nationally as a Managed Behavioral Healthcare Organization (MBHO) by NCQA. In 2017, UniCare received NCQA's Multicultural Health Care Distinction. UniCare currently rates as 4.0 out of 5 on NCQA's Health Plan rating scale, putting us in the top 23% of Medicaid health plans nationwide and tied for first among the MCOs in West Virginia. *As a result of our prioritization of our members' needs and preferences, UniCare is currently #1 in West Virginia Medicaid for consumer health care satisfaction in these ratings according to CAHPS® data.* For further detail, please see our response in QU001.



UniCare has never experienced a suspension, denial, or revocation of an NCQA accreditation, nor have Anthem, its subsidiaries, nor our affiliates.

1.2 Subcontractor Overview (If Applicable)

If the proposal includes the use of subcontractor(s), excluding direct-care providers, provide all relevant information regarding the profile of each subcontractor. The Vendor should provide their response as part of their bid in accordance with the template below. This section may be duplicated in its entirety, and a page created per subcontractor included.

The Vendor is NOT to change any of the pre-filled cells in the following tables.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Anthem, Inc. (Anthem)
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	35-2145715
Industry (NAICS)	524114
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Public
Number of Full-Time Employees	59,700
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	\$92.1 billion
Last Fiscal Year Company Net Income	\$3.75 billion
% of Revenue From State Government Clients in the United States	60.8%
Number of Years in Business	More than 80 through subsidiary health plans
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	29 providing Medicaid and CHIP managed care administrative and support services
Number of Employees Providing the Type of Services Specified in the RFP	7,545
Headquarters in the United States	Yes
Headquarters Mailing Address	220 Virginia Avenue Indianapolis, IN 46204
Street Address	220 Virginia Avenue Indianapolis, IN 46204

Subcontractor Overview		
Telephone Number	800-331-1476	
Fax Number	317-488-6477	
Locations in the United States	Little Rock, AR Fresno, CA Glendale, CA Newbury Park, CA Rancho Cordova, CA San Diego, CA Thousand Oaks, CA Visalia, CA Woodland Hills, CA Colorado Springs, CO Denver, CO Wallingford, CT Washington, DC Maitland, FL Miami, FL Plantation, FL Tampa, FL Atlanta, GA Augusta, GA Midland, GA Savannah, GA West Des Moines, IA Evansville, IN Indianapolis, IN Louisville, KY Baton Rouge, LA Metairie, LA Hanover, MD Eagan, MN Cary, NC Charlotte, NC Iselin, NJ Las Vegas, NV Albany, NY Astoria, NY Bronx, NY Brooklyn, NY Buffalo, NY Corona, NY Flushing, NY Hempstead, NY Jackson Heights, NY New York, NY Queens, NY South Richmond Hill, NY Staten Island, NY Smithfield, RI Columbia, SC Cordova, TN Knoxville, TN Nashville, TN Austin, TX El Paso, TX Grand Prairie, TX Houston, TX Lubbock, TX San Antonio, TX Norfolk, VA Reston, VA Richmond, VA Virginia Beach, VA Seattle, WA Eau Claire, WI Waukesha, WI Charleston, WV	
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: Anthem, Inc. (Anthem) Mailing Address: 220 Virginia Avenue Indianapolis, IN 46204 Street Address: 220 Virginia Avenue Indianapolis, IN 46204 Telephone Number: 800-331-1476 Fax Number: 317-488-6477	
Name of Contact Person for Bid	Felicia Norwood, Executive Vice President and President, Government Business Division	

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary>)²:

- The name and address of any person³ (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Shares of Anthem's common stock are publicly traded on the New York Stock Exchange under the symbol ANTM. As such, Anthem common stock may be acquired in the ordinary course of business through open market purchases. Per SEC filings, as of September 30, 2019, Anthem is aware of the following entities, listed in Table 3.1-6, that own beneficially 5% or more of the outstanding shares of Anthem's common stock. It should be noted that beneficial ownership is determined in accordance with the SEC's rules and regulations.

Table 3.1-6. Addresses and Ownership Details for Individuals or Corporations with Ownership or Control Interest in Anthem, Inc.

Entity or Individual Name (Officers and Directors of Anthem, Inc.)	Business Address	Tax ID	Percent Owned
Anthem, Inc.	Primary: 220 Virginia Avenue, Indianapolis, IN 46204 Additional locations: Anthem, Inc. and its subsidiaries have 81 offices where they serve Medicaid Members. See Table 3.1-4 on page 21.	35-2145715	N/A

² This request for information as noted on page 60 of the RFP, instructs Subcontractors to "...provide the following information in accordance with 42 CFR §455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary>)." 42 CFR §455.104(b)(1)(iii) applies to "...any subcontractor in which the disclosing entity (or fiscal agent or managed care entity [UniCare Health Plan of West Virginia, Inc.]) has a 5 percent or more interest." As indicated on page 23, UniCare does not have ownership interest in a subcontractor. However, based on the wording of DHHR's request for information as noted on page 60 of the RFP, it seems that the intent of the request for information is to apply the provisions of 42 CFR §455.104 to all Subcontractors as if the word "Subcontractor" were to take the place of "disclosing entity (or fiscal agent or managed care entity)". Our subcontractors have endeavored to provide this information accordingly throughout their responses to the Subcontractor ownership requests for information following RFP Section 3.2, Table 6: Subcontractor Overview tables. If DHHR seeks different or additional information, we will provide it upon request.

³ If 42 CFR §455.104(b)(1) and the applicable definition for "person" as found in 42 CFR §455.101, were reworded to apply to Subcontractors, then "person" under subpart (e) of that definition would include "...an officer or director of a [Subcontractor] that is organized as a corporation. As such, we have provided officer and director information for Anthem, Inc.'s officers and directors as part of Table 3.1-6.

Entity or Individual Name (Officers and Directors of Anthem, Inc.)	Business Address	Tax ID	Percent Owned
Gail Koziara Boudreaux, Director, President, and Chief Executive Officer	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Ronald Kerry Clark, Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Robert Lee Dixon, Jr., Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Lewis Hay III, Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Julie Anne Hill, Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Bahija Jallal, Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Antonio Fabio Neri, Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Ramiro Gomez Peru, Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Ryan Michael Schneider, Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Elizabeth Edith Tallett, Director and Chairperson	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
John Edward Gallina, Chief Financial Officer	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Scott Wayne Anglin, Treasurer	4425 Corporation Lane, Virginia Beach, VA 23462*	N/A	N/A
Kathleen Susan Kiefer, Corporate Secretary	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Ronald William Penczek, Chief Accounting Officer	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
BlackRock, Inc.	Primary: 40 East 52 nd Street, New York, NY 10022 Additional locations: BlackRock has 70 offices in 30 countries. U.S. locations are in: Newport Beach, CA; Palo Alto, CA; San Francisco, CA; Santa Monica, CA; Denver, CO; Greenwich, CT; Boca Raton, FL; Miami, FL; Ponte Vedra Beach, FL; Atlanta, GA; Chicago, IL; Boston, MA; Bloomfield Hills, MI; Princeton, NJ; New York, NY; Charlotte, NC; Philadelphia, PA; Pittsburgh, PA; Dallas, TX; Houston, TX; Seattle, WA Non-U.S. locations can be found at: https://www.blackrock.com/corporate/about-us/contacts-locations	32-0174431	8.97%
The Vanguard Group, Inc.	Primary: P.O. Box 2600, Valley Forge, PA 19482 Additional locations: The Vanguard Group, Inc. has four locations in the United States and 14 international offices in 11 countries. U.S. locations are in: Scottsdale, AZ; Washington, D.C.; Charlotte, NC; and Valley Forge, PA	23-1945930	7.78%

*For officers and directors of Anthem, Inc., addresses provided reflect business addresses of the individuals. Pursuant to DHHR's response to Q066, personal addresses will be made available to DHHR upon request post award.

Shares of Anthem, Inc.'s (Anthem's) common stock are publicly traded on the New York Stock Exchange under the symbol ANTM. As such, Anthem common stock may be acquired in the ordinary

course of business through open market purchases. Per SEC filings, as of September 30, 2019, Anthem is aware of BlackRock, Inc. and The Vanguard Group, Inc., noted in Table 3.1-6, that own beneficially 5% or more of the outstanding shares of Anthem's common stock. It should be noted that beneficial ownership is determined in accordance with the SEC's rules and regulations.

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Information on corporations with an ownership or control interest in Anthem, Inc. is provided in Table 3.1-6.

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

Anthem, Inc. is unaware of any such relationship.

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

Each of the entities listed previously has filed a Form 13F and/or Schedule 13G with the SEC to identify its holdings as an institutional investment manager. If any of these entities had acquired 5% or more of Anthem's common stock other than for investment purposes, such entity would be required to file a Form 13D with the SEC within 10 days of such acquisition. Therefore, to Anthem's knowledge, the entities listed previously have acquired Anthem's common stock for investment purposes only.

Because these are independent institutional investment managers, Anthem is unaware of and unable to discover whether they own interest in any other disclosing entities, fiscal agents, managed care entities, or in any other organizations.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Advanced Medical Reviewers, LLC (AMR)
Name of Parent Company (If Applicable)	ExamWorks, LLC
Tax Identification Number	59-3791598
Industry (NAICS)	621999
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	74
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	\$1.3 billion
Last Fiscal Year Company Net Income	\$222.2 million
% of Revenue From State Government Clients in the United States	<1%
Number of Years in Business	15
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	15
Number of Employees Providing the Type of Services Specified in the RFP	40
Headquarters in the United States	Yes
Headquarters Mailing Address	600 Corporate Pointe, Suite 300 Culver City, CA 90230
Street Address	600 Corporate Pointe, Suite 300 Culver City, CA 90230
Telephone Number	800-726-1207
Fax Number	310-470-4717
Locations in the United States	Culver City, CA
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: same as above Mailing Address: Street Address: Telephone Number: Fax Number:
Name of Contact Person for Bid	Amanda Markle, VP Strategic Partnerships

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary>):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Table 3.1-7. Addresses and Ownership Details for Individuals or Corporations with Ownership or Control Interest in AMR

Entity Name	Business Address	Percent Owned
ExamWorks, LLC	Primary: 3280 Peachtree Road NE, Suite 2625, Atlanta, GA 30305 Additional locations: Anchorage, AK; Scottsdale, AZ; Long Beach, CA; Corona, CA; Modesto, CA; Stockton, CA; Anaheim, CA; San Francisco, CA; Moreno Valley, CA; Los Angeles, CA; Glendale, CA; Bakersfield, CA; West Covina, CA; Elk Grove, CA; Sacramento, CA; Rancho Cordova, CA; Van Nuys, CA; Oakland, CA; Clovis, CA; Castroville, CA; Campbell, CA; Albany, CA; Chico, CA; Redding, CA; Santa Rosa, CA; Oldsmar, FL; Boca Raton, FL; Atlanta, GA; Rockford, IL; Fall River, MA; Woburn, MA; Waite Park, MN; Duluth, MN; St. Louis Park, MN; Roseland, NJ; Mt. Laurel, NJ; New York, NY; Garden City, NY; East Syracuse, NY; Woodbury, NY; Dublin, OH; Bend, OR; Salem, OR; Eugene, OR; Medford, OR; Portland, OR; Pendleton, OR; Bala Cynwyd, PA; New Holland, PA; Allentown, PA; Hazleton, PA; Dallas, TX; Austin, TX; Harlingen, TX; Houston, TX; Renton, WA; Everett, WA; Spokane Valley, WA; Yakima, WA; Wenatchee, WA; Tacoma, WA; Seattle, WA; Kennewick, WA; Aberdeen, WA; Puyallup, WA; Federal Way, WA; Tukwila, WA; Olympia, WA; Bellevue, WA; Vancouver, WA; Port Angeles, WA; Bellingham, WA; Bremerton, WA; Longview, WA; Mt. Vernon, WA; Wausau, WI; Eau Claire, WI; Brookfield, WI; Madison, WI	100%

Non-U.S. locations can be found at:
<https://www.examworks.com/service-centers>

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

ExamWorks — 26-1114252

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

None of the entities listed previously are related to any other person with ownership or control or interest in Advanced Medical Reviewers, LLC.

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Table 6: Subcontractor Overview

Subcontractor Overview		
Corporate (Legal) Name	Exela Technologies, Inc. (Exela)	
Name of Parent Company (If Applicable)	N/A	
Tax Identification Number	47-1347291	
Industry (NAICS)	323111, 323120, 493190, 518210, 541513, 541611, 541690, 561410, 561499, 561990	
Type of Legal Entity	Corporation	
Company Ownership (e.g., Private/Public, Joint Venture)	Public	
Number of Full-Time Employees	22,000	
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	\$1.586 billion	
Last Fiscal Year Company Net Income	(\$162.5 million)	
% of Revenue From State Government Clients in the United States	7% (includes federal and State)	
Number of Years in Business	More than 30	
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	More than 20	
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 4,500	
Headquarters in the United States	Yes	
Headquarters Mailing Address	2701 East Grauwlyer Road Irving, TX 75061	
Street Address	2701 East Grauwlyer Road Irving, TX 75061	
Telephone Number	844-935-2832	
Fax Number	248-524-7561	
Locations in the United States	Georgiana, AL Brinkley, AR Phoenix, AZ Chico, CA Carson, CA Ontario, CA Mt Vernon, KY Medford, MA Norwood, MA Livonia, MI Troy, MI Charlotte, NC	

Subcontractor Overview		
	Sacramento, CA San Francisco, CA San Jose, CA Englewood, CO Windsor, CT Tampa, FL Atlanta, GA Columbus, GA Forest Park, GA Urbandale, IA Naperville, IL Rantoul, IL London, KY Louisville, KY	Lawrenceville, NJ Rochelle Park, NJ Las Vegas, NV Binghamton, NY New York, NY Pittsburg, PA Columbia, SC Sioux Falls, SD Amarillo, TX Austin, TX El Paso, TX Fort Worth, TX Irving, TX Salt Lake City, UT
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: same as above Mailing Address: Street Address: Telephone Number: Fax Number:	
Name of Contact Person for Bid	Christy Hudson, Director, Customer Relationship Management	

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary>):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Shares of Exela's common stock are publicly traded on the New York Stock Exchange under the symbol XELA. As such, Exela's common stock may be acquired in the ordinary course of business through open market purchases. Per Exela's 2019 Proxy Statement dated April 30, 2019, Exela is aware of the following entities, listed in Table 3.1-8, that own beneficially 5% or more of the outstanding shares of Exela's common stock. It should be noted that beneficial ownership is determined in accordance with the SEC's rules and regulations.

Table 3.1-8. Addresses and Ownership Details for Individuals or Corporations with Ownership or Control Interest in Exela Technologies, Inc. (Exela)

Entity or Individual Name	Business Address	Tax ID	Percent Owned
Exela Technologies, Inc.	2701 East Grauwyler Road, Irving, TX 75061	47-1347291	N/A
Ronald Cogburn, Chief Executive Officer	2701 East Grauwyler Road, Irving, TX 75061*	N/A	N/A
James Reynolds, Chief Financial Officer	2701 East Grauwyler Road, Irving, TX 75061*	N/A	N/A
Suresh Yannamani, President	2701 East Grauwyler Road, Irving, TX 75061*	N/A	N/A
Mark Fairchild, President Exela Smart Office	2701 East Grauwyler Road, Irving, TX 75061*	N/A	N/A
Shrikant Sortur, Executive Vice President, Global Finance	2701 East Grauwyler Road, Irving, TX 75061*	N/A	N/A
Srini Murali, President Americas and APAC	2701 East Grauwyler Road, Irving, TX 75061*	N/A	N/A
Vitalie Robu, President EMEA	2701 East Grauwyler Road, Irving, TX 75061*	N/A	N/A
Various entities affiliated with Ex-Sigma 2, LLC	3003 Pennsylvania Ave, Santa Monica, CA 90404	82-2061853	52.9%
Various entities affiliated with Apollo Novitex Holdings, L P	9 West 57 th Street, 43 rd Floor, New York, NY 10019	38-3914258	18.4%
Nantahala Capital Management, LLC	19 Old Kings Highway S, Suite 200, Darien, CT 06820	20-1151760	5.4%

**For officers and directors of Exela Technologies, Inc., addresses provided reflect business addresses of the individuals. Pursuant to DHHR's response to Q066, personal addresses will be made available to DHHR upon request post award.*

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Information on corporations with an ownership or control interest in Exela Technologies, Inc. is provided in Table 3.1-8.

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

None of the entities listed previously are related to any other person with ownership or control or interest in Exela Technologies, Inc.

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

Three of the entities listed previously have filed a Schedule 13D and/or Schedule 13G with the SEC to identify its holdings as a beneficial owner as noted in p. 21 of Exela's 2019 Proxy Statement and summarized in Table 3.1-9.

Table 3.1-9. Entities with Ownership and Control Interest for Exela

Entity Name	Other Organizations Exela's 5% or Greater Beneficial Owners Also Have Ownership and Control Interest Within as Noted in Schedule 13D/G Filings
Various entities affiliated with Ex-Sigma 2, LLC	Information based on Amendment Number 2 to Schedule 13D, filed with the SEC on June 20, 2018, by HOVS LLC, HandsOn Fund 4 I LLC, HOV Capital III LLC, HOV Services Ltd., Adesi 234 LLC, HOF 2 LLC, Ex-Sigma 2 LLC, Ex-Sigma LLC, HandsOn Global Management LLC, and Par Chadha (collectively, the "HGM Reporting Persons"). Ex-Sigma LLC ("Ex-Sigma") is the sole equity holder of Ex-Sigma 2, LLC ("Ex-Sigma 2"), a Delaware limited liability company, HOVS LLC, a Delaware limited liability company ("HOVS"), HandsOnFund 4 I LLC, a Nevada limited liability company ("HOF 4"), HOV Capital III, LLC, a Nevada limited liability company ("HOV 3"), each directly own interests in Ex-Sigma. Adesi 234 LLC, a Nevada limited liability company ("Adesi"), and HOF 2 LLC, a Nevada limited liability company ("HOF 2"), together own a majority of the equity interests of HOV 3.
Various entities affiliated with Apollo Novitex Holdings, L.P.	Information based on Amendment Number 2 to Schedule 13D (the "13D"), filed with the SEC on April 11, 2018, relating to securities held of record by Apollo Novitex Holdings, L.P., a Delaware limited partnership ("Novitex Holdings"). Novitex Parent GP, LLC ("Novitex GP") is the general partner of Novitex Holdings. Apollo Management VII, L.P. ("Management VII") is the manager of Novitex GP, and AIF VII Management, LLC ("AIF VII LLC") is the general partner of Management VII. Apollo Management, L.P. ("Apollo Management") is the sole member-manager of AIF VII LLC, and Apollo Management GP, LLC ("Apollo Management GP") is the general partner of Apollo Management. Apollo Management Holdings, L.P. ("Management Holdings") is the sole member-manager of Apollo Management GP, and Apollo Management Holdings GP, LLC ("Management Holdings GP") is the general partner of Management Holdings.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	IngenioRx, Inc. (IngenioRx)
Name of Parent Company (If Applicable)	DBG Holdings, Inc. is IngenioRx's direct parent. Anthem, Inc. is IngenioRx's indirect and ultimate parent company.
Tax Identification Number	82-3062245
Industry (NAICS)	446110
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	IngenioRx, Inc. is a privately held corporation as is IngenioRx's direct parent, DBG Holdings, Inc. IngenioRx's ultimate parent, Anthem, Inc. is a publicly traded corporation.
Number of Full-Time Employees	1,770
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	\$92.1 billion ⁴
Last Fiscal Year Company Net Income	\$3.75 billion ⁴
% of Revenue From State Government Clients in the United States	60.8% ⁴
Number of Years in Business	<1
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	25 ⁵
Number of Employees Providing the Type of Services Specified in the RFP	20
Headquarters in the United States	Yes
Headquarters Mailing Address	220 Virginia Avenue Indianapolis, IN 46204

⁴ As a wholly owned subsidiary of its ultimate parent, Anthem, Inc., IngenioRx's financial data as reflected above is noted in the 10-K filings for Anthem, Inc. As with UniCare, IngenioRx has the full financial backing and support of Anthem, Inc.

⁵ IngenioRx is a new company and a new name, but the people supporting the business and the programs offered are the same that have supported Anthem members' pharmacy needs for years. IngenioRx is staffed by a team with more than 30 years of pharmacy benefits experience and with over 25 years of experience in the Medicaid space. IngenioRx also has a leadership team with more than 100 years of combined experience in the Pharmacy Benefit Partner industry. IngenioRx has approximately 15 million members with pharmacy benefits across all lines of business. Their Medicaid members make up nearly 40% of IngenioRx covered lives. For Medicaid, as of third quarter 2019, the organization served nearly six million members with pharmacy benefits in 17 markets. This experience includes managing medical injectable (physician-administered) prior authorizations and management of clinical programs.

Subcontractor Overview	
Street Address	2 Speedwell Avenue Morristown, NJ 07960
Telephone Number	833-822-0261
Fax Number	314-923-5078
Locations in the United States	Atlanta, GA Chicago, IL Las Vegas, NV Louisville, KY Mason, OH Minnetonka, MN Morristown, NJ St. Louis, MO Virginia Beach, VA Wallingford, CT
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: same as above Mailing Address: Street Address: Telephone Number: Fax Number:
Name of Contact Person for Bid	Mike Napolitano, VP Pharmacy Sales/Account Management IngenioRx

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary>):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Table 3.1-10. Addresses and Ownership Details for Individuals or Corporations with Ownership or Control Interest in IngenioRx

Entity or Individual Name (Officers and Directors of IngenioRx, Inc.)	Business Address	Tax ID	Percent Owned
IngenioRx, Inc.	Headquarters Mailing Address: 220 Virginia Avenue, Indianapolis, IN 46204 Street Address: 2 Speedwell Avenue, Morristown, NJ 07960	82-3062245	N/A
Carolyn Bielefeld Caldwell, Director	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Sidney Owen Hunt, Director and Assistant Secretary	2015 Staples Mill Road, Richmond, VA 23230*	N/A	N/A
Deepti Jain, Director and President	450 Headquarters Plaza, East Tower, 7 th Floor, Morristown, NJ 07960*	N/A	N/A
Kathleen Susan Kiefer, Secretary	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A

Entity or Individual Name (Officers and Directors of IngenioRx, Inc.)	Business Address	Tax ID	Percent Owned
Vincent Edward Scher, Treasurer	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
Eric Kenneth Noble, Assistant Treasurer	220 Virginia Avenue, Indianapolis, IN 46204*	N/A	N/A
DBG Holdings, Inc.	220 Virginia Avenue, Indianapolis, IN 46204*	82-3027094	100% direct
Anthem, Inc.	Primary: 220 Virginia Avenue, Indianapolis, IN 46204 Additional locations: Anthem, Inc. and its subsidiaries have 81 offices where they serve Medicaid Members. See Table 3.1-4 on page 21.	35-2145715	100% indirect
BlackRock, Inc.	Primary: 40 East 52 nd Street, New York, New York 10022 Additional locations: BlackRock has 70 offices in 30 countries. U.S. locations are in: Newport Beach, CA; Palo Alto, CA; San Francisco, CA; Santa Monica, CA; Denver, CO; Greenwich, CT; Boca Raton, FL; Miami, FL; Ponte Vedra Beach, FL; Atlanta, GA; Chicago, IL; Boston, MA; Bloomfield Hills, MI; Princeton, NJ; New York, NY; Charlotte, NC; Philadelphia, PA; Pittsburgh, PA; Dallas, TX; Houston, TX; Seattle, WA Non-U.S. locations can be found at: https://www.blackrock.com/corporate/about-us/contacts-locations	32-0174431	8.97% indirect (8.97% direct of Anthem, Inc.)
The Vanguard Group, Inc.	Primary: P.O. Box 2600, Valley Forge, Pennsylvania 19482 Additional locations: The Vanguard Group, Inc. has four locations in the United States and 14 international offices in 11 countries. U.S. locations are in: Scottsdale, AZ; Washington, D.C.; Charlotte, NC; and Valley Forge, PA	23-1945930	7.78% indirect (7.78% direct of Anthem, Inc.)

**For officers and directors of IngenioRx, Inc., addresses provided reflect business addresses of the individuals. Pursuant to DHHR's response to Q066, personal addresses will be made available to DHHR upon request post award.*

Shares of Anthem's common stock are publicly traded on the New York Stock Exchange under the symbol ANTM. As such, Anthem common stock may be acquired in the ordinary course of business through open market purchases. Per SEC filings, as of September 30, 2019, Anthem is aware of BlackRock, Inc. and The Vanguard Group, Inc., noted in Table 3.1-10, that own beneficially 5% or more of the outstanding shares of Anthem's common stock. It should be noted that beneficial ownership is determined in accordance with the SEC's rules and regulations.

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Information on corporations with an ownership or control interest in IngenioRx is provided in Table 3.1-10.

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

IngenioRx, Inc. (IngenioRx) is a wholly-owned subsidiary of its direct parent, DBG Holdings, Inc. DBG Holdings, Inc. is a wholly-owned subsidiary of its direct parent, Anthem, Inc. Therefore, Anthem, Inc., IngenioRx's ultimate parent, is a 100% indirect owner of IngenioRx.

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

Anthem, Inc. has ownership, control interest, or otherwise conducts managed care business through the following subsidiaries and their affiliates as reflected in Table 3.1-11.

Table 3.1-11. Anthem's Ownership, Control Interest, or Managed Care Business Through Subsidiaries and Affiliates

American Imaging Management, Inc.	CareMore, LLC	Living Complete Technologies, Inc.
America's 1st Choice of South Carolina, Inc.	CCHA, LLC	Matthew Thornton Health Plan, Inc.
America's Health Management Services, Inc.	Cerulean Companies, Inc.	MCS Holdings, Inc.
AMERIGROUP Community Care of New Mexico, Inc.	Claim Management Services, Inc.	Memphis Supportive Care Partnership, LLC
AMERIGROUP Corporation	Community Care Health Plan of Louisiana, Inc.	Meridian Resource Company, LLC
Amerigroup Delaware, Inc.	Community Care Health Plan of Nevada, Inc.	Missouri Care, Incorporated
Amerigroup District of Columbia, Inc.	Community Insurance Company	Momentum Health Partners, LLC
Amerigroup Health Plan of Louisiana, Inc.	CompCare Health Services Insurance Corporation	Nash Holding Company, LLC
Amerigroup Insurance Company	Crossroads Acquisition Corp.	National Account Service Company, LLC
Amerigroup Iowa, Inc.	DBG Holdings, Inc.	National Government Services, Inc.
Amerigroup IPA of New York, LLC	DeCare Analytics, LLC	National Telehealth Network, LLC
Amerigroup Kansas, Inc.	DeCare Dental Health International, LLC	New England Research Institutes, Inc.
AMERIGROUP Maryland, Inc.	DeCare Dental Insurance Ireland, Ltd.	NGS Federal, LLC
Amerigroup Mississippi, Inc.	DeCare Dental Networks, LLC	Optimum Healthcare, Inc.
AMERIGROUP New Jersey, Inc.	DeCare Dental, LLC	Park Square Holdings, Inc.
AMERIGROUP Ohio, Inc.	DeCare Operations Ireland, Limited	Park Square I, Inc.
Amerigroup Oklahoma Inc.	Delivery Network, LLC	Park Square II, Inc.
Amerigroup Partnership Plan, LLC	Designated Agent Company, Inc.	Pasteur Medical Bird Road, LLC

Amerigroup Pennsylvania, Inc.	EasyScripts Cutler Bay, LLC	Pasteur Medical Center, LLC
AMERIGROUP Tennessee, Inc.	EasyScripts Hialeah, LLC	Pasteur Medical Cutler Bay, LLC
AMERIGROUP Texas, Inc.	EasyScripts Westchester, LLC	Pasteur Medical Group, LLC
AMERIGROUP Washington, Inc.	EasyScripts, LLC	Pasteur Medical Hialeah Gardens, LLC
AMGP Georgia Managed Care Company, Inc.	EHC Benefits Agency, Inc.	Pasteur Medical Holdings, LLC
AMH Health Plans of Maine, Inc.	Empire HealthChoice Assurance, Inc.	Pasteur Medical Kendall, LLC
AMH Health, LLC	Empire HealthChoice HMO, Inc.	Pasteur Medical Management, LLC
Angel Care Health Networks, LLC	Federal Government Solutions, LLC	Pasteur Medical Miami Gardens, LLC
Anthem Blue Cross Life and Health Insurance Company	Freedom Health, Inc.	Pasteur Medical North Miami Beach, LLC
Anthem Financial, Inc.	GeriNet Physician Services, Inc.	Pasteur Medical Partners, LLC
Anthem Health Plans of Kentucky, Inc.	Global TPA, LLC	Physicians Immediate Care LLC
Anthem Health Plans of Maine, Inc.	Golden West Health Plan, Inc.	Preferred Diagnostic Imaging, LLC
Anthem Health Plans of New Hampshire, Inc.	Greater Georgia Life Insurance Company	PriMed Management Consulting Services, Inc.
Anthem Health Plans of Virginia, Inc.	GRID Dental Corporation	Resolution Health, Inc.
Anthem Health Plans, Inc.	Health Core, Inc.	RightCHOICE Managed Care, Inc.
Anthem Holding Corp.	Health Management Corporation	Rocky Mountain Hospital and Medical Service, Inc.
Anthem Innovation Israel, Ltd.	Health Ventures Partner, L.L.C.	SellCore, Inc.
Anthem Insurance Companies, Inc.	HealthKeepers, Inc.	Simply Healthcare Plans, Inc.
Anthem Kentucky Managed Care Plan, Inc.	HealthLink HMO, Inc.	Pursuant Health, Inc.
Anthem Life & Disability Insurance Company	HealthLink Insurance Company	Southeast Services, Inc.
Anthem Life Insurance Company	HealthLink, Inc.	State Sponsored Services, Inc.
Anthem Partnership Holding Company, LLC	HealthPlus HP, LLC	The Anthem Companies of California, Inc.
Anthem Services Company, LLC	HealthSun Health Plans, Inc.	The Anthem Companies, Inc.
Anthem Southeast, Inc.	HealthSun Holdings, LLC	TrustSolutions, LLC
Anthem UM Services, Inc.	HealthSun Management, LLC	UNICARE Health Plan of West Virginia, Inc.
Anthem Workers' Compensation, LLC	HealthSun Physicians Network I, LLC	UNICARE Illinois Services, Inc.
APC PASSE, LLC	HealthSun Physicians Network, LLC	UniCare Life & Health Insurance Company
Applied Pathways LLC	Healthy Alliance Life Insurance Company	UNICARE National Services, Inc.
Arcus Enterprises, Inc.	HEP AP Holdings, Inc.	UniCare Specialty Services, Inc.
Aspire Health, Inc.	Highland Acquisition Holdings, LLC	Valus, Inc.
Associated Group, Inc.	Highland Holdco, Inc.	WellCare of Nebraska, Inc.
ATH Holding Company, LLC	Highland Intermediate Holdings, LLC	Wellmax Health Medical Centers, LLC
Availity, L.L.C.	Highland Investor Holdings, LLC	Wellmax Health Physicians Network, LLC
BCS Financial Corporation	Highway to Health, Inc.	WellPoint Acquisition, LLC
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.	HMO Colorado, Inc.	WellPoint California Services, Inc.
Blue Cross Blue Shield of Wisconsin	HMO Missouri, Inc.	WellPoint Dental Services, Inc.

Blue Cross of California	Imaging Management Holdings, LLC	WellPoint Health Solutions, Inc.
Blue Cross of California Partnership Plan, Inc.	IngenioRx, Inc.	WellPoint Holding Corp.
CareMarket, Inc.	Legato Health Technologies LLP	WellPoint Information Technology Services, Inc.
CareMore Health Plan	Legato Health Technologies Philippines, Inc.	WellPoint Insurance Services, Inc.
CareMore Health Plan of Arizona, Inc.	Legato Holdings I, Inc.	WellPoint Military Care Corporation
CareMore Health Plan of Nevada	Legato Holdings II, LLC	Wisconsin Collaborative Insurance Company
CareMore Health Plan of Texas, Inc.	Linkwell Health, Inc.	WPML, LLC
CareMore Health System		

Additionally, two institutional investors, BlackRock, Inc. and The Vanguard Group, Inc., own shares in Anthem, Inc. Each has filed a Form 13F and/or Schedule 13G with the SEC to identify its holdings as an institutional investment manager and noted that the share purchases were acquired and are held in the ordinary course of business and were not acquired and are not held for the purpose of or with the effect of changing or influencing the control of the issuer of the securities. Therefore, as independent institutional investment managers with no direct relationship to our company and the fact that they have acquired Anthem, Inc. shares for investment purposes, we do not know and are unable to discover whether they own interest in any other disclosing entities, fiscal agents, or managed care entities.

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	SKYGEN USA, LLC (SKYGEN)
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	81-0762694
Industry (NAICS)	524292
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	Approximately 600
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	\$95.6 million
Last Fiscal Year Company Net Income	\$6.3 million
% of Revenue From State Government Clients in the United States	3.3%
Number of Years in Business	25
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	25
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 600
Headquarters in the United States	Yes
Headquarters Mailing Address	W140 N8981 Lilly Road Menomonee Falls, WI 53051
Street Address	W140 N8981 Lilly Road Menomonee Falls, WI 53051
Telephone Number	262-946-4400
Fax Number	262-347-3219
Locations in the United States	Menomonee Falls, WI Mequon, WI
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: same as above Mailing Address: Street Address: Telephone Number: Fax Number:
Name of Contact Person for Bid	Mark Dasek, Executive, Client Experience

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary>):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Table 3.1-12. Addresses and Ownership Details for Individuals or Corporations with Ownership or Control Interest in SKYGEN

Entity Name	Business Address	Percent Owned
Grambino Technologies, LLC	Primary: 10201 North Port Washington Road, Mequon, WI 53092 No additional business locations	37.5%
MOA Investments, LLC	Primary: 26119 Kingsgate Lane, Katy, TX 77494 No additional business locations	37.5%
Scion Holdings, Inc.	Primary: N92 W14612 Anthony Avenue, Menomonee Falls, WI 53051 No additional business locations	25.0%

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Grambino Technologies, LLC — 20-8448188

MOA Investments, LLC — 39-01865244

Scion Holdings, Inc. — 82-3326543

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

None of the entities listed previously are related to any other person with ownership or control or interest in SKYGEN USA, LLC.

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)
Name of Parent Company (If Applicable)	NewCo Guarantor, LLC
Tax Identification Number	46-4593394
Industry (NAICS)	541511
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	726
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	\$30,950,209
Last Fiscal Year Company Net Income	As a privately held company, SPH Analytics does not provide its financial statements.
% of Revenue From State Government Clients in the United States	<10%
Number of Years in Business	36
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	36
Number of Employees Providing the Type of Services Specified in the RFP	Approximately 625
Headquarters in the United States	Yes
Headquarters Mailing Address	11605 Haynes Bridge Road, Suite 400 Alpharetta, GA 30009
Street Address	11605 Haynes Bridge Road, Suite 400 Alpharetta, GA 30009
Telephone Number	866-460-5681
Fax Number	770-623-4075
Locations in the United States	Branford, CT Alpharetta, GA Duluth, GA Farmington Hills, MI Fort Worth, TX Arlington, VA

Subcontractor Overview	
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: same as above Mailing Address: Street Address: Telephone Number: Fax Number:
Name of Contact Person for Bid	Midge Coker, Strategic Account Executive

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary>):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Table 3.1-13. Addresses and Ownership Details for Individuals or Corporations with Ownership or Control Interest in SPH

Entity Name	Business Address	Percent Owned
Symphony Performance Health Holdings, Inc.	11605 Haynes Bridge Road, Suite 400, Alpharetta, GA 30009	100%

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Symphony Performance Health Holdings, Inc. — 46-4600805

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

None of the entities listed previously are related to any other person with ownership or control or interest in Symphony Performance Health, Inc. d/b/a SPH Analytics.

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Vision Service Plan Insurance Company (VSP)
Name of Parent Company (If Applicable)	N/A
Tax Identification Number	06-1227840
Industry (NAICS)	524114
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	2,600
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	\$4.8 billion
Last Fiscal Year Company Net Income	\$163 million
% of Revenue From State Government Clients in the United States	9.04%
Number of Years in Business	63
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	63, with 25 managing Medicaid business
Number of Employees Providing the Type of Services Specified in the RFP	2,600
Headquarters in the United States	Yes
Headquarters Mailing Address	3333 Quality Drive Rancho Cordova, CA 95670
Street Address	3333 Quality Drive Rancho Cordova, CA 95670
Telephone Number	800-852-7600
Fax Number	916-463-9002
Locations in the United States	Long Beach, CA Rancho Cordova, CA San Francisco, CA Denver, CO

Subcontractor Overview	
	Atlanta, GA Honolulu, HI Chicago, IL Indianapolis, IN Boston, MA
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: same as above Mailing Address: Street Address: Telephone Number: Fax Number:
Name of Contact Person for Bid	Annie Mayo, Area VP, Health & Government Markets

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary>):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Vision Service Plan Insurance Company is a not-for-profit corporation, governed by a board of directors, and has no owners, stockholders, or shareholders.

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Vision Service Plan Insurance Company — 06-1227840

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

None of the entities listed previously are related to any other person with ownership or control or interest in Vision Service Plan Insurance Company.

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

N/A

Table 6: Subcontractor Overview

Subcontractor Overview	
Corporate (Legal) Name	Wipro Limited (Wipro)
Name of Parent Company (If Applicable)	Wipro LLC
Tax Identification Number	98-0154401
Industry (NAICS)	541511
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Public
Number of Full-Time Employees	174,850
Last Fiscal Year Company Revenue (From Unaffiliated Parties)	\$8.5 billion
Last Fiscal Year Company Net Income	\$1.3 billion
% of Revenue From State Government Clients in the United States	25%
Number of Years in Business	75
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	30 years
Number of Employees Providing the Type of Services Specified in the RFP	11,500
Headquarters in the United States	2 Tower Center Boulevard, Suite 2200, East Brunswick, NJ 08816
Headquarters Mailing Address	Doddakannelli, Sarjapur Road, Bengaluru, Karnataka, 560035, India
Street Address	Doddakannelli, Sarjapur Road, Bengaluru, Karnataka, 560035, India
Telephone Number	91-80-28440011
Fax Number	91-80-28440256
Locations in the United States	Anchorage, AK Quincy, MA Bentonville, AR Franklin, TN Mountain View, CA Houston, TX Palmetto Bay, FL Plano, TX Tampa, FL Redmond, WA

Subcontractor Overview	
	Boston, MA
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	Name: same as above Mailing Address: Street Address: Telephone Number: Fax Number:
Name of Contact Person for Bid	Himanshu Shah, General Manager

The subcontractor should provide the following information in accordance with 42 CFR § 455.104 (<https://www.govinfo.gov/app/details/CFR-2007-title42-vol4/CFR-2007-title42-vol4-sec455-104/summary>):

- The name and address of any person (individual or corporation) with an ownership or control interest in the subcontractor. The address for corporate entities should include, as applicable, the primary business address, every business location, and the P.O. Box address.

Table 3.1-14. Addresses and Ownership Details for Individuals or Corporations with Ownership or Control Interest in Wipro

Entity Name	Business Address	Percent Owned
Wipro Limited	Primary: Doddakannelli, Sarjapur Road, Bengaluru — 560035 U.S. locations are in: Anchorage, AK; Bentonville, AR; Mountain View, CA; Washington, DC; Miami, FL; Tampa, FL; Atlanta, GA; Chicago, IL; Boston, MA; Troy, MI; Minneapolis, MN; East Brunswick, NJ; New York, NY; Syracuse, NY; Findlay, OH; Nashville, TN; Plano, TX; Houston, TX; Redmond, WA; Seattle, WA Non U.S. locations are in: Buenos Aires, Argentina; Caracas, Argentina; New South Wales, Australia; Vienna, Austria; Manama, Bahrain; Dhaka, Bangladesh; Curitiba, Brazil; Sao Paulo, Brazil; Calgary, Canada; Santiago, Chile; Shanghai, China; Chengdu, China; Dalian, China; Medellin, Columbia; San Jose, Costa Rica; Hellerup, Denmark; Copenhagen, Denmark; Giza, Egypt; Meerbusch, Germany; Fellbach, Germany; Munich, Germany; Berlin, Germany; Accra, Ghana; Budapest, Hungary; Bengaluru, India; New Delhi, India; Jakarta, Indonesia; Baghdad, Iraq; Shannon, Ireland; Tel Aviv, Israel; Kanagawa, Japan; Tokyo, Japan; Atyrau, Kazakhstan; Nuevo Leon, Mexico; Amsterdam, Netherlands; Lagos, Nigeria; Oslo, Norway; Muscat, Oman; Lima, Peru; Cebu, Philippines; Gdansk, Poland; Warsaw, Poland; Moreira-Maia, Portugal; Doha, Qatar; Bucharest, Romania; Moscow, Russia; Riyadh, Saudi Arabia; Cantonment, Singapore; Kuala Lumpur, Singapore; Johannesburg, South Africa; Madrid, Spain; Stockholm, Sweden; Bangkok, Thailand; Kiev, Ukraine; Berkshire, United Kingdom; London, United Kingdom	100%

- Tax identification number for a corporation with an ownership or control interest in the subcontractor or in a subcontractor in which the subcontractor has a five (5) percent or more interest.

Wipro Limited — 98-0154401

- Whether the person (individual or corporation) with ownership or control interest in the subcontractor and/or subcontractor is related to any other person with ownership or control interest, such as a spouse, parent, child, or sibling.

None of the entities listed previously are related to any other person with ownership or control or interest in Wipro Limited.

- The name of any other organization in which a person with ownership or control interest in the subcontractor also has an ownership or control interest.

The following companies are 100% owned by Wipro Limited.

Table 3.1-15. Subsidiaries and Affiliates 100% Owned by Wipro

Companies 100% Owned By Wipro Limited
Appirio GmbH; Appirio Limited; Appirio Limited; Appirio Inc.; Appirio, K.K; Cellent GmbH; Cellent GmbH; Cooper Software, LLC; Denim Group Limited; Denim Group Management, LLC; Designit A/S; Designit Colombia S A S; Designit Denmark A/S; Designit Germany GmbH (formerly known as Designit Munich GmbH); Designit Oslo A/S; Designit Peru SAC; Designit Spain Digital S.L.; Designit Sweden AB; Designit T.L.V. Limited; Designit Tokyo Co., Limited; Drivestream, Inc.; Frontworx Informationstechnologie GmbH; Healthplan Services Insurance Agency, LLC; Healthplan Services, LLC; Infocrossing, LLC; Opus Capital Market Consultants LLC; PT WT Indonesia; Rainbow Software LLC; Topcoder, LLC; Wipro (Dalian) Limited; Wipro (Thailand) Co. Limited; Wipro Arabia Co. Limited; Wipro Bahrain Limited Co. S.P.C (formerly known as Wipro Bahrain Limited WLL); Wipro Chengdu Limited; Wipro Corporate Technologies Ghana Ltd; Wipro Cyprus SE (Formerly known as Wipro Cyprus Public Limited); Wipro Digital APS; Wipro do Brasil Servicos de Tecnologia S.A (Formerly known as Infoserver SA); Wipro Do Brasil Sistemetas De Informatica Ltd; Wipro Do Brasil Tecnologia LTDA; Wipro Doha LLC; Wipro Europe Limited; Wipro Financial Services UK Limited; Wipro Gallagher Solutions, LLC; Wipro Gulf LLC; Wipro Holdings (UK) Limited; Wipro Holdings Hungary Korlátolt Felelősségű Társaság; Wipro Holdings Investment Korlátolt Felelősségű Társaság; Wipro HR Services India Private Limited (formerly known as Alight HR Services India Private Limited); Wipro Information Technology Egypt SAE; Wipro Information Technology Kazakhstan LLP; Wipro Information Technology Netherlands BV; Wipro Insurance Solutions, LLC; Wipro IT Services Poland SP Z.O.O.; Wipro IT Services S.R.L.; Wipro IT Services Bangladesh Limited; Wipro IT Services Ukraine, LLC; Wipro IT Services, LLC; Wipro Japan KK; Wipro Networks Pte Limited; Wipro Outsourcing Services (Ireland) Limited; Wipro Overseas IT Services Private Limited; Wipro Philippines, Inc. (formerly known as Wipro BPO Philippines Limited Inc.); Wipro Poland SP Z.O.O.; Wipro Portugal SA; Wipro Promax Analytics Solutions, LLC; Wipro SA Broad Based Ownership Scheme SPV (RF) (PTY) LTD; Wipro Shanghai Limited; Wipro Solutions Canada Limited; Wipro Technologies Chile SPA; Wipro Technologies Peru SAC; Wipro Technologies SA; Wipro Technologies SA DE CV; Wipro Technologies SDN BHD; Wipro Technologies SRL; Wipro Technologies Vz, C.A; Wipro Technologies W.T. Sociedad Anonima; Wipro Technologies Australia Pty Ltd; Wipro Technologies GmbH; Wipro Technologies Limited; Wipro Technologies Nigeria Limited; Wipro Technologies South Africa (Proprietary) Limited; Wipro Trademarks Holding Limited; Wipro Travel Services Limited; Wipro UK Limited; Wipro US Foundation; Women's Business Park Technologies Limited

2. Mandatory Qualifications

The Vendor must complete this section to demonstrate that it has the experience needed to meet requirements set forth in this RFP. The table below lists each mandatory qualification; the Vendor must provide narrative demonstrating fulfillment of the requirement and note the page number of its bid that provides this information. The Vendor should provide their response as part of their bid in accordance with the template below. The Vendor must list each project experience separately and completely every time it is referenced. Unless otherwise stated, requested documentation must be provided to the Department as part of the bid submission.

Table 7: Mandatory Qualifications

Mandatory Qualification Item(s)	Page Number
The Vendor must demonstrate adherence to Certificate of Authority (COA) requirements as outlined by the West Virginia (WV) Office of the Insurance Commissioner and be in good standing in West Virginia. The Vendor shall provide a copy of its COA as part of its Readiness Review documentation.	Attachment 3, Section 1.1, Page 1
The Vendor must be a NCQA-accredited entity within nine (9) months of the contract effective date, and remain so for the duration of the contract.	Attachment 3, Section 1.1, Pages 3-4
The Vendor must provide an organizational chart outlining the internal organizational structure for this project.	Attachment 4, Section 1, Pages 11-13
The Vendor must provide a description of the roles, responsibilities, and skill sets associated with each position outlined in the organizational chart.	Supplemental Document 3.2-1 Job Descriptions Pages 1-34
The Vendor must provide a summary description of individual key staff members and the experience that qualifies them for their roles in this project. If any subcontractor is leveraged, the Vendor shall describe the assurance of quality and timeliness of the work to be done.	Vendor Key Staff: Attachment 4, Section 2, Pages 3-47 Subcontractor: Attachment 4, Section 1, Pages 24-34
The Vendor must demonstrate experience within the last three (3) years as the prime contractor for at least three (3) federal, state, or private healthcare entities, in an MCO, where the proposed solution of similar scope is currently being or has been implemented.	Attachment 3, Section 1, Pages 3-19

Mandatory Qualification Item(s)	Page Number
The Vendor must demonstrate at least five (5) years' experience in Medicaid.	Attachment 3, Section 1, Pages 3-19
The Vendor must include at least three (3) references from clients served within the last three (3) years that demonstrate the Vendor's ability to perform the scope of work described in the RFP. Vendors may only use one reference per client served. The Department requests three (3) references from different state engagements where the proposed approach is currently in progress or has been implemented.	Attachment 3, Section 5.1, Pages 2-15
The Vendor must have at least three (3) years' experience implementing the proposed approach with an organization similar scope to the State, in an MCO capacity.	Attachment 3, Section 1, Pages 3-19

Supplemental Document 3.2-1: Job Descriptions

Role	Description of Responsibilities	Skill Sets
Chief Executive Officer/Chief Operating Officer	The Chief Executive Officer (CEO) or Chief Operating Officer (COO) is a key staff position and will continue to be throughout the entire contract term. This position is authorized and empowered to make contractual, operational, and financial decisions for the contract, related to business, claims payment, provider relations/contracting, and all other functions of the Vendor. The CEO or COO position is a direct employee of UniCare. The CEO or COO: • Attends in person, upon DHHR request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. • Establishes and maintains a positive client relationship • Makes contractual, operational, and financial decisions on behalf of the Vendor • Oversees and provides overarching contract oversight for the Vendor	At least 10 years' experience in Medicaid managed care oversight and operations; and 10 years' experience in health care administration and operations. Bachelor's degree or higher. Based in West Virginia.
Contract Liaison/MHT Administrator	The Contract Liaison/MHT Administrator is a key staff position and will continue to be throughout the entire contract term. This position is responsible for overall delivery of the project. This individual serves as a liaison with DHHR during all phases of the contract. The Contract Liaison/MHT Administrator also attends in person, upon Department request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers; and establishes and maintains a positive client relationship. Duties also include: • Provides timely and informed responses to operational and administrative inquiries that arise • Meets with DHHR staff or such other person(s) as designated by DHHR on a regular basis to provide oral and written status reports and other information as required • Able to respond to issues involving information systems and reporting, appeals, quality improvement, member services,	At least five years' experience in Medicaid managed care contract oversight. Five years' experience in health care, experience working with low-income populations, and cultural sensitivity. Bachelor's degree or higher. Based in West Virginia.

Role	Description of Responsibilities	Skill Sets
	service management, pharmacy management, medical management, and care coordination Ensures that each member has an ongoing source of care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member	
Chief Financial Officer	The Chief Financial Officer (CFO) is a key staff position and will continue to be throughout the entire contract term. This position oversees all financial activities of the project. The CFO also oversees the Vendor's provider payment arrangements, including Alternative Payment Models (APMs). This role also signs data certification forms, including, at a minimum, all encounter data and financial data and reporting for payments to contracted providers. Other duties include certifying payment information to be used for rate-setting purposes or any payment-related data required by DHHR.	At least five years' experience serving as a financial lead for a managed care entity or other health insurance provider. Bachelor's degree or higher.
Compliance Officer	The Compliance Officer is a key staff position and will continue to be throughout the entire contract term. This position is responsible for all compliance-related activities. The Compliance Officer develops and implements policies, procedures, and practices to comply with the requirements of the contract, and State and federal regulations. This role reports directly to the CEO/COO and other duties include: - Creates internal controls, policies, and procedures to prevent and detect fraud, waste, and abuse - Develops a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones - Develops and monitors a records system to track all compliance actions taken and any follow-up reviews, and provides updates on the monitoring and auditing results to the State, as requested - Monitors the activities of the SIU, as established and maintained by the Program Integrity Lead - Serves as the primary contact person for all MHT compliance requests and concerns	At least five years' experience serving as a compliance officer or lead in the health care industry for a Medicaid managed care or other healthcare entity. Bachelor's degree or higher. Based in West Virginia.

Role	Description of Responsibilities	Skill Sets
	Establishes written policies and procedures for maintaining the confidentiality of data to protect members from unauthorized disclosures	
Medical Director	The Medical Director is a key staff position and will continue to be throughout the entire contract term. This position is responsible for oversight of medical and care coordination activities of the project. The Medical Director attends in person, upon DHHR request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers. Responds to requests of DHHR's Medical Director or Contract Administrator within three (3) business days. The Medical Director also conducts utilization management activities in collaboration with the Medical Management Director and Behavioral Health Medical Director; and oversees or participates in the Quality Assurance and Performance Improvement (QAPI) Committee.	At least five years' experience in serving as Medical Director for a Medicaid program and five years' experience working in pediatric care. An active West Virginia Medical License. Based in West Virginia.
Medical Management Director	The Medical Management Director is a key staff position and will continue to be throughout the entire contract term. This position oversees utilization management (UM) activities and operations of the UM program, including management of processing referrals and pre-authorization requirements, as well as familiarity with appeal procedures. This role also responds to requests of DHHR's Medical Director or Contract Administrator within three (3) business days.	At least five (5) years' experience working as a UM manager or specialist for a Medicaid program. Registered Nurse (RN) or Licensed Clinical Social Worker (LCSW) in West Virginia. Based in West Virginia.
Care Management Director	The Care Management Director is a key staff position and will continue to be throughout the entire contract term. This position oversees project care management activities and care management program operations, including management and integration of care through the member's Primary Care Provider (PCP), referral processes for Medically Necessary services, provision of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services, and health risk assessment completion. This role also establishes and monitors care coordination staffing ratios and related activities; and oversees the continuity and coordination of care of members within this program.	At least five years' experience working as a case manager or care coordinator for a Medicaid program. RN and/or LCSW in West Virginia. Demonstrated ability to communicate with members who have complex medical needs and may have communication barriers. Based in West Virginia.

Role	Description of Responsibilities	Skill Sets
Behavioral Health Medical Director	The Behavioral Health Medical Director is a key staff position and will continue to be throughout the entire contract term. This position oversees behavioral health (BH) clinical and quality activities of the project. The Behavioral Health Medical Director must be available for BH service utilization review decisions, and should be authorized and empowered to respond to BH clinical issues, utilization review, and behavioral quality of care inquiries. This role attends in person, upon DHHR request, meetings and hearings of legislative committees and interested governmental bodies, agencies, and officers.	At least five years' experience in serving as Behavioral Health Lead or Expert for a Medicaid program and five years' experience working in behavioral health clinical care, including substance use. Active West Virginia Medical License in a related behavioral health specialty. Based in West Virginia.
Quality Director	The Quality Director is a key staff position and will continue to be throughout the entire contract term. This position oversees the quality assurance program and related activities. The Quality Director develops, administers, and oversees the QAPI program Oversees and supports accreditation activities, such as NCQA. In addition, this role: • Initiates and maintains quality improvement projects that focus on one or more quality indicators • Oversees or participates in the QAPI Committee • Develops an approach to monitoring provider performance, in collaboration with Network and Provider Relations staff • Engages in activities related to APMs as they relate to quality of care measures and performance indicators	At least five years' experience in overseeing a Medicaid quality program, either with an MCO, a state Medicaid agency, or an external quality review organization. Bachelor's degree or higher. Based in West Virginia.
Member Services Director	The Member Services Director is a key staff position and will continue to be throughout the entire contract term. This position oversees activities related to call center operations, enrollment and disenrollment activities, grievances, and other member-related inquiries and matters. The Member Services Director: • Oversees the Member Services Department to assist members in obtaining covered services • Interfaces with members and providers to handle questions and complaints • Ensures that the member services phone line meets the minimum performance requirements	At least three years' experience working with the public in an educational capacity on health insurance-related matters. Experience working in or overseeing a call center. Bachelor's degree or higher. Based in West Virginia.

Role	Description of Responsibilities	Skill Sets
	Oversees the enrollment and onboarding activities of members	
Claims Payment Director	The Claims Payment Director is a key staff position and will continue to be throughout the entire contract term. This position oversees all physical and behavioral health claims payment- and encounter-related activities. The Claims Payment Director ensures timely and accurate payment of provider claims for physical and behavioral health services, and in general monitors claims processing activities for these services. The role also oversees the reprocessing of claims due to rate changes or claims resubmissions.	At least three years' experience in claims processing and encounters with a health insurer. Bachelor's degree or higher. Based in West Virginia.
Network Development Director	The Network Development Director is a key staff position and will continue to be throughout the entire contract term. This position is responsible for network development and contracting activities for physical and behavioral health services, and the following: - 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 DHHR's Medicaid managed care network standards - Develops and submits written documentation of the adequacy of the MCO's provider network as per contractual requirements - Facilitates physical and behavioral health provider contracting activities, including creative payment arrangements and APMs - Oversees physical and behavioral health provider contracting documents and addenda - Supports the oversight of physical and behavioral health provider credentialing activities	At least five years' experience serving as a network manager in a health insurance role. Bachelor's degree or higher. Based in West Virginia.
Provider Relations Director	The Provider Relations Director is a key staff position and will continue to be throughout the entire contract term. This position is responsible for interfacing with the provider	At least three years' experience in serving as a provider relations manager or specialist in a health insurance role. Bachelor's degree or higher. Based in West Virginia.

Role	Description of Responsibilities	Skill Sets
	community and supports ongoing provider relationships. The Provider Relations 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 • Designs, develops, and implements an annual provider satisfaction survey • Ensures the development, distribution, and maintenance of a provider manual	
Program Integrity Lead	The Program Integrity Lead is a key staff position and will continue to be throughout the entire contract term. This position is responsible for all compliance-, program integrity-, and fraud-related activities. The Program Integrity Lead: • Creates internal controls, policies, and procedures to prevent and detect fraud and abuse • Establishes and maintains an SIU to investigate possible acts of fraud, waste, or abuse for all services provided under the contract • Serves as the primary contact person for all BMS and WVCHIP Program Integrity and Medicaid Fraud Control Unit (MFCU) record requests • Monitors provider fraud for underutilization of services and member/provider fraud for overutilization of services	At least 3 years' experience working on Medicaid fraud projects or bachelor's degree or higher. Based in West Virginia.
Information Technology Director	The Information Technology Director is a key staff position and will continue to be throughout the entire contract term. This position is responsible for all systems, data, and hardware activities. The Information Technology Director: • Submits required reports, requests for information, documentation, ad hoc reports, data certification forms, or any other data required as requested by DHHR within the time frames provided by the contract • Maintains reasonable safeguards against the destruction, loss, or alteration of any data in the possession of the Vendor	At least three years' experience working in Medicaid IT solutions, with an emphasis in data integrity. At least a bachelor's degree or higher.

Role	Description of Responsibilities	Skill Sets
	• 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 Vendor's EHR, claims processing system, provider data system, etc.	
Community Engagement Director	The Community Engagement Director is a key staff position and will continue to be throughout the entire contract term. This position is responsible for marketing, public relations, and community engagement activities. The Community Engagement Director: • Develops and maintains Medicaid marketing policies and procedures in adherence to state and federal regulations • Develops and submits all marketing materials to DHHR • Develops a written marketing plan, and verifies prohibited marketing activities do not occur, as stated in the contract • Engages with the community and provides educational and informational materials at outreach events, in accordance with marketing activity guidelines	At least three years' experience in working with the general public to better understand the healthcare environment and insurance. Preference given to a candidate with familiarity with West Virginia and its population characteristics Bachelor's degree or higher. Based in West Virginia.
Encounter Data Integrity Manager	The Encounter Data Integrity Manager is a key staff position and will continue to be throughout the entire contract term. This position oversees all physical and behavioral health claims payment- and encounter-related activities. The Encounter Data Integrity Manager: • Meets in-person with DHHR staff or such other person(s) as designated by DHHR to provide oral and written status reports and other information as required • Ensures timely, accurate, and complete reporting of all encounter data submissions, including subcontractor data • Oversees the resubmission of encounter data due to identified claim adjustments due to rate changes or claims resubmissions • Oversees the submission and data integrity of encounter claims	At least three years' experience in encounters and data integrity activities with a health insurer. Bachelor's degree or higher.

Role	Description of Responsibilities	Skill Sets
MHT Member Advocate	The MHT Member Advocate is a key staff position and will continue to be throughout the entire contract term. This position interacts with the population, and makes sure that members are referred and connected to appropriate resources. The MHT Member Advocate also: • Collaborates with the Care Management Director and care coordinators • Provides member support related to enrollment, access, and continuity of care issues • Supports members throughout any grievances or appeals activities • Assists members in obtaining materials in alternative formats, as applicable • Interacts with members in a culturally sensitive manner	At least five years' experience in healthcare, working with low income populations, and cultural sensitivity. Bachelor's degree or higher. Based in West Virginia.
Dental Director	The Dental Director is a key staff position and will continue to be throughout the entire contract term. This position oversees the administration of dental services within the contract, including utilization of covered dental services under this contract. The role also conducts dental utilization review decisions and is authorized to respond to dental clinical issues, utilization review, and dental quality of care inquiries.	At least five years' experience in serving as a dental manager or director for a Medicaid program. Active license to practice dentistry in West Virginia.
Accreditation Manager	The Accreditation Manager oversees accreditation activities necessary for attaining and maintaining accreditation from various accrediting organizations, such as URAC and NCQA. Primary duties: • Interfaces with internal and external clients, quality committees, and departments in the review of quality improvement data and in the implementation of appropriate interventions to effect improvement • Manages the overall accreditation processes and resources required to successfully lead the team • Evaluates, interprets and summarizes accreditation guidelines and manages the process for accreditation activities • Identifies appropriate resources and accountabilities for project teams involved with accreditation	Requires BA/BS in a health care field, and three to five years of health care-related experience in addition to three plus years' experience in a quality-related position, project management, and strong quantitative, qualitative and analytical skills or any combination of education and experience, which would provide an equivalent background. Successful NCQA/URAC accreditation process completion and continuous process improvement experience in an NCQA/URAC setting highly preferred.

Role	Description of Responsibilities	Skill Sets
	- Conducts the ongoing evaluation and interpretation of quality standards and accreditation standards to ensure compliance through reporting and measurement studies/methodologies - Serves as expert resource to quality committees and business owners across the organization - Leads and provides oversight of quality studies/projects - Facilitates project management and develops comprehensive accreditation work plans by establishing deliverables, accountabilities, and timelines - Performs quantitative and qualitative analysis of quality related data and reports activities, improvements, and recommendations to the quality committee	
Behavioral Health Crisis Line Clinicians	BH Crisis Line Clinicians answer all incoming hotline calls and immediately assess and respond to safety needs of all callers who may be experiencing a crisis. The Clinicians apply clinical criteria to authorize BH care, pre-certify services, and conduct concurrent reviews.	Must be an RN, Clinical Psychologist, or master's level clinician, such as an LCSW, LMFT, or LPC. Must also have experience with adolescents who have severe emotional disturbances, SUD, dual diagnosis, and severe and persistent mental illness. Minimum of three years of experience in BH, case management, discharge planning, or clinical supervision.
Care Delivery Transformation Consultant	The Care Delivery Transformation (CDT) Consultants maintain responsibility for consulting with providers to improve the effectiveness and efficiencies of provider practices and clinical processes. Their primary duties may include analyzing practice specific cost and quality data and reports for cost of care and quality opportunities; helping practices to target high-risk members and gaps in care based on reports provided; supporting practice implementation of population health management, care coordination, and care management strategies; identifying action plans for providers to implement to improve cost, quality, and the patient experience; and participating in design, development, and implementation of community learning forums. These CDT Consultants serve as the point of contact for providers and primary care practices for program onboarding and the facilitation of routine meetings between UniCare and the provider office.	Requires a bachelor's degree along with five to ten years of health care experience; or any combination of education and experience that would provide an equivalent background. Physician environment experience in practice transformation/quality improvement, ambulatory care setting quality and efficiency metrics, population health and care management structures, data analytics, and electronic health records is preferred. Clinical background and/or MBA not required but a plus.

Role	Description of Responsibilities	Skill Sets
Claims Processing Analyst	The Claims Processing Analyst is responsible for keying, processing, and/or adjusting health claims in accordance with claims policies and procedures. They review, analyze, and process claims/policies related to events; and they research claims issues and respond to inquiries.	Requires a high school diploma or equivalent plus one to three years of claims processing experience; previous experience using PC, database system, and related software (word processing, spreadsheets, etc.); or any combination of education and experience that would provide an equivalent background.
Clinical Programs Project Manager	The Clinical Programs Project Manager oversees the quality improvement activities/projects as outlined in the Quality Improvement (QI) work plan and as required by applicable law, regulations and accreditation standards. Primary duties: • Ensures integration of quality into the overall business process • Performs assessments to identify gaps in the enterprises quality and technology assessment processes and initiates actions to correct these gaps • Assures accuracy and completeness of input provided to internal and external QI committees and timely implementation of appropriate interventions • Oversees the clinical quality improvement activities/projects to implement appropriate clinical interventions to improve the quality of care for members • Assures compliance with corporate QI work plans. Assures QI activities are relevant to the targeted population • Assures compliance to Practice Guideline, Delegation and Continuity and Coordination of Care Standards • Maintains documentation of research programs to meet regulatory and Accreditation Standards • Provides oversight to assure accurate and complete quantitative analysis of clinical data and presentation of results • May provide oversight to the Healthcare Effectiveness Data and Information Set (HEDIS) project team	Requires a BS in health administration, nursing or related clinical field; five years of health care quality or data analysis experience; or any combination of education and experience, which would provide an equivalent background. Current unrestricted license or certification in applicable field preferred (such as CPHQ). MS in the health field (such as Nursing) preferred.

Role	Description of Responsibilities	Skill Sets
Clinical Quality Program Consultant	The Clinical Quality Project Consultant assists the Clinical Programs Project Manager in overseeing the quality improvement activities/projects as outlined in the Quality Improvement (QI) work plan and as required by applicable law, regulations and accreditation standards. Primary duties: • Ensures integration of quality into the overall business process • Performs assessments to identify gaps in the enterprises quality and technology assessment processes and initiates actions to correct these gaps • Assures accuracy and completeness of input provided to internal and external QI committees and timely implementation of appropriate interventions • Supports clinical quality improvement activities/projects to implement appropriate clinical interventions to improve the quality of care for members • Assures compliance with corporate QI work plans • Assures QI activities are relevant to the targeted population • Maintains compliance with Practice Guideline, Delegation and Continuity and Coordination of care Standards • Maintains documentation of research programs to meet regulatory and Accreditation Standards • Helps assure accurate and complete quantitative analysis of clinical data and presentation of results • May provide oversight to the HEDIS project team	Requires a BS in health administration, nursing or related clinical field; three years of health care quality or data analysis experience; or any combination of education and experience, which would provide an equivalent background. Current unrestricted license or certification in applicable field preferred (such as CPHQ). MS in the health field (such as Nursing) preferred.

Role	Description of Responsibilities	Skill Sets
Community Engagement Representative	The Community Engagement Representative develops and maintains a positive working relationship with the member population for the primary purpose of increasing enrollment and decreasing disenrollment. This role: • Ensures consistent compliance with state, federal, and company specific requirements • Develops a standard process for assessing the feasibility and development of sponsored event programs • Conducts marketing activities, events, exhibits, education, and presentations in an effort to gain members and maintain and/or establish relationships with providers, community, and faith based organizations • Identifies and enlists the cooperation of individuals, groups, social service agencies and other community organizations in educational and outreach activities • Identifies cultural issues regarding current and potential members; communicate those issues and concerns to management immediately	Requires an associate's degree; four years of experience in managed care/healthcare or sales/marketing environment; or any combination of education and experience, which would provide an equivalent background. BA/BS preferred. Valid drivers license and access to a motor vehicle with valid motor vehicle insurance required. State health insurance licensure preferred.
Community Navigators/ Housing/Employment/ Transportation Liaisons	Community Navigators /liaisons are responsible for engaging with UniCare members to remove barriers to Social Determinants of Health (SDOH) such as housing, employment, transportation and acting as the communication liaison between our health plan and referral sources. Primary duties: • Engage with members who have been identified as possessing significant SDOH barriers • Work with the member to establish goals and next steps for addressing SDOH • Support member in selecting provider or programs most appropriate for supporting their needs • Interface with care management to help ensure that the individualized care plan is aligned with existing or needed case management efforts • Act as a liaison between referral sources and the health plan	Bachelor's Degree in Public Health, Social Work, Rehabilitation Counseling or related field and two to three years' experience with marketing, job development, job placement or social work or the equivalent in education and experience. Knowledge of Vocational Rehabilitation. Travel may be required.

Role	Description of Responsibilities	Skill Sets
Director Integrated Care Management	The Director, Integrated Care Management oversees utilization or care management process for members who have varying medical complexity ensuring the delivery of essential services that address their total health care needs. Primary duties: • Implements and manages health care management, utilization, cost, and quality objectives • Ensures program compliance and identifies opportunities to improve the customer service and quality outcomes • Oversees the development and execution of medical and case management policies, procedures, and guidelines; assists in developing clinical management guidelines • Confirms medical management activities are contracted, reviewed and reported • Supports quality initiatives and activities including clinical indicators reporting, focus studies, and HEDIS reporting • Hires, trains, coaches, counsels, and evaluates performance of direct reports	Requires a BA/BS in a health care field; 8 years of clinical experience, including prior management experience; or any combination of education and experience, which would provide an equivalent background. RN, LCSW, or LPC preferred. National Committee for Quality Assurance (NCQA) accreditation and HEDIS reporting experience preferred. Masters in a health care field or MBA with Health Care concentration preferred. Certified Case Manager preferred.
Director Population Health	The Director of Population Health is responsible for directing and overseeing the operations in alignment to a special product/programs such as long term service and supports (LTSS), Foster Care, Intellectual and developmental disabilities (IDD), HIV/AIDS population etc., with a focus on program performance, operating policies, process improvements, program enhancements, managing interdependencies and risks, program status and evaluation reporting, and growth/expansion. Primary duties: • Directs and oversees program operations in support of health plan management in execution of clinical service delivery • Monitors national and local health plan market trends relative to the clinical span of the program • Leads and/or participates in cross-functional workgroups created to maintain and develop clinical programs • Evaluates all facets of the clinical program to improve efficiency of operations, financial return, customer service, and provider engagement	Requires a BA/BS; eight years of experience in a related field, including prior management experience and clinical, quality, and/or utilization management experience in a managed care setting; or any combination of education and experience, which would provide an equivalent background. MBA preferred. RN, LSW, or LPN/LVN license preferred.

Role	Description of Responsibilities	Skill Sets
	• Develops, communicates, and monitors program schedule, budget, and resources plan; coordinates program deliverables and resolves issues that may hinder clinical program success • Hires, trains, coaches, counsels, and evaluates performance of direct reports	
Encounters Analyst	The Encounter Analyst are responsible for serving as the liaison between the business and IT in translating complex business needs into application software. Primary duties: • Analyzes complex end user needs to determine optimal means of meeting those needs • Determines specific business application software requirements to address complex business needs Develops project plans and identifies and coordinates resources, involving those outside the unit • Works with programming staff to ensure requirements will be incorporated into system design and testing • Acts as a resource to users of the software to address questions/issue • May provide direction and guidance to team members and serves as an expert for the team	Requires a BS/BA degree, five to seven years of business analysis experience that includes knowledge of systems capabilities and business operations; or any combination of education and experienced, which would provide an equivalent background.
EPSDT Program Manager	The EPSDT Program Manager is responsible for the administration of one or more EPSDT programs for West Virginia Medicaid members. Program administrators typically support business strategies through an integrated portfolio of external client facing projects or initiatives. Primary duties: • Administers the implementation and compliance of ongoing EPSDT Programs and initiatives • Ensures the EPSDT program meets its stated objectives; provides subject matter expertise in response to day to day business issues; researches applicable subject matter practices and remains aware of industry trends • Manages relationships and partners with corporate and regional business areas; coordinates training related to EPSDT; develops program success measures and performs periodic assessments of external client facing program success	Requires a BA/BS in a related field; two plus years of experience in external client facing program or other health care related field; or any combination of education and experience, which would provide an equivalent background. Professional designation related to field or project management experience preferred.

Role	Description of Responsibilities	Skill Sets
	- Schedules, conducts and attends meetings, supports management in overall objectives, assesses costs and savings and may assist in the payment of vendor invoices - Complies complex data and able to prepare and deliver presentations	
Grievance Coordinator	The Grievance Coordinator is responsible for investigating and reviewing customer grievances and appeals regarding provision of service and benefit coverage issues. The role triages clinical and non-clinical inquiries, grievances and appeals, prepares case files for member grievance committees/hearings. Primary duties: - Summarizes and presents essential information for the clinical specialist or medical/dental director and legal counsel - Responds to oral and written complaints sent to the Office of the Chairman, President or Vice President complaints - Ensures appropriate resolution to inquiries, grievances and appeals within specified timeframes established by either regulatory/accreditation agencies or customer needs - Contacts members to gather information and communicate disposition of case; documents interactions - Generates written correspondence to members, providers and regulatory agencies - Identifies barriers to customer satisfaction and recommends actions to address operational challenges - Pursues ongoing education/training on benefits/services to ensure accurate resolution of grievances and appeals, and overall industry knowledge and development (i.e. HIAA, LOMA, etc.)	Requires a high school diploma or equivalent and four years progressively complex experience working in grievances and appeals; or any combination of education and experience, which would provide an equivalent background.
Health Coach	The Health Coach is responsible for providing health coaching to members with chronic diseases. Primary duties: - Conducts behavioral assessments to identify individual member knowledge, skills, and behavioral needs - Coordinates specific health coaching as directed by nurse case manager to address objectives and goals as identified during assessment	Requires a BA/BS in appropriate field of specialization (Health Education, Exercise Physiology, Respiratory Therapy or Dietician); three years of related experience in health education, exercise instruction, or patient education; or any combination of education and experience, which would provide an equivalent background. Certification, advanced certification, and/or license appropriate to field of specialty as required. Prior experience in health coaching,

Role	Description of Responsibilities	Skill Sets
	• Implements coaching plan by using behavior change principles to identify member barriers and develop ways to overcome those barriers • Coordinates with the nurse case manager to provide feedback on member goal attainment and clinical issues • Monitors and evaluates the interventions and modifies	disease management and knowledge of behavioral and/or clinical assessment techniques, health and/or patient education and behavior change techniques preferred. Understanding of disease management principles preferred.
Health Program Representatives	Health Program Representatives are responsible for providing initial contact between distinct Care Management programs and specific identified members. Primary duties: • Provides technical support to various staff • Understands and applies specific workflow, processes, departmental priorities and guidelines • Resolves complex situations and ensures assigned staff are directed to the appropriate resources • Resolves escalated calls from team members • Under supervision, provides training and mentoring of staff and can role-play expected steps • Gathers information from hospitals, health plans, physicians, patients, vendors and other referral sources	Requires one year of experience in complex customer service or call center environment; or any combination of education and experience, which would provide an equivalent background. Prior experience mentoring others and providing job specific technical support preferred.
HEDIS Manager	The HEDIS Manager is responsible for coordinating, implementing, and executing HEDIS Quality Department specific projects, ensuring consistency with company strategy, commitments, and goals. Primary duties: • Leads and manages annual HEDIS process within plan or region; serves as subject matter expert to enterprise team • Identifies, develops, and improves processes, procedures, and operations, conducts analysis, leads cross functional teams, and schedules, develops, and implements initiatives to strategically improve project processes • Secures and coordinates resources, temporary staff, space and equipment, and system requirements • Evaluates and monitors performance and efficiency of programs to ensure that implementation meets targeted timelines	Requires a BA/BS in public health, nursing or related field; five plus years of experience involving direct health care background and analyses of health care data, including one or more years of experience with HEDIS activity coordination and experience working with Managed/Acute/Provider Care environment; or any combination of education and experience, which would provide an equivalent background. Master's in Public Health, Health Services Administration, Nursing, or Business Administration preferred. RN, RHIA or RHIT and CPHQ license preferred. NCQA and HEDIS experience preferred.

Role	Description of Responsibilities	Skill Sets
	• Develops strategy with multiple enterprise departments and external vendor to annually field a new HEDIS pursuit application • Synthesizes performance data, prepares presentation materials, and presents comparative complex reports to local and enterprise quality committees • Builds relationships with internal and external customers	
Integrated Care Managers	Integrated Care Managers conduct care management within the scope of their licensure for members with complex and chronic care needs by assessing, developing, implementing, coordinating, monitoring, and evaluating care plans designed to optimize member health care across the care continuum. They perform duties telephonically or on-site such as at hospitals for discharge planning. Primary duties: • Make sure members have access to services appropriate to their health needs, and conducting assessments to identify individual needs and a specific care management plan to address objectives and goals as identified during assessment • Implement care plans by facilitating authorizations/referrals as appropriate within benefits structure or through extra-contractual arrangements; coordinate internal and external resources to meet identified needs; monitor and evaluate effectiveness of the care management plan and modify it as necessary	Requires a bachelor's plus three years of experience in health care management; or any combination of education and experience that would provide an equivalent background. Must hold a current active unrestricted license as an RN, physician assistant, licensed social worker, LCSW, LPC, LMHC, or other accepted license. Master's degree in a related field preferred. Certified Case Manager Certification preferred.
Interventions Project Manager	The Interventions Project Manager works with moderate guidance and is responsible for applying project management knowledge, skills, tools and techniques to project deliverables, processes, and systems. This position operates within defined parameters using project management methodology. Primary duties: • Manages the development of a prescribed planning document ▪ develops project charter; partners with sponsors to secure project approval; develops communication management plan; defines project team roles and responsibilities, develops work plan structure and project schedule; develops deployment plan; leads project meetings;	Requires a BA/BS in a related field; 3 years professional project management experience required during which at least 2 years are spent leading and directing project tasks, or any combination of education and experience, which would provide an equivalent background. Project Management Professional (PMP) certification preferred. Experience working in a lead role on one or more projects required.

Role	Description of Responsibilities	Skill Sets
	identifies, documents and prioritizes scope changes and facilitates approval process; maintains and updates all project documents; secures the appropriate skill sets for project; sets and manages expectations with resource managers and team members; provides performance feedback to team members and resource managers; maintains issue log; facilitates resolution of issues; executes communication plans; regularly reports status of reports; manages and monitors ROI throughout the project lifecycle; tracks and manages time and budget against plan; develops testing strategy; conduct project close-out activities; prepares and participates in quality review checkpoints; obtain/secure and archive necessary approvals; manage and update project plan. This role must have the ability to create an effective team environment, build strong relationships, solve problems and issues in a matrix environment and communicate effectively at all levels of an organization	
Judicial Liaison	Our Liaison will have an experience or understanding of trauma-informed care, Medicaid services, and managed care. The position will be responsible for building and maintaining positive relationships as well as information links between judicial agencies in West Virginia (including child welfare and juvenile justice), UniCare's care management team, and members and families	This position must also hold a bachelor's degree plus five years of experience in social work or a related role working with local government entities. This position requires experience in the child welfare system and juvenile justice, specifically as it pertains to the interactions between child welfare and the courts, including working with court or justice-related advocacy groups and court programs.
Manager Utilization Management	The Manager, Utilization Management is responsible for managing a team of physical and/or behavioral health practitioners responsible for coordinating member service, utilization, access, care management and/or concurrent review to ensure cost-effective utilization of health, mental health, and substance abuse services for members with varying medically complex needs, ensuring the delivery of essential services that address their total health care needs. Primary duties: Manages and oversees team responsible in case finding and coordinating cases that involve comorbid conditions	Requires a BA/BS; five years of experience in care management; or any combination of education and experience, which would provide an equivalent background. Current active unrestricted RN, PA, LSW, LCSW, LPC, LMHC or other accepted license (as allowed by applicable state laws); and any other state or federal requirements that may apply is required. MSN, MPH, MPA, MSW or MBA with Health Care Concentration preferred. Certified Case Manager Certification preferred.

Role	Description of Responsibilities	Skill Sets
	• Coordinates service delivery to include member assessment of physical and psychological factors • Partners with providers to establish short and long term goals that meet the members' needs, functional abilities, and referral sources requirements • Identifies members with potential for high risk complications • Reviews benefit systems and cost benefit analysis • Evaluates medical, mental health and substance abuse service for cost containment • Supports program compliance and assists in identifying opportunities to improve the customer service and quality outcomes • Supports quality initiatives and activities, including adherence to National Committee for Quality Assurance (NCQA) standards and HEDIS reporting • Hires, trains, coaches, counsels, and evaluates performance of direct reports	
Member and Provider Services Representative	The Member and Provider Services Representative is responsible for providing exceptional customer service for specific accounts ensuring satisfaction with products and service. Interprets plan benefit design; resolves complex claim, benefit, and enrollment issues; performs research to respond to inquiries and interprets policy provisions to determine most effective response; keeps account manager informed of account status. Must be fully proficient in all key areas of customer service.	Requires a high school diploma or GED; 5 + years of the company's customer service experience; or any combination of education and experience, which would provide an equivalent background.
MHT Regulatory Manager	The MHT Regulatory Manager is responsible for managing foundational and strategic compliance responsibilities. Primary duties: • Manages/oversees projects, initiatives, regulatory audits or exams, internal audits, accreditations, on-site reviews, risk assessments; audit planning, conducting mock audits, conducting audit training, managing audit evidence preparation, and assessing audit preparedness • Establishes project plans, gap analysis, milestone dates, and other significant aspects, and provide leadership updates	Requires a BA/BS; Master of Science (MS)/MBA/Juris Doctorate (JD) or professional designation preferred; at least six years of health care, regulatory, ethics, compliance, or privacy experience; or any combination of education and experience that would provide an equivalent background.

Role	Description of Responsibilities	Skill Sets
	• Maintains knowledge of laws, regulations, company strategies to assess impact, and consult with clients as subject matter expert • Conducts complex investigations, document findings, and ensure corrective actions are made. Interfaces with external clients, regulators, vendors, supplier; internal stakeholders, high level of management	
Network Management Representative	The Network Management Representative provides comprehensive services to the provider community. Primary duties: • Serves as point of contact for other internal departments regarding provider issues that may impact provider satisfaction • Researches and resolves the complex provider issues and appeals for prompt resolution • Coordinates prompt claims resolution through direct contact with providers and claims department • May perform periodic provider on-site visits • Provides assistance with policy interpretation • Researches, analyzes and recommends resolution of provider disputes, issues with billing, and other practices • Assists providers with provider demographic changes as appropriate • Responds to provider issues related to billing, pricing, policy, systems and reimbursements • Identifies and reports on provider utilization patterns which have a direct impact on the quality of service delivery • Determines if providers were paid according to contracted terms	Requires a high school diploma; three years of customer service experience; or any combination of education and experience, which would provide an equivalent background. Requires strong oral, written and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

Role	Description of Responsibilities	Skill Sets
Network Relations Consultant	The Network Relations Consultant develops and maintains positive relationships with providers and strategies for recruitment and contracting. Primary duties: • Develop and maintain positive relationships with the provider community by periodic on-site visits, communicating administrative or programmatic changes, and facilitating the resolution of provider issues • Recruit providers to build a cost-effective, high-quality provider network • Conduct negotiations and lead contracting efforts with providers to build and maintain a cost-effective, accessible provider network • Research, analyze, and recommend resolution for contract dispute, non-routine claim issues, billing questions, and other practices • Coordinate communication process on such issues as administrative and medical policy, reimbursement, and provider utilization patterns • Conduct seminars to support the understanding of managed care and UniCare policies and procedures. • Identify network access and deficiencies and develops recruitment and contracting strategies • Coordinate and conducts provider training	Requires a bachelor's degree, plus three years of related experience (provider relations, network management, customer service, sales-negotiation); prior negotiation experience; or any combination of education and experience that would provide an equivalent background.
Network Relations Manager	The Network Relations Manager oversees activities related to the development and maintenance of the provider delivery system through provider relations representatives. The Manager's primary duties include managing processes for communication and complaint resolution between physicians, hospitals, members, and the public as well as managing the workflow of the provider relations area.	Requires a bachelor's degree, plus three years of experience, or any combination of education and experience that would provide an equivalent background.

Role	Description of Responsibilities	Skill Sets
Nurse Hotline Nurse	Nurse Hotline Nurses are responsible for telephone triage to assess callers' needs and provide relevant health information to assist callers in making health care decisions. Primary duties: • Establish and maintain supportive relationships with callers and their families and assessing caller's needs with accurate, concise documentation • Conduct thorough symptom assessment of the caller's situation using established criteria and protocol, and applies established software, written materials, online resources and nursing background to provide callers with appropriate medical information • Provide callers with appropriate community resources as necessary, and refers more complex issues as needed for consultation	Requires an associate's or bachelor's degree in nursing, plus two years of acute clinical experience; or any combination of education and experience that would provide an equivalent background. Current unrestricted RN license in applicable state(s) is also required. A Bachelor of Science in Nursing and previous triage experience preferred.
Operations Director	The Operations Director is responsible operations functions, including coordination between internal departments, ensuring the appropriate strategy, tactics and processes are in place to affect solid organizational operations and oversight. Primary duties: • Resolve programmatic challenges related to operations including member issues, provider claims issues, contract configuration issues, etc. • Serve as liaison to support services, which could include: Claims, Enrollment, NCC, PDM/PDQ, configuration; Quality, Regulatory Compliance, IT, and Reimbursement Policy • Identify opportunities for Operational Excellence and work to create seamless processes across functional areas • Develop and implement key operational indicators to be used for monitoring and analysis of operations • Serve as a liaison with state regulatory agencies when appropriate	Requires a BA/BS in Business, Healthcare Administration or related field; 10 years of relevant experience including eight years of in-depth experience in managed care operations; or any combination of education and experience, which would provide an equivalent background. Master's degree preferred. Six Sigma Black Belt preferred.

Role	Description of Responsibilities	Skill Sets
Outreach Care Specialists	Outreach Care Specialists are responsible for ensuring that appropriate member care plans are followed on less complex cases and for proactively identifying ways to improve the health of our members and meet quality goals. Primary duties: • Coordinate follow-up care plan needs for members by scheduling appointments or enrolling members in programs • Assess member compliance with medical treatment plans via telephone or through on-site visits • Identify barriers to plan compliance and coordinates resolutions as well as opportunities that impact quality goals and recommends process improvements • Recommend care plan modifications and determine need for additional services, in conjunction with case management and provider • Coordinate identification of and referral to local, state or federally funded programs • Coach members on ways to reduce health risks • Prepare reports to document case and compliance updates • Establish and maintain relationships with agencies identified in appropriate contract	Requires a high school diploma; one year of related experience; or any combination of education and experience, which would provide an equivalent background. Certified nurse assistant or certified medical assistant and/or BS/BA degree in a related field preferred. Bilingual candidates preferred. For URAC accredited areas the following applies: Requires strong oral, written and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.
Patient Centered Care Consultant	The Patient Centered Care Consultant provides support to providers to improve the effectiveness and efficiencies of provider practices. Primary duties may include analyzing quality metrics and reports for care opportunities and supporting practice implementation of care coordination and care management. These Consultants also collaborate with the Patient Centered Primary Care team and participate in developing program recommendations and action plans (internal). They support the efforts of providers and practice teams on office-based care delivery interventions, resulting in cost of care savings and improved health outcomes for patients, and they promote practice transformation to team-based patient-centered care delivery. The role also provides education for practices to develop expertise with metrics and data review for quality improvement.	Requires a bachelor's degree plus three years of health care experience; or any combination of education and experience that would provide an equivalent background. Physician environment experience in practice transformation/quality improvement, ambulatory care setting quality and efficiency metrics, and electronic health records preferred.

Role	Description of Responsibilities	Skill Sets
Peer Support Specialist	The Peer Support Specialist is responsible for care coordination and/or care management activities, which includes identifying opportunities for engagement of members and their families in forming a supportive, recovery network. The role works collaboratively with our clinical team as a member advocate in discharge planning education, resolution of barriers, and service transitions. The role also acts a resource for staff on decision-making and problem-solving.	Requires an associate's degree plus two years of experience in health services or BH field or in a peer support services role, knowledge of care coordination and case management concepts; or any combination of education and experience that would provide an equivalent background. BA/BS or MBA preferred. Peer Specialist Certification required.
Pharmacy Director	The Pharmacy Director supports disease management programs and care plans through drug therapy evaluation and consultation for members and their parents/caregivers. This includes evaluating prescription needs and therapies through review of medication history to determine if medications are appropriate; and assessing compliance with the care plan through direct contact with members (and parents/caregivers) and their physicians. The Director also determines potential barriers to compliance; and identifies solutions to overcome barriers. In addition, the role helps ensures that members understand appropriate use of current prescriptions, reviews medications with physicians when therapies do not meet national standards, and counsels physicians around alternative medications.	Must be a Registered Pharmacist currently licensed with at least two years of clinical experience; or any combination of education and experience that would provide an equivalent background. Doctor of Pharmacy preferred. Experience with direct patient counseling or education is also preferred.
Population Health Engagement Leader	The Population Health Engagement Leader is responsible for the administration of one or more client facing programs within a business unit. Primary duties: • Administer the implementation and compliance of on-going external client facing programs; ensure program meets its stated objectives • Provide subject matter expertise in response to day to day business issues; research applicable subject matter practices and remain aware of industry trends • Manage relationships and partner with corporate and regional business areas; coordinate training related to the client facing program; develop program success measures and perform periodic assessments of external client facing program success	Requires a BA/BS in a related field; two plus years of experience in external client facing program or other healthcare related field; or any combination of education and experience, which would provide an equivalent background. Professional designation related to field or project management experience preferred.

Role	Description of Responsibilities	Skill Sets
	- Schedule, conduct, and attend meetings; support management in overall objectives, assess costs and savings; and may assist in the payment of vendor invoices - Comply complex data and able to prepare and deliver presentations	
Population Health Reporting and Analytics	The Population Health Reporting and Analytics complete projects and performs complex actuarial studies. Primary duties: - Obtain, verify, analyze, and model data including risk reporting and forecasting - Calculate monthly claims liability reserves, develop merit rating factors, and prepare Department of Insurance annual statement exhibits	Requires a BS/BA degree in Mathematics, Statistics or related field; three to five years related experience in an actuarial environment performing financial reporting, rate development, evaluation of risk contingencies and trend projections; or any combination of education and experience, which would provide an equivalent background. Experience specific to group insurance or health insurance environments or graduate level related education may also be used to offset some years of experience.
Process Improvement Manager	The Process Improvement Manager is responsible for process improvement projects to increase the quality and performance of a business unit. Primary duties: - Provide process improvement methodology, coaching and training to associates and team members who are participating in process improvement projects - Collaborate with cross-functional teams in the identification, research and implementation of process improvements - Lead projects of significant scope - Manage internal and external process improvement projects with team members who work across regional and enterprise wide organizational structures and with external parties (providers and trade organizations) to formulate consensus on improvements and to implement internal and external systems, policies and procedures.	Requires a BA/BS in a related field, five to eight years of process improvement or project management experience; or any combination of education and experience, which would provide an equivalent background. Six Sigma Black Belt certification or related process improvement certification preferred.

Role	Description of Responsibilities	Skill Sets
Project Administrator	The Project Administrator is responsible for supporting projects and the project staff in a dedicated project management business unit. This is the entry level position in the project management career path, and primary duties include building and maintaining a project plan and schedule, contributing to ensuring project deliverables are met, and assisting in documentation and project status tracing. This role monitors activities to ensure project objectives are met within established timeframes and budgets. Additional responsibilities will include scheduling, conducting and attending meetings, supporting management in overall objectives, assessing costs and savings, and assisting in the payments of vendor invoices.	Requires a high school diploma or GED plus three to five years of business experience in health care or a related field; or any combination of education and experience that would provide an equivalent background. A bachelor's degree is preferred.
Provider Concierge Program Account Service Coordinator	The Provider Concierge Program Account Service Coordinator is responsible for providing advanced customer service representation for accounts. Primary duties: • Interpret and support plan benefit design • Resolve complex claims, benefit, and enrollment issues • Make routine account visits • Coordinate open enrollment meetings, renewal process and training sessions; and on-site facility visits	Requires a BA/BS; three years of related experience; or any combination of education and experience, which would provide an equivalent background. Account management experience preferred. Sales license may be required. Travel may be required.
Provider Network Managers	The Provider Network Manager develops the provider network through contract negotiations, relationship development, and servicing. Primary focus of this role is contracting and negotiating contract terms. Typically works with less complex providers which may include, professional providers, practice groups, small medical groups, providers in less competitive markets, and providers with greater familiarity with managed care concepts. Contracts tend to be more standard and afford less opportunity for customization; fee schedules are fairly standardized with reimbursement models limited and well-defined. Primary duties: • May participate in intradepartmental projects or smaller projects impacting multiple departments • Operate with general supervision, elevating unusual situations to management as required	Requires a BA/BS degree; two years' experience in contracting, provider relations, provider servicing; or any combination of education and experience, which would provide an equivalent background. Requires travel.

Role	Description of Responsibilities	Skill Sets
	• Solicit participation in the network and conducts re-contracting efforts as needed • Serve as a communication link between professional providers and the company • Conduct limited negotiations and draft documents • Assist in preparing financial projections as required	
Public Health Coordinators	The Public Health Coordinators is responsible for ensuring contract compliance with state mandated cultural and linguistic, health education requirements, or other programs required by contracts. Primary duties: • Assist with the State/Region/Local Needs Assessment document and identifies/develops resources to meet health education needs • Define the marketing environment through development of key stakeholder criteria, identification of desirable community partners, availability of local programs and opportunities for marketing programs and services • Provide/promote provider training to assure compliance with government mandated health education programs and the health education referral system • Establish positive relationships with community-based organizations and other key partners to gain understanding of the cultural and linguistic needs of members • Recommend health education programs based on analysis of State/Regional/Local health statistics, disease prevalence, census data, and health care service usage • Maps community-based assets and collaborate with key stakeholders to leverage available resources for development of new and accessibility to existing health education/promotion programs • Develop and implement strategies that promote local health education resources and address identified member health education needs	Requires a BA; two years of experience; or any combination of education and experience, which would provide an equivalent background.

Role	Description of Responsibilities	Skill Sets
Public Health Manager	The Public Health Manager is responsible for managing and coordinating comprehensive programs targeted at public health and health promotion activities that enhance the value of our services and supports. This includes the development of selected health-related policies and services, and design of health education materials. Primary duties: • Assure compliance with contract requirements and ensures member and provider materials are State approved • Coordinate the development and implementation of education targeting prevention and maintenance of physical, developmental, emotional, and addictive diseases • Act as a liaison to quality management, health care management services, and the disease management program for the coordination of joint public health activities • Research and recommend management strategies that can enhance ability to provide members and providers with cutting edge services and programs • Identify and recommend activities and services that promote member compliance, participation, and retention • May also manage community events, member services (complaints, claims reimbursement), CAHPS survey, etc. • Hires, trains, coaches, counsels, and evaluates performance of direct reports	Requires a BA/BS in Health Promotion, Health Education or related field; six years of experience in a related field, including management experience; or any combination of education and experience, which would provide an equivalent background. Certified Health Education Specialist preferred.
Public Health Strategy Leader	The Public Health Strategy Leader is responsible for the development and ongoing management of one or more multi-year external client facing programs within a business unit. Primary duties: • Manage and coordinate the development, approval, implementation and compliance of ongoing external client facing programs related to public health • Develops program budget; ensures program meets its stated objectives; provides subject matter expertise in response to public health-related issues • Researches applicable subject matter practices and remains aware of community and national trends • Manages relationships with community and public health agencies	Requires a BA/BS degree; 5-7 years of external client facing experience in program/project management; or any combination of education and experience, which would provide an equivalent background. Graduate degree preferred. Project management certification preferred.

Role	Description of Responsibilities	Skill Sets
	• Coordinate training related on key topics related to public health • Develops program success measures and performs periodic assessments of program success	
QM Member Liaison	The QM Member Liaison is responsible for member retention by investigating and leading the resolution of member complaints. This role serves as a liaison/mediator between member, provider and Plan. Primary duties: • Investigate, resolve, and document member complaints in accordance with policies and state requirements • Conduct out-of-office/home visits with members to educate and advise on programs, policy, and benefits • Investigate and resolve issues regarding members with non-compliant, behavioral, and abusive conduct identified by providers • Conduct member interviews to ensure that members are informed of their rights and responsibilities • Assist member as needed, including locating a Primary Care Physician, obtaining medical records, transportation, and completing required forms • Review complaint reports for accuracy and completeness and ensure required reports meet timely filing requirements	Requires an AA/AS; three or more years of experience in a social or health related service-oriented industry; or any combination of education and experience, which would provide an equivalent background.
QM Member Liaison Manager	The QM Member Liaison Manager is responsible for developing, coordinating, and implementing member advocacy initiatives within the health plan as well as member retention by investigating and leading the resolution of member complaints. This role coordinates the member advocacy program throughout the functional areas of the health plan. Primary duties: • Investigate, resolve, and document member complaints in accordance with policies and state requirements • Implement comprehensive Member Advocacy Program to meet the needs members • Investigate and resolve issues regarding members with non-compliant, behavioral, or abusive conduct with providers	Requires a BA/BS in healthcare or related field; five years of experience in a social or health related service-oriented industry; or any combination of education and experience, which would provide an equivalent background.

Role	Description of Responsibilities	Skill Sets
	- Identify and submit updates upon receipt of any regulatory updates or changes - Collaborate with local consumer advocacy groups to gain insight regarding the special health care needs of Medicaid enrollees - Track, trend, and report quality and access complaints; coordinates and documents follow-up actions - Serve as a liaison with state hot line staff and internal compliance personnel	
Quality Manager	The Quality Manager is responsible for developing, coordinating, and implementing quality initiatives within the health plan. The role provides process and technical supervision to a team responsible for monitoring and evaluating the quality of care/service, appropriateness, continuous improvement, member satisfaction, and results of actions across the continuum of care to members. Primary duties: - Assist in establishing Quality Management objectives and annual goals. Implements the comprehensive Quality Management Program to meet the demographic and epidemiological needs of the population served - Promote plan-wide understanding, communication, and coordination of the quality management program - Trend quality data and develops aggregate and individual plan reports as indicated; analyzes validity of data/reports - Coordinate the development, implementation, and evaluation of quality improvement action plans - Coordinate the state regulatory quality reporting for the health plan - Hire, train, coach, counsel, and evaluate performance of direct reports	Requires an associate's degree; five years of experience in quality improvement and/or utilization review in HMO setting, including prior management experience; or any combination of education and experience, which would provide an equivalent background. BA/BS, MSN, MPH, or MPA preferred. National Committee for Quality Assurance (NCQA) accreditation and Healthcare Effectiveness Data Information Set (HEDIS) reporting experience preferred. Urban Medicaid population experience preferred.

Role	Description of Responsibilities	Skill Sets
Special Investigations Unit Staff	The Special Investigations Unit (SIU) coordinates and conducts case reviews for quality assurance, investigative sufficiency, and case data management; and directing day-to-day operations as assigned by management. Through use of appropriate system tools, the SIU Lead will also provide training for and analysis of data to detect fraudulent, abusive, or wasteful payments to providers and subscribers. The SIU Lead will also prepare statistical/financial analyses and reports to document findings and maintain up-to-date case files for management review, and will prepares final report and notification of findings letter suitable for distribution to providers and legal counsel. The SIU Lead will create and present settlement offers for provider issues for review and approval by management and/or legal. Additionally, the SIU will communicate with all customers, internal and external, regarding findings, provide recommendation in support of the development of policy and/or procedures to prevent loss of company assets, and prepare and deliver training to internal and external entities.	Requires a bachelor's degree plus eight or more years of related experience in health care insurance and investigation; or any combination of education and experience that would provide an equivalent background. Professional certifications (Certified Fraud Examiner [CFE], Accredited Health Care Fraud Investigator [AHFI], Certified Professional Coder [CPC], Paralegal, Registered Nurse [RN], Juris Doctorate [JD]) or other job-related designation preferred. Knowledge of plan policies and procedures in all facets of benefit programs management with heavy emphasis in negotiation is also preferred.
Transition Coordinator	The Transition Coordinator is responsible for the administration of one or more client facing programs within a business unit. The Transition Coordinator typically supports business strategies through an integrated portfolio of external client facing projects or initiatives. Primary duties may include, but are not limited to: Administers the implementation and compliance of ongoing external client facing programs; ensures program meets its stated objectives; provides subject matter expertise in response to day to day business issues; researches applicable subject matter practices and remains aware of industry trends. Manages relationships and partners with corporate and regional business areas; coordinates training related to the client facing program; develops program success measures and performs periodic assessments of external client facing program success. Schedules, conducts and attends meetings, supports management in overall objectives, assesses costs and savings and may assist in the	Requires a BA/BS in a related field; two plus years of experience in external client facing program or other health care related field; or any combination of education and experience, which would provide an equivalent background. Professional designation related to field or project management experience preferred.

Role	Description of Responsibilities	Skill Sets
	payment of vendor invoices. Compiles complex data and able to prepare and deliver presentations.	
Utilization Management Clinicians	UM Clinicians are responsible for collaborating with health care providers and members to promote quality member outcomes, to optimize member benefits, and to promote effective use of resources. The role helps ensure that members receive medically appropriate, high-quality, cost-effective care by assessing the medical necessity of inpatient admissions, outpatient services, focused surgical and diagnostic procedures, out-of-network services, and appropriateness of treatment setting through use of medical policy and industry standards, and steering members to appropriate providers, programs, or community resources. UM Clinicians work with clinical and medical directors in interpreting appropriateness of care and accurate claims payment. They may also manage appeals for services denied. Primary duties: • Conduct pre-certification, continued stay review, care coordination, or discharge planning for appropriateness of treatment setting reviews to ensure compliance with applicable criteria, medical policy, and member eligibility, benefits, and contracts • Assure member access to medical necessary, quality health care in a cost-effective setting according to contract • Consult with clinical reviewers and/or medical directors to ensure medically appropriate, high-quality, cost-effective care throughout the medical management process • Collaborate with providers to assess members' needs for early identification of and proactive planning for discharge planning • Facilitate member care transition through the health care continuum and refer treatment plans/care plan to clinical reviewers as required and does not issue non-certifications • Facilitate accreditation by knowing, understanding, correctly interpreting, and accurately applying accrediting and regulatory requirements and standards	Requires current active unrestricted RN license to practice as a health professional within the scope of practice in applicable state(s) or territory of the United States and two years acute care clinical experience. Requires strong oral, written, and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

Role	Description of Responsibilities	Skill Sets
Subcontractor Oversight Manager	The Subcontractor Oversight Manager maintains responsibility for managing relationships with multiple vendors to ensure business goals are achieved. Duties include managing the day-to-day execution of vendor agreements to ensure compliance, monitor quality, and when necessary, develop corrective action plans. This role also reconciles vendor invoices, and may participate in fact-based negotiations of agreements and/or participate or lead cross-functional teams to implement vendor services.	Requires a bachelor's degree in business or related field required, plus five to seven years of increasingly responsible professional level contract management/vendor management experience; or any combination of education and experience that would provide an equivalent background.
Wellness Recovery Specialist	The Wellness Recovery Specialist is responsible for care coordination and/or care management activities focused on the wellness and recovery of members. Primary duties: - Identify opportunities for engagement of members and their families in forming a supportive, recovery network - Develop and implement provision of on-site psychiatric discharge planning education at Recovery and Resiliency sites - Collaborate with stabilization teams as a member advocate in discharge planning education, resolution of barriers, and service transitions - Act as a resource for staff on decision-making and problem-solving - Initiate and maintain contact with assigned individuals and providers to determine members' response to services	Requires an Associate's degree; two years of experience in health services or BH field or in a peer support services role, knowledge of care coordination and case management concepts; or any combination of education and experience that would provide an equivalent background. BA/BS or MBA preferred. Peer Specialist Certification required.
Medical Management Support	Medical Management Support is responsible for providing non-clinical support to the Utilization Management area. Primary duties may include, but are not limited to: Gathers clinical information regarding case and determines appropriate area to refer or assign case (utilization management, case management, QI, Med Review). Provides information regarding network providers or general program information when requested. May assist with complex cases. Maintains and updates tracking databases. Prepares reports and documents all actions. Responsibilities exclude conducting any utilization management review activities which require interpretation of clinical information.	Requires a high school diploma; 1 year of experience with an understanding of managed care or Medicaid/Medicare; or any combination of education and experience, which would provide an equivalent background. For URAC accredited areas the following applies: Requires strong oral, written and interpersonal communication skills, problem-solving skills, facilitation skills, and analytical skills.

3. Existing Business Relationships With the State

Describe any existing or recent (within the last five [5] years) business relationships the Vendor or any of its affiliates or proposed subcontractors have with the State, the State's counties, and/or the State's local municipalities. The Vendor should provide their response as part of their bid.

Existing Business Relationships with the State

In this section, we describe business relationships that UniCare, our affiliates, and proposed subcontractors have with the State, the State's counties, or the State's local municipalities. We provide information on existing (or current) business relationships, as well as those completed within the last five years (January 1, 2015 through January 15, 2020).

UniCare

UniCare is dedicated to serving West Virginia MHT programs. Our only business relationships with the State and the State's counties are in support of MHT programs. We have no business relationship with local municipalities.

UniCare has an existing contract with DHHR to provide Medicaid managed care services. UniCare is an MCO and serves West Virginia members statewide as part of the MHT programs. Our first contract started on January 1, 2003 and our current contract term is from July 1, 2019 through June 30, 2020.

UniCare has existing relationships with 27 county health departments. County health departments are contracted participating providers that perform billable services for our members, such as immunizations and family planning. We have existing relationships with the following county health departments:

- | | |
|-------------------------------------|---------------------------------------|
| ▪ Barbour County Health Department | ▪ Clay County Health Department |
| ▪ Beckley-Raleigh Health Department | ▪ Doddridge County Health Department |
| ▪ Berkeley-Morgan Health Department | ▪ Grant County Health Department |
| ▪ Boone County Health Department | ▪ Greenbrier County Health Department |

- | | |
|---|---|
| <ul style="list-style-type: none"> ▪ Hampshire County Health Department ▪ Hancock County Health Department ▪ Hardy County Health Department ▪ Harrison Clarksburg Health Department ▪ Jackson County Health Department ▪ Kanawha-Charleston Health Department ▪ Lewis County Health Department ▪ Lincoln County Health Department ▪ Marshall County Health Department ▪ McDowell County Health Department | <ul style="list-style-type: none"> ▪ Mercer County Health Department ▪ Mid-Ohio Valley Health Department ▪ Mineral County Health Department ▪ Monongalia County Health Department ▪ Pendleton County Health Department ▪ Randolph-Elkins Health Department ▪ Tucker County Health Department ▪ Wayne County Health Department ▪ Wetzel-Tyler Health Department |
|---|---|

UniCare also has an existing business relationship with the Kanawha County Emergency Ambulance Authority (KCEAA), a non-profit organization created in 1977 by the Kanawha County Commission. This business relationship started in November of 2018, to support our efforts to locate members we are unable to contact.

Affiliates

UniCare's affiliates have no existing or recent business relationships with the State, the State's counties, or the State's local municipalities.

Proposed Subcontractors

One of our proposed subcontractors reports existing or recent business relationships with the State, the State's counties, or the State's local municipalities.

Vision Service Plan, our vision benefits provider, discloses the following business relationships for which they provide vision care administration:

■ Existing

- Child Protect of Mercer County, Inc.
- City of Wheeling
- Harrison County Emergency Squad
- Star City Volunteer Fire Department
- Wetzel County Committee on Aging

■ Recent

- City of Hinton (ended November 1, 2016)
- City of New Martinsville (ended October 1, 2017)
- City of Vienna (ended July 1, 2017)
- Monongalia County Solid Waste Authority (ended December 1, 2015)
- Wayne County Community Services (ended July 1, 2016)
- Wetzel County Emergency Ambulance Authority (ended August 1, 2015)

4. Business Disputes

List any regulatory actions, sanctions, citations, deficiencies, audit findings, investigations, contingencies, or recommendations received in any state within the last two (2) years, along with the Vendor's response and plan of correction. The Vendor should provide their response as part of their bid.

Disclose if the Vendor or its parent company (including other managed care subsidiaries of the parent) has had a Medicaid, Medicare, or any other federal health program managed care contract terminated or not renewed for any reason within the past five (5) years, or if it has elected to terminate or non-renew. In instances of involuntary termination or non-renewal, the Vendor should describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The Vendor should also describe any corrective action taken to prevent any future occurrence of the problem(s) that may have led to the termination or non-renewal. In instances of voluntary termination or non-renewal, the Vendor should describe the factors contributing to its decision. The Vendor should provide their response as part of their bid.

Business Disputes

UniCare and our affiliates operating Medicaid managed care contracts have not been subject to an investigation in the last two years. Additionally, UniCare and our affiliates have never had a Medicaid, Medicare, or any other federal health program managed care contract involuntarily terminated or not renewed.

In the following sections, we provide information on regulatory actions (including sanctions, deficiencies, audit findings, contingencies or recommendations) and contract terminations first for UniCare, and then for our parent company and our affiliates (other managed care subsidiaries of our ultimate parent company). We follow these disclosures with a discussion of UniCare's *Investment in Compliance*, which outlines the actions we take to maintain compliance in our MHT programs.

UniCare

Regulatory Actions

UniCare is committed to compliance with our SPA and State and federal guidelines and transparency with DHHR and the Bureau for Medical Services (BMS). We educate employees, subcontractors, and

providers; develop and update policies and procedures; implement monitoring and audit mechanisms; and enforce strict guidelines to comply with SPA requirements. We provide additional information about our commitment and our organization, tools, and processes at the end of this section.

As requested, we provide information on regulatory actions, sanctions, citations, deficiencies, contingencies, audit findings, and recommendations received by UniCare within the last two years (January 16, 2018 through January 15, 2020), along with the response and plan of correction. *UniCare has never been subject to an investigation.*

In the last two years, BMS has requested one Corrective Action Plan (CAP) and assessed liquidated damages one time. UniCare has also been subject to two External Quality Review (EQR) audits in the last two years, auditing calendar years 2017 and 2018. We describe each of these in the following sections.

BMS CAP. On March 1, 2019, UniCare received notice of non-compliance with the enrollment of physician assistants as PCPs per Section II, §6.2 of the agreement. UniCare was reminded that should a physician assistant wish to be a PCP and meet the requirement of a collaborative agreement with a supervising physician that permits independent practice, we must reimburse the physician assistant as a rendering, independent provider. The CAP required UniCare to identify and reprocess claims from physician assistants that were denied and submit documentary evidence that we have operational processes in place to allow them to practice and bill independently and serve as PCPs. As of April 1, 2019, UniCare satisfied the requirements of the CAP.

BMS Liquidated Damages. On December 14, 2018, UniCare was assessed \$5,000 in liquidated damages for not notifying impacted provider(s), as directed by the BMS, of the revised drug testing policy and the prorated testing limits allowed before prior authorization is required. UniCare quickly engaged with providers directly to make sure they understood the revised policy, and to address questions. Since

then, we have increased our provider education efforts through newsletters, bulletins, and fax blasts to keep providers informed of policy and operational changes. For example, with the recent carve-in of the substance use disorder (SUD) benefit, we posted information to our provider website to educate providers on the SUD waiver and where they can get additional information. In 2019 we posted more than 50 individual bulletins, invitations, and updates to the *Provider Manual and Important Updates* section of our provider website.

Audits

On March 6, 2019, UniCare's EQR for 2018 was conducted. The review focused on grievances, appeals, and denials. After receipt of the March 15, 2019 Exit Letter, UniCare began to address the findings and submitted updated drafts of grievance and appeal policies on March 29, 2019. In the final 2018 System Performance Review report, received on August 14, 2019, the auditor requested six CAPs related to specific elements. We submitted our CAP response on October 1, 2019. In our quarterly CAP update to the auditor on January 8, 2020, we provided documentation to demonstrate the action items for all CAPs are complete.

On March 20, 2018, UniCare's EQR for 2017 was conducted to assess compliance with federal and State regulations and requirements for the MHT contract. The EQR focused on member rights, MCO standards, and program integrity contractual requirements. The Exit Letter UniCare received on March 30, 2018 described three issues we quickly addressed by updating our internal policy to align with coordination and continuity of care requirements. UniCare also provided additional evidence to support the program integrity requirements. In the final 2017 System Performance Report issued in June 2018, UniCare received a 100% compliance rate on this audit, and no CAP was issued.

Contract Terminations or Non-renewals

UniCare has never had all or part of a managed care contract partially or fully terminated or not renewed for any reason, voluntary or involuntary.

Affiliates

We provide information on regulatory actions, sanctions, citations, deficiencies, contingencies, audit findings, and recommendations received by our affiliates operating Medicaid, Medicare, or any other federal health program managed care contracts within the last two years (January 16, 2018 through January 15, 2020), along with the response and plan of correction in Supplemental Document 3.4-1a: Medicaid Affiliate Regulatory Actions and Supplemental Document 3.4-1b: Medicare and Federal Programs Affiliate Regulatory Actions. *None of these affiliates have been subject to an investigation in the last two years.*

Contract Terminations or Non-renewals

Together, UniCare and our affiliates currently serve more than 11.2 million members across the country through Medicaid, Medicare, or other federal health program managed care contracts. *UniCare and our affiliates have never had all or part of a Medicaid managed care contract partially or fully terminated or not renewed for any reason.* Within each of these contracts, UniCare and our affiliate health plans have been reliable and accountable sources of managed health care for a variety of populations. We are proud that UniCare and our affiliates have never terminated a Medicaid managed care contract due to disagreements regarding rates or contract terms.

Voluntary Termination or Non-renewal

In 2015, our New York affiliate, HealthPlus HP, LLC (HealthPlus), was operating under a three-year Fully Integrated Duals Advantage Demonstration contract with CMS and the New York State Department

of Health (NY DOH). By mutual agreement with CMS and NY DOH, and in accordance with contract provisions, HealthPlus ended participation in the project after the first year in order to focus resources on the successful carve-in of additional benefits and programs under their core Medicaid contracts, such as the Health and Recovery Plans product. HealthPlus cooperated with CMS to provide covered services to participants until successful transition. The address for HealthPlus is 14 Wall Street, New York, New York 10005, and the telephone number is 212-563-5570.

Our Investment in Compliance in West Virginia

UniCare has a strong, proactive Compliance program led by our West Virginia-based Compliance Officer, Richard Chapman, and supported by the extensive resources and best practices of our national Compliance department. Our dedicated West Virginia Compliance team maintains comprehensive repository of all our contractual requirements and commitments.

Our Compliance program maintains a robust system of processes and controls to prevent, identify, and mitigate potential risks. It is founded on the principles of the U.S. Department of Justice's (USDOJ) seven fundamental elements of an effective Compliance program:

1. Implementing written policies, procedures, and standards of conduct
2. Designating a compliance officer and compliance committee
3. Conducting effective training and education
4. Conducting internal monitoring and auditing
5. Reporting and investigating
6. Enforcing standards through well-publicized disciplinary guidelines
7. Responding promptly to detected offenses and undertaking corrective action

Our commitment to compliance is reflected in one of our core values — Integrity — Do the right thing, with a spirit of excellence. We believe that integrity, including fostering open, honest communication and dialogue across our health plan and with DHHR, is at the core of our ability to meet the expectations and goals of DHHR, providers, members, and the communities we serve.

To support our commitment to integrity, UniCare invests in dedicated resources that strongly focus on SPA compliance and education, monitoring and oversight, and risk identification and mitigation.

Our entire full-time dedicated West Virginia Compliance team, our Compliance Officer, MHT Regulatory Manager, and Compliance Analyst, benefits from oversight, guidance, and sharing best practices with our affiliate health plans. An outline of the components of our West Virginia program and support resources using the USDOJ framework follows.

Implementing Written Policies, Procedures, and Standards of Conduct

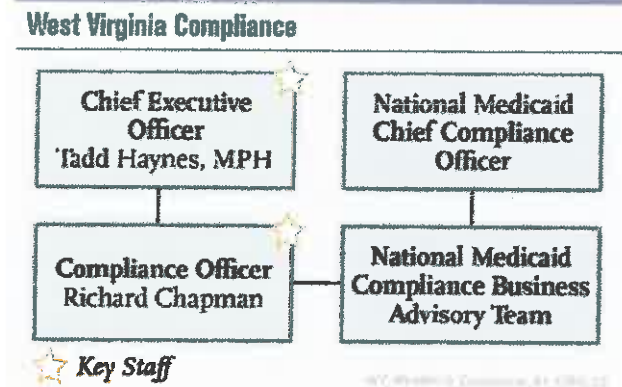
Policies and Procedures. UniCare maintains a robust library of policies and procedures that address regulatory, contractual, and other program requirements. Functional managers throughout the organization develop our policies in consultation with our dedicated Compliance Officer and MHT Regulatory Manager. These policies play a major role in guiding health plan activities and operations. We regularly monitor and review policies and procedures and publish them on an internal website accessible by all employees. Our Compliance Officer reviews all policies at least annually, triggered by a regulatory action or business need or as part of a required annual review. In 2019, our Compliance Officer reviewed and approved 352 policies and procedures to confirm compliance with State and federal laws, as well as contract guidelines. As a result of the new requirements in the State Fiscal Year 2020 contract, we recently updated our member appeals policy to comply with the new continuation of benefits language.

Standards of Ethical Business Conduct (the Code). All UniCare employees must acknowledge and agree to comply with the Code as a condition of employment. It applies to UniCare and all our affiliate health plans, and is designed to help employees understand and comply with legal, regulatory, and contractual responsibilities and act in a way that supports our principles.

Designating a Compliance Officer and Compliance Committee

Compliance Officer. Our Compliance Officer, Richard Chapman, works out of our office in Charleston and reports directly to our CEO and up to our organization's National Medicaid Chief

Figure 3.4-1. West Virginia Compliance Leadership



Compliance Officer. He partners with health plan leadership to provide extensive and focused engagement on issues, including education and training; risk identification and mitigation; identification of process gaps; validation of compliance levels; and development and oversight of corrective actions and remediation plans. Richard designs and implements the annual Compliance Plan while working with UniCare leadership to develop strategic plans and make process improvement recommendations. Additionally, our Compliance Officer provides executive-level oversight and works collaboratively across all functional areas to infuse compliance into everything we do. Ongoing meetings that include counterparts at our affiliate Medicaid health plans (illustrated in Figure 3.4-1) help our Compliance Officer stay abreast of any related potential compliance issues across the Medicaid line of business.

MHT Regulatory Manager. Our MHT Regulatory Manager, Amber Nary, is our primary liaison with DHHR for day-to-day contract management and oversight issues and also works out of our Charleston office. Amber manages submission of all required regulatory reporting and serves as our internal subject

matter expert and resource on UniCare's contractual and regulatory obligations. We continue to have an excellent reporting relationship with BMS. From 2018-2019, reporting timeliness was 100% and no reports were returned for quality issues. Our MHT Regulatory Manager also serves as BMS' primary point of contact to quickly resolve provider and member issues that BMS receives.

UniCare Compliance Committee (UCC). Chaired by our CEO, Tadd Haynes, and led by our Compliance Officer, Richard Chapman, our UCC comprises executive-level leadership, our MHT Regulatory Manager, as well as leaders from various departments, including Quality, Utilization Management, Care Management, Operations (claims, encounters, and call centers), Network Management, Program Integrity, Member Services, Provider Services, and Human Resources. The UCC meets at least quarterly and provides a forum for health plan leadership to review and discuss emerging issues and upcoming activities, assess potential risks, and provide input into mitigation activities and corrective action plans. Topics discussed during the meetings include regulatory updates, compliance issues, and risks that are being monitored by the Compliance team, as well as serving as an open forum for UCC members to discuss any potential compliance issues.

Conducting Effective Training and Education

Extensive Compliance Training. All UniCare employees receive mandatory compliance training at initial hire and annually. The training covers key topics, including fraud, waste, and abuse; HIPAA; and other aspects of the program, such as the Code, cultural competency, and drug-free workplace policies and procedures. We track and monitor completion of required training through our online learning systems and the Compliance team works with Human Resources to confirm completion.

Quarterly Continuing Education. During the first quarter of 2020, our Compliance team will begin a series of quarterly employee education sessions to reinforce our commitment to ethics, compliance, and

privacy. Our training for each quarter of 2020 will highlight topics from the Code of Ethics, which is the foundation of our Ethics, Compliance, and Privacy program. During our March session, we will provide employees with an overview of our commitment to integrity, our shared responsibilities, and ways to report any violations of the Code. Each quarter afterwards, we will build on the Code and offer additional topics, such as our work environment, protecting information, ethical business practices, and compliance with State and federal laws and program requirements.

Reinforcing Awareness. We conduct additional compliance education and awareness activities throughout the year. An annual Ethics, Compliance, and Privacy Awareness Week includes activities and information highlighting how employee commitment supports overall success. During the 2019 week, held in late October, one topic addressed the importance of privacy, including statistics on numbers of records stolen worldwide (71 per second), the average cost of health care breaches compared to other industries (\$429 per record), and the obligation of each employee to protect privacy. In addition, our national Medicaid Special Investigations Unit sponsors periodic awareness initiatives that include educational materials and activities to help employees better understand how they can help identify and prevent fraud, waste, and abuse (FWA). The annual Fraud Awareness Week (held in November 2019), expanded awareness through screen savers on all employee computers, imagery on office TV screens, articles on the intranet highlighting public cases, and an end-of-week review in the intranet newsletter.

Conducting Internal Monitoring and Auditing

Compliance Program and Work Plan. Our Compliance Officer develops and maintains a Compliance program and Work Plan. The UCC reviews and approves the Work Plan each year and receives regular progress updates. The core functions of the Work Plan track the seven elements of an effective

Compliance program: written standards, structured program, training and education, auditing and monitoring, reporting and investigation, enforcement and discipline, and response and prevention.

National Medicaid Chief Compliance Officer. UniCare has ready access to the resources of our National Medicaid Chief Compliance Officer and the Medicaid Compliance Business Advisory team. Collectively, this team manages Medicaid Compliance program initiatives, including effectiveness reviews, standardized risk identification, prioritization and mitigation framework, and overall direction and guidance by sharing best practices with our Compliance Officer and committees.

Partnership with Internal Audit. Our Compliance team and national Internal Audit department work together to help make sure master audit plans include key compliance issues and risks for detailed review, evaluation, monitoring, and corrective action as needed.

Reporting and Investigating

Speaking Up. Along with our affiliates, we work to establish a culture that encourages employees to “speak up” to identify any potential compliance concerns or issues through multiple reporting avenues. We maintain a strict and highly publicized policy of non-retaliation for any employee who proactively comes forward to identify potential risks or concerns. Posters, like

Figure 3.4-2. Posters in Our Office Reinforce Ethics Training



the one shown in Figure 3.4-2, are located in common areas of our office remind employees of compliance standards and provide resources.

Confidential Compliance HelpLine. An Ethics and Compliance HelpLine supports confidential (anonymous as requested) and secure reporting of potential violations. We investigate all reports and communicate the results to the national Medicaid Compliance Officer.

Enforcing Standards Through Well-publicized Disciplinary Guidelines

National Ethics and Compliance Office. The Ethics and Compliance Office administers and advises employees on the Standards of Ethical Business Conduct (described previously), serves as an independent resource to receive and investigate allegations of misconduct, provides training on ethics and compliance issues, and provides high-level oversight of those programs across the company.

Responding Promptly to Detected Offenses and Undertaking Corrective Action

Corrective Action. When we learn of any deficiency — whether identified by DHHR, a provider, a member, or internally — our Compliance Officer, in collaboration with other internal stakeholders and business owners, investigates the root cause of the problem and develops an action plan to address it and prevent a recurrence.

Taken together, these Compliance program components and national support resources represent a comprehensive, proactive approach to monitoring and enforcement. They promote full compliance with all State and federal requirements, provide comprehensive protection of our members' rights, and directly support the goals and objectives of DHHR's mission to provide high-quality health care services at reasonable and predictable costs.

Compliance 360 Supports Contract Compliance Activities

UniCare is committed to continuing to maintain high performance and meet DHHR's expectations and requirements under our current contracts. To augment our Compliance program and activities, we maintain a systematic approach to assessing, tracking, and reporting adherence to our contractual obligations, assisted by our Compliance 360 tool.

We use Compliance 360 to make sure we comply with new or revised regulatory requirements. Whenever there is a new or revised requirement, such as a contract amendment, policy update, or provider rate change, our MHT Regulatory Manager creates an alert and disseminates it to a wide range of employees and stakeholders. Leads from each functional area who are designated as Assessors evaluate alerts to determine whether the regulatory content affects their units. If it does, Assessors list planned tasks to meet contract requirements and document their completion. Our Compliance Officer monitors timely assessments and task completion. UniCare issued 117 Compliance 360 alerts in 2018 and 90 alerts in 2019.

Supplemental Document 3.4-1: Medicaid Affiliate Regulatory Actions

Supplemental Document 3.4-1 includes the following:

- Supplemental Document 3.4-1a: Medicaid Affiliate Regulatory Actions
- Supplemental Document 3.4-1b: Medicare and Federal Programs Affiliate Regulatory Actions

Medicaid Affiliate Regulatory Actions Audit Findings

Audit findings for Medicaid affiliates for audits conducted within the last two years, January 16, 2018 through January 15, 2020.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
1/10/20	NY	Regulator Audit	During this 2019 targeted operational survey, a review of provider contracts sampled found deficiencies.	Development of an action plan to address findings is in process and due for submission in February.
1/1/20	NY	Operational Audit	Findings in several areas, including grievance and appeal resolution timeframes, notification of fair hearing process, content of adverse determination notices, member notification of excluded provider, and behavioral health (BH) call center training.	Corrective Action Plan (CAP) to address findings is under development.
11/15/19	NJ	Regulator Audit	The state noted decreases in care management measures, including identification of members with care management needs, care management measures, continuity of care, timely outreach, coordination of services, and lead screening rates.	Created and executed work plan to address findings. Work plan included action plan category, goal, barrier, ongoing interventions, responsible party, and status update. Action plan categories addressed member identification, member outreach, timely care plan completion, documentation of coordination of services, and preventive lead screenings.
10/31/19	LA	Financial Exam	The state had questions on the amount reported on Line 17, other taxes and licensing and regulatory fees, and recommended an adjustment and process revision.	Executed a careful review of the audit findings and recommendations and provided a response letter to the auditor.
10/15/19	KY	External Quality Review	This audit identified six findings related to utilization management (UM), pharmacy, and program integrity. Specific deficiencies included lack of detail in policies and procedures and failure to provide documentation to demonstrate compliance.	Created and executed CAP to address findings, including updating grievance and appeal processes and updating member handbook.
10/9/19	TX	Operational Audit	Findings across several areas, including UM, care management (confirm approved durable medical equipment [DME] services were delivered, coordination with waiver program), claims (fee schedule updates and retroactive processing), grievances and appeals (appeal receipt notification, oral appeal written follow-up, updated policies and procedures), call center (training on Abuse, Neglect, and Exploitation), pharmacy (claim filing deadline), and website (information and provider directory function)	Provided requested DME sample reports to demonstrate compliance with requirements.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
10/1/19	WA	Regulator Audit	Findings across several areas: care management (file review, coordination of care), UM (authorization of services, timeframe for decisions), behavioral health (second opinion for children on non-medication recommendations), grievances and appeals (notice of action letter elements, expedited appeal resolution, and specific grievance resolution), quality (quality assessment and performance improvement program), provider network (expansion of Applied Behavior Analysis [ABA] providers), and health education (member health action plan, staff EPSDT training).	Created and executed CAP to address findings. Actions included the following: submission of completed PRC Claim Review Worksheets and updated procedures; revision of authorization procedures, including EPSDT; incorporation of "Top five Inpatient Diagnoses" data and analysis into UM program evaluation; modifications to the authorization work queue processes; review and improvement of the QM PIP program; and additional network analysis and outreach regarding ABA providers.
9/17/19	FL	Financial Exam	Audit of 2018 financial statement resulted in adjustment recommendations: use 2018 long-term care (LTC) PMPM amount (used 2017), adjustment to total LTC administrative maximum (understatement due to incorrect PMPM), need to include the amount of patient responsibility refunded to the plan by the state, and need to include related nursing facility and hospice days in prior year adjustment column.	Executed a careful review of the audit findings and recommendations without further action required or penalties.
8/21/19	NY	Operational Audit	A review of initial adverse determination notices found that they did not all contain the correct information (form effective date) and found that clinical rationale was not member-specific.	Executed action plan to update adverse determination notices to contain required and correct information and retrained employees on applying and documenting member-specific clinical rationale.
8/14/19	CA	Regulator Audit	Findings were in several areas: grievance and appeal (process and timing, tracking/trending issues, form on website), UM (communication did not include a direct line to physician, performance of delegated functions), pharmacy (clear clinical reason for denials), and quality (enrollee involvement, MD involvement).	Created and executed a plan of correction to address all findings areas. Action items included updating documentation and providing requested information. The state will visit the health plan in March 2020 to conduct a follow-up survey.
8/12/19	FL	External Quality Review	Findings were in care management policies and procedures, adding three conditions to definition of medical necessity, pharmacy prior authorizations (telephone notification of a denial), and subcontractor oversight (contract language).	Created and executed action plan to address findings, including reviewing and updating P&Ps for: medical necessity, pharmacy prior authorization, health care management denial information, and care coordination and case management (effective dates, specific to population and plan of care review/revision). Subcontractor contract addendums were drafted and completed.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
8/12/19	SC	External Quality Review	Findings across several areas, including: prior authorizations (timelines listed in notice of action letter and UM program description), grievance and appeals (language in acknowledgement letter, continuation of benefits pending outcome, policies and procedures, provider manual language), program integrity (add staff role to plan).	Various actions taken to address the findings and all revised material submissions were accepted by the reviewer as addressing the findings. This includes, but is not limited to: updates to anti-fraud plan to include information on the role of the Program Integrity Coordinator, revisions to the grievance and appeals information sheet to include additional details on processing timeframes, and changes to website glossary terms to from industry standard to more contract-specific.
8/1/19	NY	Regulator Audit	A review of Child Health Plus found that 27 of 50 enrollee files had missing or conflicting information with state files.	Provided information to address all findings and retrained staff to make sure information is correctly recorded in the case record and the system.
7/15/19	TX	Regulator Audit	In this service coordination audit, the state found deficiencies in face-to-face visits, confirmation of member receipt of approved services, and assessment of members in nursing facilities within 30 days of admission.	Provided requested Utilization Review findings and decisions for sample of hospital claims requested by the Office of the Inspector General (OIG).
7/2/19	FL	Regulator Audit	Annual CHIP network adequacy analysis included a recommendation to improve access to allergy and immunology and dermatology specialists in rural areas. Additionally, recommended review of pediatric specialists in rural areas to see if additional providers are available.	Created and executed action plan to address findings, including a careful review of provider types by county and submitting waiver requests to the state where there are no additional providers to recruit in order to meet access requirements.
7/1/19	GA	External Quality Review	The 2019 EQR for the Georgia Families program had findings across several areas, including member handbook, process for Member Advisory Committee, grievance and appeals (timely resolution, documenting name of reviewer in case file, timely/complete notifications), and subcontractor encounter quality/completeness review.	Created and executed a CAP to address findings. Actions included adding required definitions to the member handbook, retraining grievance and appeal staff on documentation standards and required resolution timelines, updating the Member Advisory Committee process to include member participation process, reviewing vendor agreements, and providing requested policy and process documentation for patient safety, claims, encounters, and program integrity.
7/1/19	MO	External Quality Review	A 2018 EQRO Audit identified deficiencies in the way the health plan documents disease management activities.	Created and currently executing an action plan to address findings.
6/28/19	CO	External Quality Review	The 2019 EQR included findings that EPSDT was not included in BH clinical criteria for UM and that the BH provider manual and other provider communications did not clearly document responsibilities related to EPSDT.	Created and executed a CAP to address findings. Actions included enhancing BH provider EPSDT communication, website 508 compliance, and alignment of medical necessity criteria for EPSDT-related services.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
6/28/19	GA	External Quality Review	The 2019 EQR for the Georgia Families 360 SM program (foster care) had findings across several areas, including: member handbook, prior authorizations (timely notification), grievance and appeal (timely resolution, timely/complete notifications), inconsistent medical necessary services language, and process for subcontractor encounter quality/completeness review.	Created and executed a CAP to address findings. Actions included adding required definitions to the member handbook, retraining grievance and appeal staff on documentation standards and acknowledgement and required resolution timelines, updating medically necessary services language to correct inconsistencies, reviewing vendor agreements, and providing requested policy and process documentation for patient safety, claims, encounters, and program integrity.
6/28/19	TX	Financial Exam	This 2016 financial statement audit findings included: insufficient documentation for other medical expenses, misstated capitated service expenses, unallowable executive compensation and administrative expenses, and pricing errors in medical and pharmacy claims tested.	Executed action plan to address findings, including: retraining employees on proper documentation; using Claims Audit program to identify issues; initiating an audit of all providers who receive capitation payments against contracts; and incorporating new data queries into financial systems to support FSR team analysis. After discussion with the state, the health plan also shifted the way it reports Pharmacy Benefit Manager (PBM) administration.
6/20/19	SC	External Quality Review	The 2018 EQR had two findings related to the member handbook, one related to disenrollment and one related to advance directives.	Member handbook was updated to correct a typographical error related to a hyperlink and clarify the disenrollment request review and approval process.
6/17/19	CA	Medical Audit	This 2018 audit identified five findings related to case management policies and procedures, medical director review of quality of care grievances, breach reporting, and provider training tracking.	Developed and executed action plan to address findings, such as review, update and submission of policies and procedures; retroactive review of 2018 clinical grievances; implementing new internal controls related to breach reporting; and new Provider Training Tracker.
6/7/19	MD	External Quality Review	The 2018 audit had an overall composite score of 95% with opportunities for improvement related to oversight of delegated entities, utilization review and policies and procedures.	Executed action plan to address findings, such as updating policies and procedures to reflect revised contractual requirements and clearer roles and responsibilities, increased communication to providers on program updates and modifying internal service level standards.
6/6/19	NJ	External Quality Review	The 2018 EQR found deficiencies in several areas, including network, Care Manager assignment changes, and that files selected for review were unavailable to auditors at the time of the on-site audit.	Created and executed CAPs to address findings in each area. Actions included continuing efforts to improve and maintain network, including appointment availability and after-hours standards; improve analytics for quality improvement plan processes; tracking for MLTSS provider education and office visits; timely notification of Care Manager assignment changes; and timely availability of all files requested for review.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
5/14/19	IA	External Quality Review	Achieved overall compliance score of 95%, with 4 of 80 elements identified as "not met" across three compliance monitoring standards: Availability of Services; Grievances, Appeals, and State Fair Hearings; and Quality Assessment and Performance Improvement.	Executed action plan to address findings, such as ensuring that optometry service appointment times meet standards, treating oral appeals in the same manner as written appeals, documenting reasonable efforts to provide oral notice of expedited appeal resolution, and as part of QM/QI program, monitor the prescribing patterns of psychotropic medication to children.
5/2/19	DC	External Quality Review	In this performance measure validation audit of EPSDT form CMS-416 performance measures, all but three elements met requirements.	No CAP issued by the state. Reviewed findings and recommendations to improve the training and supervision of the medical record review process.
4/18/19	TN	Regulator Audit	The Fall CHOICES member record review received an overall score of 97%, with two elements scoring less than 90%.	No CAP issued by the state. Reviewed findings and recommendations to identify opportunities for improvement.
3/14/19	TN	Regulator Audit	In the Fall Employment and Community First (ECF) CHOICES enrollee record review received an overall score of 96%, with three elements scoring less than 90%.	No CAP issued by the state. Reviewed findings and recommendations to identify opportunities for improvement.
3/13/19	KY	External Quality Review	Findings in several areas, including member handbook information, updating policies with new contract language, missing documentation for pharmacy, required updates to anti-fraud plan, and missing information from the UM and credentialing and recredentialing policies.	Developed and executed action plan to address findings, including updating the member handbook, providing missing documentation, updating the anti-fraud plan, and updating multiple policies and procedures.
3/5/19	CA	Regulator Audit	Findings across several areas, including credentialing (policies, file review), provider training (cultural and linguistic), claims processing (oversight, dispute resolution process, third party liability), member grievances, and pharmacy (denial/appeal file review).	Created and executed CAPs to address findings across deficient areas.
2/11/19	DC	External Quality Review	Findings across several areas, including adding additional information to the hard copy provider directory and updating the policy; corrective actions for provider non-compliance with timely access standards; and review/update of member notice content and compliance with timing requirements.	Executed action plan to address findings, such as updating the provider directory policy and working with subcontractors to ensure compliance with provider directory requirements, adding corrective action process to the appointment guidelines policy, and updating member notice content and implementing monitoring reports to confirm timeliness.
11/27/18	TX	Regulator Audit	The audit had findings in three areas: reporting of medical and prescription expenses, improving financial reporting process, and pharmacy claims payment timeliness.	Executed action plan to address findings, such as developing new analytic programs and databases to support accurate classification of costs and placing the pharmacy subcontractor on a CAP to improve performance.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
11/19/18	FL	Regulator Audit	Findings included one related to claims rate cells and deficiencies in actuarial reporting.	Executed action plan to address findings, such as correcting actuarial findings and having the premium reconciliation team run a monthly report comparing 834 and 820 files at a member level and report under/overpayments to the state.
11/16/18	MD	Financial Exam	Findings on HealthChoice Financial Monitoring Report in several areas, including incentive and Federally Qualified Health Center payments, medical expense paid, inpatient days, and other expenses.	Executed thorough review of findings and took appropriate actions to address.
10/5/18	WA	Regulator Audit	Findings in several areas, including provider networks (providing evidence of monthly excluded provider monitoring, credentialing decisions following nondiscrimination policy), member information (tracking distribution of materials in alternative formats, policy and processes on provider billing of members), care management (inconsistent notification system for emergency room [ER] or inpatient stay admission/discharge), and pharmacy authorization deficiencies.	Executed action plan to address findings, such as providing requested documentation and policies, developing a new tracking process for member collaterals, and implementing remediation actions for pharmacy authorizations.
9/18/18	NJ	External Quality Review	This MLTSS nursing facility care management audit identified several opportunities for improvement.	Developed and executed action plan to address findings related to plan of care in an institutional setting, including documentation of agreement/disagreement with the plan of care, member goals including all five components, member inclusion in on-site visits and that the plan of care is updated for a significant change.
9/12/18	IA	External Quality Review	Findings related to care management (providing care plan to PCP), provider network (processes to monitor wait times, access, and timeliness), and grievances and appeals (update letters/notices).	Executed action plan to address findings, such as updating care plan policy, updating network monitoring policies, expanding provider types for appointment wait time survey, and revising grievance resolution and notice of action letters.
9/7/18	NJ	External Quality Review	This care management audit identified two categories/populations that scored below 80% for the 2016 findings, preventive services for the general population and for children — lead screening. Improvement was noted in the 2017 audit for both categories/populations.	Developed and executed action plan to address findings and continue efforts to improve results across all categories/populations.
8/31/18	FL	External Quality Review	Policies and procedures for member grievances and appeals need updates and the member handbook should include additional information about filing grievances and appeals.	Executed an action plan to address findings, such as updating the member complaints and grievances policy and procedure and the member handbook.

Supplemental Document 3.4-1a: Medicaid Affiliate Regulatory Actions

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
8/30/18	CA	Regulator Audit	Findings include need to update and implement behavioral health policies and procedures, improve process for reporting breaches, medical director review of quality of care grievances, and better tracking and monitoring of specialty referrals.	Executed action plan to address findings, such as: updating policies and procedures in several areas (clinical decisions and treatment plans adherence to the All Plan Letter requirements and privacy breach reporting); assigned a dedicated physician for grievance and appeals; and added elements to the UM audit tool for specialty referrals.
8/21/18	NY	Operational Audit	Findings in three areas: provider/network (three missing contract approval letters and network submission incorrectly listed one provider), subcontractor oversight (subcontractor did not send written notices of determinations to enrollees' providers), and UM (member notices).	Executed action plan to address findings, such as reviewing all provider contracts, auditing provider data prior to submission, increased subcontractor oversight, and monthly audits of subcontractors to include review of letters and denial decisions.
8/10/18	NY	Operational Audit	Findings included delegating services to a subcontractor without submitting contract to the state for approval and the subcontractor organization is not a New York state-registered utilization review agent.	Submitted contract to the state for approval and implemented processes to address use of subcontractor.
8/10/18	TN	Regulator Audit	In the fall enrollee record review, four elements received scores less than 90%.	A dedicated auditing position for ECF was added to provide additional monitoring, tracking and feedback for improved performance.
8/1/18	LA	Medical Loss Ratio	Audit identified misalignment between how MCO and state classified certain expenses and financial data such as UM and incurred medical expenses.	Facilitated discussions between MCO and state to explain rationale and provide statutory support for classification. Issue resolved.
6/29/18	LA	Agreed Upon Procedure	Findings included minor variances when tracing and agreeing specific elements of MCO's general ledger and financial statements.	Reviewed findings to manage ongoing accuracy of financial statements.
6/29/18	NJ	Agreed Upon Procedure	Findings were related to lag reports, income statement by rate cell grouping, and minor discrepancies in maternity outcome counts and income statement.	Reviewed findings and worked to ensure ongoing accuracy of financial reports.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
6/20/18	SC	External Quality Review	Findings across multiple areas, including operations (compliance committee membership), grievance and appeal (notice/handbook discrepancies and timely resolution), member correspondence (member handbook deficiencies and inconsistencies with website), preventive care (outdated preventive health guidelines brochure), and quality assessment and improvement (medical record review audit tool does not address all areas).	Executed action plan to address findings, such as updating the provider manual and website, updating the member handbook, revising grievance/appeal letters and processes, and updating the medical record review audit tool and associated policies.
6/13/18	FL	External Quality Review	Improve access to physical and occupational therapy and substance use specialists.	Execute action plan to solve network gaps and ensure proper representation of provider information in network files.
6/1/18	NV	External Quality Review	Findings indicated that no evidence was presented demonstrating state approval of subcontractor agreements and GeoAccess® review found six members where no PCP is within 25 miles.	Documentation provided showing state approval of subcontractor agreements, as well as policy that defines the requirement. Updated the policy addressing members residing more than 25 miles away from a PCP to include multiple methods of member outreach.
6/1/18	NY	Operational Audit	Member services representative provided incorrect information.	Research determined this to be an isolated incident due to a staff member issue. The staff member was retrained and counseled and broader department-wide education session executed.
5/21/18	TN	External Quality Review	ECF providers not included in the annual recredentialing policy.	Updated annual recredentialing policy to include ECF providers.
5/21/18	TN	External Quality Review	In the UM denial review, one member not notified within the required timeframe.	Conducted a review to identify the root cause of the missed timeframe and implemented additional monitoring processes.
4/19/18	IA	Regulator Audit	This focused study on person-centered planning and identified deficiencies.	Executed an action plan to address deficiencies, such as creating self-audit tool for state approval, and enhancing policies and procedures, and augmenting training plan.
4/2/18	IA	Regulator Audit	This Encounter Data/Program Integrity audit identified seven post audit action items, such as providing detailed documentation regarding pharmacy encounters, sending a list of claim IDs for removal from the missing reconciliation list, and determining a plan for correcting outstanding rejects related to missing National Provider Identifiers (NPIs) in transportation encounters.	Completed all action items as documented.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
3/30/18	DC	External Quality Review	Findings across several areas, including subcontractor agreement language, including additional information in provider directory and making it available on the website, cultural competency training, member rights and responsibilities policy, and member notices (such as adverse benefit determination).	Executed action plan to address findings, such as adding fields for URL, Americans with Disabilities Act (ADA), and cultural competency to the provider directory and loading a machine readable file format to the website, adding required language to the rights and responsibilities policy, and amending subcontractor agreements.
3/30/18	NJ	Agreed Upon Procedure	The audit had two findings related to claims. For one pharmacy claim in the sample, the paid amount did not match the supporting documentation. For two other claims, interest was not paid on late claims.	Developed and executed action plan to address findings.
3/16/18	NJ	Operational Audit	One routine and one retrospective core Medicaid UM file were untimely.	Reviewed findings and implemented procedures to ensure that services are authorized and retrospective authorizations are completed in a timely manner.
3/7/18	IA	External Quality Review	Findings included minor gaps in performance measure validation and use of incorrect specifications.	Improved measure calculations to better align with recommendations and state expectations.
2/1/18	TN	Regulator Audit	Instances of non-compliance noted in two regions for failure to administer home- and community-based services (HCBS) within prescribed timeframes.	Revised authorization process to include a standard operating procedure and trained the care coordination team.
2/1/18	TN	Regulator Audit	In the Abortion, Sterilization, and Hysterectomy (ASH) audit, one region did not achieve 100% compliance because three records reviewed were non-compliant due to issues with payment of claims or completion of the proper form for ASH procedure.	Reprocessed claims, as necessary, and delivered education to applicable providers on proper processing and filing of ASH claims.
2/1/18	TN	Regulator Audit	In the Q1 critical incident audit, non-compliance noted in all three regions for providers' failure to report critical incidents within the proper timeframes.	Critical incident reports continue to be reviewed daily. Non-compliant providers are issued a notice of non-compliance.
1/19/18	NY	Operational Audit	Findings covered multiple areas, including care management (lack of a back-up plan), operations (Board of Directors meeting minutes lacked detail), member correspondence (no evidence of annual notification of certain information and not routinely sending written notices on grievances not resolved immediately), and assessments (not routinely finalized within required timeframe).	Executed action plan to address findings, such as adding additional information to the annual member notice, implementing new process for non-same day grievances, including review of minutes during board meetings, and creating a new report and centralized function to monitor assessment finalization.

Other Actions

Disclosure of other actions received by Medicaid affiliates within the last two years, January 16, 2018 through January 15, 2020.

Date	State	Type	Description	Response/Plan of Correction
1/15/20	TN	Fine	Did not comply with approval and scheduling requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
1/10/20	KY	CAP	The SFY 2019 IPRO Prenatal Smoking Performance Improvement Plan found deficiencies within the PIP Review.	Action plan focuses on delivering accurate data collection and reporting for future PIPs. Tasks include documentation that clearly outlines the study and criteria for measures, adding PIP discussion as a standing item on the Member Advisory Committee agenda, and seeking out provider input related to barriers to care or ideas for improvement when performing medical record audits.
1/10/20	TN	Fine	Did not demonstrate a two-point improvement from the prior period on the 2019 Q3 provider directory audit.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
1/7/20	IN	Fine	Untimely response to an internet quorum (complaint received by the state).	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
1/3/20	TN	Fine	Transportation vendor did not comply with urgent trip requirements for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
1/3/20	TN	Fine	Did not comply with transportation approval and scheduling requirements for two members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
12/30/19	IN	Fine	Did not obtain state approval for one document posted on the member website.	Reminded business owner of contractual requirements and timeframes for state approval.
12/30/19	LA	Fine - Disincentive	Did not improve on 2 of 16 measures in quality performance measure withhold program for 2018.	Reviewed data for the two missed measures and created action plan to generate improvements.
12/20/19	FL	Fine	In September 2019, did not send notices of denial/reduction within the required timeframes.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
12/20/19	FL	Fine	In July/August 2019, did not meet network adequacy standards for specific specialties in specific regions.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
12/20/19	FL	Fine	Did not update printable provider directory monthly.	Educated business owner on need to adhere to internal and external due dates.

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Date	State	Type	Description	Response/Plan of Correction
12/20/19	FL	Fine	August 2019 report was not completed properly on the report template.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
12/19/19	FL	Fine	Untimely notification to the state of a HIPAA disclosure.	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
12/19/19	FL	Fine	State review of long-term care case records found some to be non-compliant with contract requirements related to documenting all activities and interactions.	Held team meeting and/or focused provider training to address need to adhere to contractual standards and the expected level of detail. Increased oversight monitoring.
12/19/19	FL	Fine	In August, September, and October 2019, nursing facility and hospice claims paid within 10 days did not meet standard.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional on-the-job (OTJ) training for applicable processors. Increased monitoring of claims aging and system alerts.
12/19/19	KY	Fine	Encounter submission did not meet performance measures for timeliness and accuracy in November 2019.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
12/19/19	TN	Fine	Transportation vendor did not comply with police report requirements after an accident.	Reviewed contractual standards with vendor regarding processes after an accident or incident. Increased vendor oversight/monitoring.
12/19/19	TN	Fine	Did not comply with transportation approval and scheduling requirements for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
12/19/19	TN	Fine	Late submission of November 2019 Patient Centered Medical Home (PCMH) payment report.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
12/19/19	TN	Deficiency Notice	December 2019 HCBS claims did not meet 14-day and 21-day processing metrics.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
12/18/19	FL	Fine	Encounter data submitted more than seven days after the adjudication date.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
12/17/19	TX	CAP	SFY 2017 — did not meet EPSDT timely check-up requirement.	Action plan to address findings is under development.
12/16/19	FL	Fine	Secret shopper calls found discrepancies with provider location data listed in the online directory.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.

Date	State	Type	Description	Response/Plan of Correction
12/16/19	TN	Fine	For Q3 2019, did not achieve required accuracy rates for provider telephone numbers and addresses on the provider enrollment file.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
12/13/19	TX	CAP	Claims project created to address reimbursement issues for a single provider was not completed within 60 days of project initiation.	Implemented a series of training and quality checks to make sure newly hired staff and organizational changes did not affect future claims projects. Actions included: distribute new claims payment policies to business units via Compliance 360 to assess impact. Initiated bi-weekly meetings to review Compliance 360 alerts and action plans in the benefits, pricing, and operational areas. Add additional quality checks for benefit pricing changes before implementation.
12/11/19	TN	Fine	Did not comply with transportation pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
12/11/19	TN	Fine	Late submission of Q3 2019 provider report.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
12/9/19	KY	CAP	Appeals team provided incorrect information to callers on how to submit an appeal request that may have affected other providers.	Submitted documentation to demonstrate compliance with state appeal processes.
12/9/19	TN	Fine	Late submission of Q3 2019 provider report.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
12/6/19	FL	Fine	Did not provide coverage for certain brand-name drugs on the state's Preferred Drug List (PDL).	Met with vendor to discuss compliance with state's PDL. Reviewed documentation to verify compliance. Increased vendor oversight/monitoring.
12/4/19	TN	Fine	Did not comply with transportation approval and scheduling requirements for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
12/3/19	TN	Fine	Did not comply with transportation pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
12/3/19	TX	CAP	OIG audit identified three areas: providing required face-to-face visits, timely follow-up on member receipt of approved services, and timely assessment of members after Nursing Facility (NF) admission.	As a result of other findings around these same timeframes, actions included hiring and implementing a four-week follow-up call team in late 2018 and early 2019 to improve the timeliness of member follow-up and service delivery. The Service Coordination team continues to work diligently to streamline processes and reduce unnecessary paperwork, resulting in more time to see all members as required.

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Date	State	Type	Description	Response/Plan of Correction
12/2/19	TN	Fine	Did not meet transportation approval and scheduling requirements (11 instances).	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
12/2/19	TN	Fine	Did not comply with transportation pickup and delivery standards (five instances).	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
12/2/19	TN	Fine	Did not comply with transportation urgent trip requirements for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
11/26/19	TN	CAP	October 2019 claims payment accuracy for nursing facility claims was one point away from the standard.	Actions included review of LTC NF claims after a patient liability rules update by claims analysts and re-education of claims analysts regarding non-patient liability claims errors. Affected claims were reprocessed.
11/25/19	IN	Fine	Q3 2019 member and provider call center metrics for calls answered by a live person within 30 seconds not met.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
11/25/19	IN	Fine	Percent of after-hours member calls returned within one business day not met in Q3 2019.	Identified root cause of performance variance and implemented process improvements including updates to real-time workforce management tool alerts.
11/25/19	IN	Fine	Q3 2019 member grievances and appeals not resolved within timeframe requirements.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
11/20/19	TN	Fine	Did not comply with transportation approval and scheduling requirements (four instances).	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
11/20/19	TN	Fine	Did not comply with transportation pickup and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
11/19/19	TX	Fine	Late submission of Financial Statistical Reports.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
11/19/19	TX	Fine	Did not respond timely or in the requested format to information requests from the Office of Inspector General.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
11/19/19	TX	Fine	EPSDT annual report not submitted timely and accurately.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders and on importance of verifying accuracy and completeness prior to submission.

Date	State	Type	Description	Response/Plan of Correction
11/15/19	KY	Fine	Encounter submission did not meet performance measures for timeliness and accuracy in October 2019.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
11/12/19	TN	Fine	Did not comply with transportation pickup and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
11/12/19	TN	Fine	Did not comply with transportation approval and scheduling requirements for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
11/12/19	TX	Fine	Did not correct nursing facility claims issues by the CAP due date. Remediation occurred beyond the original target date.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.
11/12/19	TX	Fine	Did not correct encounter data issues by the CAP due date. Remediation occurred past the original target date.	Worked with the Configuration Root Cause team to correct the error; identified and resubmitted affected encounter records.
11/12/19	TX	Fine	Late submission of Financial Statistical Report and Form B Registration Statement.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
11/12/19	TX	Fine	Pharmacy encounters not submitted timely.	Worked with the pharmacy vendor to clarify their contractual requirement to submit timely encounter data to the health plan. Implemented additional monitoring to alert the encounter team to missing pharmacy encounter files or encounters submitted past the requirement.
11/12/19	TX	Fine	February 2018 — missed appealed claims timeliness metric by one point.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
11/12/19	TX	Fine	Response to requests for information from OIG were untimely and inaccurate.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
11/8/19	FL	Fine	A review found long-term care case records that were not compliant with contract requirements.	Held team meeting and/or focused provider training to address need to adhere to contractual standards and the expected level of detail. Increased oversight monitoring.
11/8/19	KY	CAP	Provider manual did not include prepayment process language.	Updated provider manual with state-approved prepayment process language.

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Date	State	Type	Description	Response/Plan of Correction
11/8/19	TX	CAP	State Financial Reporting and Audit Coordination review of FY15 and FY16 found deficiencies.	CAP actions included: 1) retraining employees on proper documentation; 2) using Claims Audit program to identify issues; 3) initiating an audit of all providers who receive capitation payments against contracts; and 4) incorporating new data queries into financial systems to support FSR team analysis. After discussion with the state, the health plan also shifted the way it reports PBM administration.
11/7/19	TN	Fine	Twenty-seven rejected encounters not resubmitted within 45 days of rejection.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
11/7/19	TN	Fine	Did not comply with transportation approval and scheduling requirements for three members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
11/6/19	TN	Fine	Did not comply with transportation approval and scheduling requirements for three members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
11/5/19	FL	Fine	In March 2019, did not send a notice of adverse benefit determination to one member.	Conducted OTJ training on documentation requirements.
11/5/19	TN	CAP	In August 2019, focused claims review found one claim paid in error.	Actions included coaching the employee who made the error and sharing information with the team. Affected claim was reprocessed for correct payment.
10/29/19	IA	Fine and CAP	Q3 and Q4 SFY 2019 member grievance and appeal turnaround times did not meet standard.	The Grievance and Appeal Manager continues to use a daily report to track and monitor grievance and appeal resolution timeliness through frequent aging reports.
10/29/19	IA	Fine	Inaccuracies found in six Q3 SFY 2019 reports.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
10/29/19	IA	Fine	Two occurrences where prior authorizations did not meet standards.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
10/29/19	IA	Fine	Untimely completion of two care plans.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
10/28/19	TN	CAP	For August 2019, member services, provider services, and UM phone lines did not meet the standard for calls answered within 30 seconds.	This was a one-time incident related to technical issues in a phone system migration. The problem was identified immediately and quickly resolved by the IT team.
10/24/19	TN	Fine	Did not comply with transportation drug and alcohol requirement after an accident/incident.	Reviewed contractual standards with vendor regarding processes after an accident or incident. Increased vendor oversight/monitoring.

Date	State	Type	Description	Response/Plan of Correction
10/24/19	TN	Fine	In June 2019, claims payment accuracy for HCBS was below the standard.	Reviewed front-end audit configuration for accuracy and updated as necessary. Conducted OTJ training of claims processor on correct disposition.
10/22/19	TN	Fine	Did not submit information about transportation accident/incident within five business days.	Reviewed contractual standards with vendor regarding processes after an accident or incident. Increased vendor oversight/monitoring.
10/21/19	KY	Fine	In September 2019, did not meet encounter performance measures for timeliness and accuracy.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
10/18/19	FL	Fine	For April–July 2019, did not meet 10 business day requirement for NF and hospice claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
10/14/19	TN	CAP	For Q3 2019, did not achieve required accuracy rates for provider telephone numbers and addresses on the provider enrollment file.	CAP actions include educating providers refusing to participate in the validation survey, regular site visits to validate information, use of data vendors to improve accuracy of missing or incomplete provider data elements, and after-hours surveys to validate provider data and compliance with routine and urgent care service standards.
10/10/19	IA	Fine	Inaccuracies found in a July 2019 report.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
10/9/19	FL	Fine	Provider network file was submitted on time, but failed to import successfully.	Educated business owner on importance of verifying accuracy of data files prior to submission and monitor file upload process and state import results. Data files included as part of ongoing business owner report cards.
10/9/19	TX	CAP	Operational review of the LTSS and intellectual and developmental disability programs, with comprehensive focus on clinical processes related to the authorization and delivery of services, identified deficiencies.	Action plan focused largely on training, reviewing, and updating policies and procedures. Training/retraining topics included peer-to-peer process and timelines, therapy medical necessity reviews, medically necessity waiver services, completion of Individualized Service Plan narrative, and Abuse, Neglect, and Exploitation training. Updated prior authorization P&P with timeframe calculations and to address incomplete requests and updated member complaint and appeal P&Ps. Also updated adverse determination letter (content and format) and website content and links.
10/1/19	TN	Fine	Transportation vendor did not comply with the drug and alcohol requirement after an accident/incident.	Reviewed contractual standards with vendor regarding processes after an accident or incident. Increased vendor oversight/monitoring.

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Date	State	Type	Description	Response/Plan of Correction
10/1/19	TN	Fine	In Q2 2019, incorrect provider reports needed to be replaced on the provider portal.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
9/24/19	FL	Fine	Late submission of a weekly file.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
9/23/19	TN	Fine	Did not comply with transportation approval and scheduling requirements for three members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
9/23/19	TN	Fine	Did not comply with transportation pickup and delivery standards for seven members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
9/23/19	TN	Fine	Q2 2019 THL Provider Report was incomplete.	Educated business owner on importance of verifying completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
9/23/19	TN	Fine	Did not achieve 90% accuracy rates for telephone numbers and prenatal services on the provider enrollment file for Q2 2019.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
9/20/19	TN	Fine	Did not comply with transportation approval and scheduling requirements for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
9/20/19	TN	Fine	Did not comply with transportation pickup and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
9/19/19	KY	Fine	In August 2019, did not meet encounter performance measures for timeliness and accuracy.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
9/19/19	KY	CAP	The urine drug screening frequency change order implemented on July 1, 2019 was not configured correctly, causing incorrect claims denials.	CAP actions included claims system re-configuration and reprocessing of affected claims.
9/9/19	FL	Fine	Late submission of a weekly provider network file.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
9/9/19	KY	CAP	The SFY 2019 Medicaid Compliance Review conducted by IPRO found areas of non-compliance.	Updated policies and procedures to reflect appropriate contractual language.

Date	State	Type	Description	Response/Plan of Correction
9/5/19	LA	Fine	Q2 2019 IRPO audit compliance score was below minimum requirement for provider data accuracy.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
9/4/19	TN	Fine	Did not comply with approval and scheduling requirements (three members).	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
9/4/19	TN	Fine	Did not comply with pickup and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
9/3/19	TX	Fine	Did not correct identified field level issues with encounter data by the CAP due date. Remediation occurred beyond the originally reported target date.	Worked with the applicable functional lead team to identify the root cause of and implement processes to correct the error.
9/3/19	TX	Fine	Did not correct NF and non-NF duplicate claims issues by the CAP due date. Remediation occurred beyond the original target date.	Worked with the applicable functional lead team to identify the root cause of and implement processes to correct, the error.
9/3/19	TX	Fine	Health plan did not timely address OB/GYN providers identified in a prenatal appointment availability study in accordance with CAP.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
9/3/19	TX	Fine	Untimely submission of a CAP to address providers non-compliant with appointment availability standards.	Reminded business owners of contractual requirements and timeframes related to CAP submissions.
9/3/19	TX	Fine	Did not meet abandonment rate for the behavioral health crisis line.	Identified root cause of performance variance and implemented process improvements, including updates to real-time workforce management tool alerts.
9/3/19	TX	Fine	Pharmacy encounters not submitted timely.	Worked with the pharmacy vendor to clarify their contractual requirement to submit timely encounter data to the health plan. Implemented additional monitoring to alert the encounter team to missing pharmacy encounter files or encounters submitted past the requirement.
9/3/19	TX	Fine	Delay in response to several requests for information from the Texas Office of Inspector General and some data and information required resubmission due to format or accuracy.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.

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Date	State	Type	Description	Response/Plan of Correction
8/23/19	IN	Fine	100% of member appeals not resolved within time period during Q2 2019.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
8/23/19	IN	Fine	Prior authorizations processed within seven days was 96.93% for Q2 2019, just missing the 97% metric.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
8/23/19	IN	Fine	For Q1 2019, did not meet 98% threshold for encounter data completion and accuracy.	Conducted a detailed review of the variance, including root cause analysis.
8/22/19	TN	Fine	Did not comply with transportation pickup and delivery standards for three members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
8/22/19	TN	Fine	Semi-annual Heat Maps report had missing information.	Educated business owner on importance of verifying completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
8/21/19	TN	Fine	Did not comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
8/21/19	TN	Fine	Did not comply with approval and scheduling requirements for five members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
8/21/19	TN	Fine	Did not comply with drug and alcohol requirement after an accident/incident.	Reviewed contractual standards with vendor regarding processes after an accident or incident. Increased vendor oversight/monitoring.
8/21/19	TN	Fine	Q2 2019 Health Link provider sample report had missing information.	Educated business owner on importance of verifying completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
8/16/19	KY	Fine	July 2019 did not meet encounter performance measures for timeliness and accuracy.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
8/15/19	FL	Fine	Late submission of a provider network file.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
8/7/19	KY	CAP	Provider Prepayment Notification Letter did not include the specific reason for review, grievance and appeals rights, or the process to request removal of prepayment review.	Placed dental vendor on CAP. Dental vendor promptly updated system configuration to comply with cost sharing regulation. Completed claims adjustment and reprocessing for affected claims.

Date	State	Type	Description	Response/Plan of Correction
8/2/19	TN	CAP	Deficiencies in semi-annual heat map report. CAP requested with steps to improve quality control processes.	Actions included modifying intake processes to improve the quality and timeliness of reports, data submissions, and other deliverables related to the PCMH program, including: implementing version control and tracking of changes requested by the state, conducting collaborative review sessions with the state, and implementation additional quality control processes.
7/31/19	FL	Fine	Two disclosures of PHI were submitted to the state five days late.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
7/30/19	FL	Fine	LTC record review showed instances where timeframes for developing and approving a plan of care were not met.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
7/25/19	FL	Fine	May network file submission showed three instances (specific specialty and region) where network standards were not met.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
7/24/19	LA	Fine	The PBM made outbound calls to members in a manner that is prohibited.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring.
7/24/19	TN	CAP	In June 2019, claims payment accuracy for HCBS was less than the 97% standard.	This was a one-time occurrence in claims processing error. Affected claims were reprocessed appropriately and the claims team educated.
7/19/19	KY	Fine	In June 2019, did not meet encounter performance measures for timeliness and accuracy.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
7/16/19	TX	CAP	In the 2018 appointment and availability study for PCPs, did not meet the standard of 99% within 90 days for the LTSS program.	Actions included an annual audit survey of providers who show open panel but decline to see a member and outreach to educate provider offices on appointment standards. Health plan workgroup will continue to address survey results and address providers with continued non-compliance.
7/15/19	TN	Fine	Failure to comply with pickup and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
7/11/19	IN	Fine	Member appeals resolution metric not met for Q1 2019.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
7/11/19	IN	Fine	In Q1 2019, 100% of provider after-hours calls not returned within one business day.	Identified root cause of performance variance and implemented process improvements, including updates to real-time workforce management tool alerts.
7/11/19	IN	Fine	Timeliness metric for prior authorizations not met in Q1 2019.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.

Date	State	Type	Description	Response/Plan of Correction
7/11/19	TN	CAP	Q2 2019 provider data file did not meet accuracy requirement for telephone numbers and addresses.	CAP actions include educating providers refusing to participate in the validation survey, regular site visits to validate information, use of data vendors to improve accuracy of missing or incomplete provider data elements, and after-hours surveys to validate provider data and compliance with routine and urgent care service standards.
7/8/19	FL	Fine	Did not meet standard for nursing facility claims paid within 10 business days for December 2018 and January–March 2019.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
7/1/19	TN	Fine	In March 2019, claims payment accuracy for nursing facilities was below the 97% standard.	Reviewed front-end audit configuration for accuracy and updated as necessary. Conducted OTJ training of claims processor on correct disposition.
7/1/19	TN	Fine	In August 2018, vision provider missed metric for calls answered within 30 seconds by one point.	Increased vendor oversight/monitoring with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
6/27/19	CO	CAP	Website is not readily accessible per Section 508 guidelines (two regions).	CAP actions included: 1) website document accessibility course for communications team members; 2) hiring of Section 508 and accessibility lead for print and web materials; and 3) review of website using accessibility tool and implementation of enhancements.
6/27/19	CO	CAP	Need to enhance provider communication regarding requirements for providing EPSDT-related behavioral health services and update EPSDT medical necessity criteria to align with updated definition (two regions).	CAP actions included updating the BH provider manual with all appropriate EPSDT-related services, including developmental screenings and provision of diagnostic services in addition to treatment. Updated the UM policy and procedure to ensure all EPSDT-related requirements are captured and provided the updated policy to UM staff.
6/25/19	TN	Fine	Failure to comply with pickup and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
6/19/19	KY	Fine	In May 2019, did not meet encounter performance measures for timeliness and accuracy.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
6/19/19	KY	CAP	Dental vendor did not properly implement a requirement and was calculating copayments incorrectly.	CAP actions include correcting the copay configuration date of service logic to comply with state requirement, reprocessing impacted provider claims, notifying impacted providers and implementing a three level quality control check process.
6/19/19	KY	Fine	Late response to a request for an update on a provider complaint.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.

Date	State	Type	Description	Response/Plan of Correction
6/5/19	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
6/5/19	TN	Fine	Failure to comply with approval and scheduling requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
6/4/19	KY	Fine	Late response to a request for an update on a provider complaint.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
6/4/19	KY	Fine	Late response to a request for an update on a provider complaint.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
5/29/19	TN	Fine	Failure to comply with approval and scheduling requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
5/29/19	TN	Fine	Failure to comply with urgent trip requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
5/21/19	FL	Fine	Provider network file identifies deficiencies in specific specialties and specific regions.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
5/21/19	TN	Fine	Daily data file sent to the state did not include the required PCP field for some records.	Educated business owner on importance of verifying accuracy of data files prior to submission. Data files included as part of ongoing business owner report cards.
5/21/19	TN	Fine	In October 2018, claims payment accuracy for nursing facilities in one region were below standard.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
5/20/19	KY	Fine	In April 2019, did not meet encounter performance measures for timeliness and accuracy.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
5/20/19	TN	CAP	Annual Quality Study found that performance metric was missed for credentialing and UM notice of action letters.	CAP actions included revising credentialing reporting logic to include a review of any multi-market provider files to confirm reporting includes only the applicable status and initial credentialing or recredentialing for Tennessee CHOICES provider files. For the UM denial issue, performed staff retraining and implemented a daily pend authorization report and review process.

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Date	State	Type	Description	Response/Plan of Correction
5/17/19	TX	CAP	Did not meet the 100% threshold for clinician administered drugs for Q3 SFY 18.	Actions included correcting processing error to make sure NDC is populated on clinician administered drug encounters. Resubmitted corrected records. Additionally, conducted employee retraining on clinician administered drug claims process.
5/16/19	FL	Fine	An unapproved webpage was used to provide information on a health plan name change.	Conducted OTJ training for marketing team on contract requirements related to advance approval (where applicable) and internal/external document review and approval process.
5/16/19	FL	Fine	Distribution of unapproved materials at three marketing events.	Conducted OTJ training for marketing team on contract requirements related to advance approval (where applicable) and internal/external document review and approval process.
5/7/19	FL	Fine	Care Coordinator failed to attend a scheduled multidisciplinary team meeting.	Revised process to identify back-up staff for meetings and that escalation protections working properly.
4/26/19	TN	CAP	In March 2019, claims payment accuracy for nursing facilities was below standard.	For partial month and claims in history patient liability system issues, performed system recoding and testing. For manual claim errors, conducted claims staff retraining. Reprocessed all affected claims.
4/22/19	TN	CAP	January 2019 Focused Claims — claims were affected by a system error and did not reprocess correctly for one region.	CAP actions include making a system configuration change to update Level 1 nursing facility authorization requirement. Additionally, a review of all affected services paid when there was an incorrect system authorization override to ensure an authorization was in place.
4/19/19	KY	Fine	Did not meet timeliness and accuracy performance measures for encounters submitted during March 2019.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
4/19/19	NY	CAP	Did not meet encounter data quality measures.	Implemented manual and automated fixes to prevent recurrence. A senior analyst will review files until automated process is in place. Increased oversight of dental subcontractor.
4/17/19	FL	Fine	Untimely notification of a security incident that occurred with a subcontractor.	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
4/12/19	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
4/12/19	TN	Fine	In February 2019, claims payment accuracy for nursing facilities was below standard.	Reviewed front-end audit configuration for accuracy and updated as necessary. Conducted OTJ training of claims processor on correct disposition.
4/11/19	TN	CAP	In Q1 2019, did not achieve accuracy rate for telephone numbers on the provider enrollment file.	CAP actions include educating providers refusing to participate in the validation survey, terminating inactive provider records, and use of data vendors to improve accuracy of missing or incomplete provider data elements.

Date	State	Type	Description	Response/Plan of Correction
4/2/19	LA	Fine	Transportation vendor did not meet prompt pay metrics for February 2019.	Increased vendor oversight/monitoring with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
4/1/19	TN	Fine	Did not meet January 2019 prompt pay requirements for HCBS claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
3/26/19	TN	CAP	In February 2019, claims accuracy for nursing facilities was below standard.	CAP actions included system recoding and testing to address partial month patient liability claims system issues. For manual claim errors, conducted claims staff retraining. Reprocessed all affected claims.
3/25/19	TN	CAP	December 2018 Focused Claims — claims were affected by a system error and did not reprocess correctly for one region.	CAP actions included clean-up of all providers linked to the incorrect NPI and reprocessed any claims affected by the linking error.
3/22/19	TN	Fine	In Q4 2018, did not achieve accuracy rate for telephone numbers on the provider enrollment file.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
3/19/19	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
3/19/19	TN	Fine	Missed private duty nursing shifts for one member from July 10, 2018 to November 28, 2018.	Conducted OTJ training for assigned Care Coordinator and provider on contractual standards. Worked with vendor on corrective action.
3/15/19	KY	Fine	Did not meet timeliness and accuracy performance measures for encounters submitted during February 2019.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
3/13/19	FL	Fine	Transportation vendor was late for member pick up.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
3/13/19	IA	Fine	Inaccurate or incomplete submission of four reports.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
3/13/19	IA	Fine and CAP	Appeals processing did not meet timeliness standards.	The Grievance and Appeal Manager developed a daily report to track and monitor appeal resolution timeliness.

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Date	State	Type	Description	Response/Plan of Correction
3/13/19	IA	Fine and CAP	Member call center had 98% of calls answered, missing the 99% metric.	Underreporting by a subcontractor resulted in a missed contractual standard as reported. Subcontractor corrected reports going forward. If the calls are not answered by a person within 30 seconds, they are answered by an electronic device. Increased monitoring of subcontractor.
3/12/19	TX	Fine	In Q4 SFY 2017, did not correct duplicate claims issues by the due date.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.
3/12/19	TX	Fine	In Q4 SFY 2017, did not correct encounter issues by the due date.	Worked with the Configuration Root Cause team to correct the error; identified and resubmitted affected encounter records.
3/12/19	TX	Fine	In Q4 SFY 2017, untimely processing of CHIP vision claims in one service area.	Increased vendor oversight/monitoring with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
3/12/19	TX	Fine	In Q4 SFY 2017, submission of late and/or inaccurate financial statistical reports.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
3/12/19	TX	Fine	In Q4 SFY 2017, did not comply with the requirements of the state-approved fraud, waste, and abuse compliance plan.	Worked with the applicable functional lead team to identify the root cause of, and implement processes to correct the error.
3/12/19	TX	Fine	In Q4 SFY 2017, failure to respond to Inspector General request for information in the manner and format requested.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
3/11/19	IN	Fine	In Q4 2018, did not meet the timeliness standards for processing paper claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
3/11/19	IN	Fine	In Q4 2018, missed metric for new member health screenings.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
3/7/19	TX	CAP	The state's 2018 appointment and availability study found that the vision vendor missed the vision appointment standard for one population group.	Created fax blasts to educate vision providers of appointment and availability and referral requirements and instructed vision subcontractor to educate providers on standards. Incorporated Vision into Internal Workgroup initiatives to address non-compliant providers as part of action plans. Also increased continuous auditing of provider directories to assure accurate information. Finally, added vision as a specialty to conduct appointment and availability surveys.
3/6/19	TN	Fine	Failure to comply with pickup and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.

Date	State	Type	Description	Response/Plan of Correction
3/1/19	TX	CAP	A 2018 audit of state fiscal year 2016 had findings related to the allocation of medical expenses and administrative costs.	Actions included working with Internal Audit and IT departments to develop analytic programs and databases to help identify misclassified costs. The Internal Audit team data mine the General Ledger using key words to identify any potential unallowable costs.
2/25/19	FL	Fine	Multiple occurrences between September and December 2018 of member complaints related to late transportation pickups and drop offs.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/25/19	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/25/19	TN	CAP	Did not achieve 100% compliance with 2018 ASH Claims Payment Audit.	CAP actions include medical management staff training and recoupment for one improperly paid ASH claim.
2/21/19	TN	Fine	Failure to comply with the approval and scheduling requirements for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
2/21/19	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/21/19	TN	CAP	Did not meet January 2019 prompt pay requirements.	Re-educated the Electronic Data Interchange (EDI) team and updated instructions to ensure that no special characters are in the file naming convention. Additionally, implemented an overall front-end edit in production.
2/20/19	KY	Fine	Did not meet timeliness and accuracy performance measures for encounters submitted during January 2019.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
2/19/19	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/18/19	FL	Fine	Encounter data not submitted within seven days of adjudication for one week in November.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
2/18/19	FL	Fine	Encounter data not submitted within seven days of adjudication for one week in October and one week in November.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
2/18/19	FL	Fine	Did not meet timely notice of appeal resolution for two members.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting.

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Date	State	Type	Description	Response/Plan of Correction
2/15/19	FL	Fine	Suspected fraud and abuse was not reported within the required number of days.	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
2/15/19	LA	Deficiency Notice	Secret shopper survey for Q4 2018 found that provider directory information accuracy did not meet the 90% standard.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
2/15/19	TN	Fine	Untimely response to state request for information.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
2/15/19	TX	CAP	Benefit for overhead lifts inappropriately denied for some members.	Actions included conducting extensive training with providers, members, and our employees regarding the overall benefit and process for overhead lifts and implementing a dedicated team to monitor and process overhead lifts to improve timelines.
2/1/19	TX	CAP	Participation rates for members from birth through age 20 receiving timely checkups fell below 50% for certain service delivery areas in SFY 2016.	Actions include continuing to use a variety of outreach efforts to members and providers. Outreach methods include outbound calls to members about timely checkups, how to get help with transportation or scheduling appointments, and answer questions; reminders sent to members via text message; an award program that rewards members receiving timely exams; educational and training sessions/programs; and generating Missed Opportunity Panel reports for providers.
1/23/19	TN	CAP	Did not meet December 2018 prompt pay requirements.	Re-educated the EDI team and updated instructions to ensure that no special characters are in the file naming convention. Additionally, implemented an overall front-end edit in production.
1/18/19	KY	Fine	Did not meet encounter performance measures for December 2018.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
1/14/19	IA	Fine and CAP	Claims non-compliance included pharmacy vendor pricing issues and not collecting the correct client participation amount.	The CAP included: 1) working with the pharmacy vendor to correct pricing issues, reconcile claims, and resubmit encounters; and 2) modifying claims configuration to calculate the correct client participation amount, identify and recover amounts from providers, and resubmit encounters.
1/14/19	TX	CAP	The state's 2018 appointment and availability study found that OB/GYN providers were not meeting appointment wait time standards for high-risk pregnancies.	CAP actions include direct outreach to providers with open panels who decline to see members and continuing to include OB providers in the annual after-hours and appointment availability survey. Created a workgroup to address areas of improvement from appointment and availability surveys. Also created a dedicated OB Case Management team and program that assists members with obtaining and scheduling prenatal care appointments for both routine and high-risk appointments.

Date	State	Type	Description	Response/Plan of Correction
1/10/19	TN	CAP	In Q4 2018, did not achieve accuracy rate for telephone numbers on the provider enrollment file.	CAP actions include educating providers refusing to participate in the validation survey, terminating inactive provider records, and use of data vendors to improve accuracy of missing or incomplete provider data elements.
12/28/18	FL	Fine	Review of long-term care case records revealed incidents of non-compliance with contract requirements.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
12/21/18	KY	Fine	Did not meet performance measures for encounters submitted during November 2018.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
12/20/18	TN	Fine	Failure to comply with pickup and delivery standards.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
12/12/18	TX	CAP	During an SFY2017 information controls and security audit, the health plan did not provide requested information timely. During the review, monitoring of data center badge access was out of compliance with state guidelines.	Actions included drafting a new monthly process to review data center physical access logs that cover employee and visitor access. Upon review and if further action is needed, data center management engages with corporate security to investigate and/or address the issue.
12/11/18	IN	Fine	Did not return 100% of after-hours member calls within one business day in Q3 2018.	Identified root cause of performance variance and implemented process improvements, including updates to real-time workforce management tool alerts.
12/11/18	IN	Fine	Did not meet metric to provide health needs screen to new members within 90 days of enrollment in Q3 2018.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
12/7/18	TN	Fine	Late submission of requested ad hoc report.	Educated business owner on need to adhere to internal and external due dates identified for ad hoc reports.
12/6/18	NY	CAP	Q3 2018 encounter data completeness percent change was greater than 10% quarter over quarter.	Discussed dental encounters issue with the state and will resubmit encounters as needed. For institutional and professional, will review how the new logic handles administrative denials and if claims are being excluded from encounter submissions, logic will be fixed and encounters resubmitted.
12/5/18	TX	CAP	For Q4 SFY 2018, network adequacy for time and distance did not meet the threshold for several provider types in some contracted counties and service areas.	The CAP included validating provider profile panel information for accuracy. The health plan explained to the state that in some counties, providers are not available for contracting and members seek services in neighboring counties. The health plan will continue to offer transportation to the closest in-network and open panel practitioner.

Date	State	Type	Description	Response/Plan of Correction
12/4/18	LA	Fine	Two performance measures for 2017 fell below benchmarks: cesarean rate for low-risk first birth women and ambulatory care emergency department (ED) visits. For the ED measure, all five MCOs missed the target by a considerable margin.	Identified root cause of poor performance and implemented process improvements and additional outreach to increase score on measures.
12/4/18	NY	CAP	Of 150 providers called, 40 did not meet compliance measure. The rate of 73.3% is below the state's 75% threshold.	Actions include conducting periodic scheduled and unscheduled site visits and "secret shopper" calls and sending an informational letter to providers detailing the Standard Requirements.
12/4/18	NY	CAP	Out of 105 providers called, 29 providers failed the after-hours access requirement. Failure reasons included: told to leave a message and timeframe not specified, no answering service, and no live voice at second number.	Actions include conducting periodic scheduled and unscheduled site visits and "secret shopper" calls and sending an informational letter to providers detailing the Standard Requirements.
12/4/18	TN	Fine	Failure to comply with transportation urgent trips requirement for one member.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
12/4/18	TX	CAP	Participation rate for members (birth through age 20) receiving timely EPSDT checkups fell below 50% in some service areas for SFY 2016.	Actions include continuing to use a variety of outreach efforts to members and providers. Outreach methods include outbound calls to members about timely checkups, how to get help with transportation or scheduling appointments, and answer questions; reminders sent via text message; an award program for members receiving timely exams; educational and training sessions/programs; and generating Missed Opportunity Panel reports for providers.
11/30/18	IN	Fine	In Q1 2018, 98% encounter completion and accuracy rate not met.	Conducted a detailed review of the variance, including root cause analysis.
11/30/18	TN	CAP	September 2018 focused claims audit found claims denied incorrectly due to a system error that did not route claims appropriately for adjudication.	CAP actions included correction of medical coding edit causing claims to be incorrectly denied and weekly claims sweep implemented to identify impacted claims for reprocessing.
11/28/18	IN	Fine	Did not meet the required 98% threshold for institutional paper claims processed within 30 days (rate was 97%).	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.

Date	State	Type	Description	Response/Plan of Correction
11/28/18	IN	Fine	In Q1 2018, 100% of after-hours member calls were not returned within one business day.	Identified root cause of performance variance and implemented process improvements, including updates to real-time workforce management tool alerts.
11/28/18	IN	Fine	Did not meet the prior authorization timeliness threshold in Q1 2018.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
11/28/18	IN	Fine	For Q1 2018, did not meet metric to provide health needs screen to new members within 90 days of enrollment.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
11/28/18	IN	Fine	In Q1 2018, 100% of after-hours provider and member calls were not returned within one business day.	Identified root cause of performance variance and implemented process improvements, including updates to real-time workforce management tool alerts.
11/28/18	IN	Fine	For Q2 2018, did not meet metric to provide health needs screen to new members within 90 days of enrollment.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
11/26/18	TN	Fine	Did not comply with transportation pickup and delivery standards for eight members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
11/26/18	TN	Fine	Failure to comply with transportation urgent trips requirement for two members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
11/26/18	TN	CAP	October 2018 payment accuracy for nursing facilities in one region were below standard due, primarily, to manual processing errors.	CAP actions included staff retraining for manual claims processing errors and reprocessing affected claims paid incorrectly.
11/16/18	KY	Fine	Did not meet performance measures for encounters submitted during October 2018.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
11/9/18	IA	Fine	Prior authorizations did not meet contractual standards in Q4 SFY 2018.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
11/7/18	FL	Fine	Did not meet the minimum standards for some HEDIS® performance measures in 2017.	Identified root cause of poor performance and implemented process improvements and additional outreach to increase score on measures.
11/7/18	FL	Fine	Review of submitted continuity of care data found deficiencies.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.

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Date	State	Type	Description	Response/Plan of Correction
11/2/18	TN	CAP	August 2018 focused claims audit found that claims were not processed appropriately due to a file not being loaded timely.	CAP actions included loading backlog files into claims system and reprocessing impacted claims.
10/30/18	IN	Fine	Did not meet the encounter data completeness threshold in Q3 2017.	Conducted a detailed review of the variance, including root cause analysis.
10/30/18	KY	CAP	Vision vendor failed to load member eligibility file correctly, affecting the ability of members to receive services.	Vision vendor implemented additional controls to ensure immediate identification of any issues (for example, eligibility file monitoring process and errors being worked immediately) and conversion from full eligibility files to incremental enrollment files to allow for faster and cleaner quality review.
10/26/18	TN	Fine	Did not comply with transportation pickup and delivery standards for four members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
10/19/18	KY	Fine	Did not meet timeliness and accuracy performance measures for encounters submitted during September 2018.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
10/11/18	TN	CAP	Q3 2018 provider data did not meet accuracy rate for telephone numbers.	CAP actions included educating providers refusing to participate in the validation survey, terminating inactive provider records, and use of data vendors to improve accuracy of missing or incomplete provider data elements.
10/2/18	TN	Fine	Did not comply with transportation pickup and delivery standards for three members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
10/1/18	FL	Fine	Did not meet provider network standards specified in the contract.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
10/1/18	NY	Deficiency Notice	Health plan entered into an agreement without prior review and approval.	Reminded business owner of contractual requirements and timeframes for state approval.
10/1/18	NY	Deficiency Notice	Delegated claims payment and utilization review functions without state approval.	Reminded business owner of contractual requirements and timeframes for state approval.
9/28/18	FL	Fine and CAP	Between February 2016 and September 2017, there were instances where hospice claims were erroneously denied or paid incorrectly.	The CAP includes activities to ensure accurate and timely payment of hospice claims such as addressing all identified problem areas, training of employees, hospice claims processing audit, and potential reprocessing claims.
9/27/18	TN	CAP	August 2018 payment accuracy for nursing facility claims did not meet the 97% threshold in one region.	CAP actions included configuration change to add a warning message for Change of Ownership (CHOW) LTSS NF providers and updated NF claims processing instructions. Established update to knowledge library to make sure the posted CHOW list is current. Reprocessed affected claims.

Date	State	Type	Description	Response/Plan of Correction
9/25/18	FL	Fine	Failure to timely comply with enrollee resolution requirements.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting.
9/25/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
9/25/18	FL	Fine	One expedited appeal was not resolved within 72-hour timeframe.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting.
9/19/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
9/14/18	KY	Fine	August 2018 encounter submission did not meet requirements.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
9/14/18	TN	Fine	Q2 2018 provider data file did not meet accuracy requirement for telephone numbers.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
9/14/18	TN	Fine	Transportation vendor was two days late with notification of an accident.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
9/7/18	TN	Fine	Semi-annual report was late.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
8/27/18	NY	CAP	Did not submit encounter data for Q2 2018 in accordance with contract requirements.	A control was added that identifies accepted vendor claims from previous batches and will not allow them to be included an outbound file.
8/24/18	TN	Fine	Response to ad hoc report was not the information the requested asked for.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
8/22/18	TN	CAP	May 2018 focused claims found errors related to a CMS locality change not updated in the claims processing system.	The CAP included reprocessing claims affected by the system error a review of the end-to-end CMS fee schedule change process. The review formalized a process to notify key stakeholders of a potential delay between effective date and load date of changes to allow proactive manual mitigation.

Date	State	Type	Description	Response/Plan of Correction
8/20/18	NY	Deficiency Notice	2018 Operational Survey found deficiencies in provider notifications. Did not notify provider 60 days prior to potential contract termination and did not provide evidence of provider phone notification of adverse determination in 3 of 24 cases.	Reminded business owners of contractual requirements and timeframes related to provider notifications.
8/20/18	NY	Deficiency Notice	2018 Operational Survey found that did not provide approval letters to the state for all contracts.	Educated business owner on importance of verifying completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
8/20/18	NY	Deficiency Notice	2018 Operational Survey found one provider in the 4 th quarter submission that was no longer participating.	Reviewed situation to identify root cause and implement corrective action.
8/20/18	NY	Deficiency Notice	2018 Operational Survey found that a vendor did not ensure that clinical rationale was member-specific and did not send written notice of determination to enrollees' providers.	Worked with vendor on contract requirements and increased oversight.
8/20/18	NY	Deficiency Notice	2018 Operational Survey found that notices to members did not contain the correct fair hearing information and did not fully comply with Managed Care Action Taken requirements in all cases.	Reviewed existing materials to verify correct notice used when communicating with members.
8/18/18	KY	Fine	July 2018 encounter submission did not meet requirements.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
8/10/18	TX	CAP	Did not meet the performance standard for timely submission of pharmacy encounters.	Improvement actions include increased frequency for the submission cycle and enhanced monitoring controls. The state recently agreed that only certain types of denied encounters should be submitted. With clarification of the pharmacy submissions, internal control report indicates compliance with timeliness of pharmacy encounter submissions.
8/1/18	NY	CAP	LTC member services department provided incorrect answers on two questions.	The CAP includes employee retraining, monitoring via secret shopper calls, and updates to member services representative resources.
8/1/18	TN	Fine	Untimely response to prior authorization request.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.

Date	State	Type	Description	Response/Plan of Correction
7/31/18	IA	Fine	Five reports submitted late, inaccurate, or incomplete.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders and on importance of verifying accuracy and completeness prior to submission.
7/31/18	IA	CAP	Member pharmacy helpline performance did not meet performance standards.	The CAP includes a reevaluation of staffing needs to meet service level requirements, identified need for additional staff and cross-training additional resources, and monitoring hourly to make resource adjustments as needed during the day.
7/25/18	KY	Fine	Did not meet accuracy measures for encounters submitted in June 2018.	Conducted a detailed review of the variance, including root cause analysis.
7/24/18	TN	CAP	File submission included only one record.	This CAP included an additional process to perform a file conversion related to a company system conversion from FTP to SFTP.
7/19/18	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
7/19/18	TN	CAP	Vision vendor did not meet prompt pay benchmark to pay 100% of claims within 60 days, paying 33 claims late.	This CAP included the vision vendor establishing a daily claims queue monitoring process where the vision vendor's claims management team monitors the queue to ensure claims processors are researching and resolving claims in a timely manner.
7/17/18	TN	Fine	Failure to comply with pickup and delivery standards (two instances).	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
7/16/18	TN	CAP	Special Investigations Unit (SIU) investigators conducted an on-site visit of a provider without obtaining written permission from the state.	The CAP included re-education of SIU investigators to make sure written permission is obtained from the state before conducting an on-site visit of a provider under state investigation.
7/16/18	TN	CAP	Q2 2018 provider data file did not meet accuracy requirement for telephone numbers.	This CAP included education to providers refusing to participate in the validation survey, terminating inactive provider records, and use of data vendors to improve accuracy of missing or incomplete provider data elements.
7/10/18	TN	CAP	In fall 2017 audit (August 2016–July 2017), health plan fell below the compliance threshold in risk assessment and caregiver assessment.	CAP actions included staff training, implemented Person Centered Support Plan (PCSP) which includes fields for completing a risk assessment and caregiver assessment, launch of PCSP via iPad care management platform, development of guidance document, and development of PCSP internal audit process to monitor appropriateness of PCSP completion, including risk assessment and caregiver assessment.

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Date	State	Type	Description	Response/Plan of Correction
7/3/18	TN	Fine	Failure to comply with pickup and delivery standards (four instances).	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
6/25/18	LA	Fine	Secret shopper survey identified inaccuracies in provider directory information.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
6/22/18	FL	Fine	Did not respond timely to an ad hoc request for submission of policies and procedures.	Educated business owner on need to adhere to internal and external due dates identified for ad hoc reports.
6/21/18	FL	Fine	Did not meet provider network standards.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
6/20/18	FL	Fine	Encounter data submitted more than seven days after the adjudication date.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
6/18/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
6/15/18	KY	Fine	May 2018 encounters did not meet timeliness and accuracy measures.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
6/12/18	TX	CAP	A review of certain quarterly reports by a state-contracted third party identified four recommendations to improve the documentation of reported data.	Implemented internal corrective actions when reporting issues were identified in the audit. State conducted a training session for all MCOs in May 2018 and health plan is reviewing recommendations and requested corrective actions.
6/11/18	TX	CAP	2016 BH appointment availability study findings show availability standards.	Providers who indicate they do not have appointments available will receive individualized training to reiterate the appointment requirements, make sure they know they hold an active contract, and to provide timely notification of changes in status.
6/8/18	FL	Fine	Deficient submission of long-term care case records.	Held team meeting and/or focused provider training to address need to adhere to contractual standards and the detail expected in care plans. Increased oversight monitoring.
6/8/18	KY	Fine	Provider request for an external independent review not submitted to the state within the required five days.	Conducted OTJ training of impacted staff of process, documentation requirements, and completeness standard.

Date	State	Type	Description	Response/Plan of Correction
6/4/18	TX	CAP	Failed to timely update a provider's agreement to include a fee schedule so that the provider could be reimbursed at an LTSS benefit level for a service that is provided as acute care service and LTSS.	Amended the provider's agreement and put in place measures to make sure such agreements are not overlooked when revisions are needed. Also developed a tool to help the authorization team issue authorizations based on the terms of each provider's agreement.
5/24/18	NY	CAP	Q1 2018 failed to submit encounter data in accordance with contract requirements.	Actions included updating encounter procedures with additional controls.
5/24/18	TX	Fine	Failure to correct encounter issues by the due date.	Worked with the Configuration Root Cause team to correct the error; identified and resubmitted affected encounter records.
5/24/18	TX	Fine	Appealed claims processing did not meet 98% adjudicated within 30 days.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
5/24/18	TX	Fine	Claims processing did not meet 98% adjudicated within 10 days for nursing facility clean claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
5/24/18	TX	Fine	Pharmacy encounter data submitted late.	Worked with the pharmacy vendor to clarify their contractual requirement to submit timely encounter data to the health plan. Implemented additional monitoring to alert the encounter team to missing pharmacy encounter files or encounters submitted past the requirement.
5/24/18	TX	Fine	Financial Statistical Report submitted inaccurately.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
5/24/18	TX	Fine	Claims Lag Reports submitted inaccurately.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
5/24/18	TX	Fine	Did not respond accurately to Inspector General request for information.	Educated business owner on need to adhere to internal and external due dates identified for information requests from the state.
5/24/18	TX	Fine	Medical necessity level of care assessment not submitted within 45 days.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
5/24/18	TX	Fine	EPSDT annual report not submitted timely and accurately.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders and on importance of verifying accuracy and completeness prior to submission.
5/24/18	TX	Fine	Did not timely provide an administrative service.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.

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Date	State	Type	Description	Response/Plan of Correction
5/24/18	TX	Fine	Vision subcontractor did not process 98% of clean claims within 30 days.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring.
5/24/18	TX	Fine	Did not timely provide a covered service.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
5/22/18	TN	CAP	Annual Quality Study identified areas of non-compliance.	The CAP includes activities to revise the credentialing policy to address a specific group and creating a denial log workflow for UM.
5/18/18	KY	Fine	April 2018 encounters did not meet timeliness and accuracy measures.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
5/4/18	FL	Fine	Weekly provider network file uploaded incorrectly.	Educated business owner on importance of verifying accuracy of data files prior to submission. Data files included as part of ongoing business owner report cards.
5/4/18	FL	Fine	Encounter data submitted more than 7 days after the adjudication date.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
5/2/18	TX	CAP	For SFY17 Q4, submitted encounters for clinician administered drugs with invalid NDCs.	Activities include updating internal configuration and processes and submitting corrected records. Conducted additional employee education on NDC requirements to prevent manual errors.
4/30/18	FL	Fine	Did not meet the provider network standards for ENT (one region), pediatric nephrology (two regions), and rheumatology (one region).	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
4/23/18	FL	Fine	Review of behavioral health inpatient case records showed non-compliance with contract requirements.	Focused provider education/training on requirements related to developing and recording an individualized discharge plan.
4/20/18	FL	Fine	Did not submit a report indicating changes in event schedule start/end time.	Reminded business owners of contractual requirements and timeframes related to notifications to the state.
4/20/18	FL	Fine	Inaccurate long-term care reports submitted in November 2017, December 2017, and January 2018.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
4/20/18	KY	Fine	March 2018 encounters did not meet timeliness and accuracy measures.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
4/20/18	TN	Fine	Did not provide an acceptable CAP.	Educated business owner on importance of verifying accuracy and completeness of CAPs prior to submission.

Date	State	Type	Description	Response/Plan of Correction
4/20/18	TN	Fine	Report submitted one day late.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
4/19/18	TN	CAP	2017 EPSDT screening rates were deficient.	The CAP includes activities to improve screening rates for EPSDT age members, including a provider incentive pilot and embedding an employee in one region.
4/18/18	TN	Fine	Failure to comply with the approval and scheduling requirements for two members.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
4/18/18	TN	Fine	Failure to comply with the urgent trips requirements.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
4/13/18	FL	Fine	Q4 2017 Provider Complaint Report identified non-compliance issues.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
4/13/18	FL	Fine	Review of provider hospital contracts identified instances where it did not meet requirements.	Reviewed situation to identify root cause and implement corrective action.
4/13/18	TN	Fine	Missed home health aide shifts for a member between December 9, 2017 and January 12, 2017.	Conducted OTJ training for assigned Care Coordinator and provider on contractual standards. Worked with vendor on corrective action.
4/12/18	TN	CAP	Q1 2018 provider data file did not meet accuracy requirement for telephone numbers.	The CAP includes activities to improve provider telephone accuracy in the provider enrollment file, including continued work with data vendors, and continued regular provider visits to validate each element on the provider file.
4/11/18	IA	Fine	Submission of three untimely, inaccurate, or incomplete reports.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
4/10/18	FL	Fine	Did not include data in two required fields of the provider network file in April 2018.	Educated business owner on importance of verifying accuracy of data files prior to submission. Data files included as part of ongoing business owner report cards.
4/10/18	IN	Fine	For Q4 2017, did not respond to 100% of member grievances within the required timeframe.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
4/10/18	IN	Fine	For Q4 2017, did not resolve to 100% of member appeals within the required timeframe.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.

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Date	State	Type	Description	Response/Plan of Correction
4/10/18	IN	Fine	For Q4 2017, did not meet prior authorization metric.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
4/10/18	IN	Fine	For Q4 2017, did not return all after-hours helpline calls within one business day.	Identified root cause of performance variance and implemented process improvements, including updates to real-time workforce management tool alerts.
4/10/18	IN	Fine	For Q4 2017, did not meet health needs screen requirements for newly enrolled members.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
4/9/18	IA	Fine	Did not meet contractual standards for grievances and appeals.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
4/9/18	IA	Fine	Did not meet contractual standards for prior authorizations.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
4/5/18	FL	Fine	Did not meet provider network standards specified in the contract.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
4/3/18	NY	Deficiency Notice	Did not renew management services agreement with vendor prior to expiration.	Reminded business owner of contract requirements.
4/3/18	TX	CAP	For SFY 2017, PCP network did not meet thresholds for appointment wait times.	Providers who indicate they do not have appointments available will receive individualized training to reiterate the appointment requirements, make sure they know they hold an active contract, and to provide timely notification of status changes.
3/16/18	FL	Fine	Non-compliance issues found in the Enrollee Complaints, Grievances, and Appeals report.	Educated business owner on importance of verifying accuracy and completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
3/16/18	KY	Fine	Encounter submissions for February 2018 did not meet timeliness and accuracy measures.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
3/16/18	TN	CAP	ASH Claims Payment Audit did not achieve 100% compliance for one region.	The CAP included the following activities: reprocessing two claims denied in error; obtaining a valid form for one claims; and claims staff education reminders.
3/15/18	FL	Fine	Did not meet provider network standards specified. Examples include nephrology, rheumatology, and otolaryngology.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
3/15/18	FL	Fine	Review identified discrepancies between the provider network verification file and the online provider directory.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.

Date	State	Type	Description	Response/Plan of Correction
3/15/18	TN	Fine	Q4 2017 provider data file did not meet accuracy requirement for telephone numbers.	Identified root cause of issue was provider-provided data. Provider Relations educating contracted providers on need to provide timely updates to demographics.
3/13/18	FL	Fine	January 2018, week one, Encounter data submitted more than seven days after the adjudication date.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
3/9/18	FL	Fine	Encounter data submitted more than seven days after the adjudication date.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts.
3/9/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
3/6/18	FL	Fine	Did not provide transportation services as described in the contract.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
3/5/18	TN	CAP	Semi-annual audit found that critical incidents were not reported timely and untimely initiation of HCBS to members.	For critical incidents, actions included refresher training, manager review of charts and one-on-one Care Coordinator re-education, and a workgroup to evaluate the process and initiate improvement. For HCBS, actions included developing a new authorization process.
3/1/18	FL	Fine	Transportation vendor used non-credentialed providers.	Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance. Continuing to monitor on an ongoing basis.
2/16/18	KY	Fine	Untimely and inaccurate encounter submissions in January.	Reviewed encounters process and schedule against contract requirements and made adjustments. Implemented additional monitoring and alerts. Increased quality control checks before encounter submission.
2/16/18	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/12/18	FL	Fine	For Q3 of 2017, did not meet standards for timely processing of nursing facility and hospice claims.	Reviewed claims process and workload. Communicated need to adhere to contractual standards with claims team. Conducted additional OTJ training for applicable processors. Increased monitoring of claims aging and system alerts.
2/7/18	TX	CAP	For SFY17 Q4, did not meet 75% GeoAccess threshold for cardiovascular disease, ENT, prenatal care, and psychiatrist provider types.	Confirmed areas where providers have already been added to the network since the time of the review, noted where qualified providers are not available, and defined an outreach plan for recruiting newly available providers.

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Date	State	Type	Description	Response/Plan of Correction
2/7/18	TX	CAP	For SFY 2017, audit found insufficient internal controls and quality assurance processes related to the management and timely provision of long-term services and supports.	Enhanced controls and processes include an automated tracking system, improved training, hiring a dedicated Service Coordination Trainer, hiring additional Service Coordinators, and developing a quick response process to address any issues.
2/6/18	FL	Fine	Did not meet provider network standards specified. Examples include nephrology, rheumatology, and ophthalmology.	Continued monitoring of GeoAccess reports and out-of-network utilization to prioritize addressing potential gaps in access.
2/5/18	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
2/2/18	FL	Fine	Deficient submission of requested long-term care case records to the state.	Held team meeting and/or focused provider training to address need to adhere to contractual standards and the detail expected in care plans. Increased oversight monitoring.
1/30/18	TN	Fine	Private duty shifts were missed for a member.	Conducted OTJ training for assigned Care Coordinator and provider on contractual standards. Worked with vendor on corrective action.
1/26/18	FL	Fine	Inaccurate August 2017 submission of enrollee complaints, grievances, and appeals report.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
1/26/18	FL	Fine	Inaccurate submission of ad hoc report request.	Educated business owner on importance of verifying accuracy of reports prior to submission. Reports included as part of ongoing business owner report cards.
1/23/18	IN	Fine and CAP	In Q2 2017, did not meet the encounter reconciliation completeness metric.	CAP includes the following activities: 1) Perform claim reconciliations of encounters to financial and state data for dental, pharmacy, and outpatient; 2) Execute an automated reconciliation of cash disbursement journal to inbound vendor encounter files; and 3) reconcile cash disbursement journal to state accepted 837 files for vendor data.
1/19/18	FL	Fine	Incomplete submission of provider complaint report.	Educated business owner on importance of verifying completeness of reports prior to submission. Reports included as part of ongoing business owner report cards.
1/19/18	FL	Fine	Incorrect denial of Medicare crossover claims for timely filing.	Worked with the Configuration Root Cause team to correct the error; identified and reprocessed affected claims.

Date	State	Type	Description	Response/Plan of Correction
1/19/18	NY	Deficiency Notice	Did not provide evidence that: at least 20% of board members are enrollees; a member advisory council has been established; or board approval of the quality plan.	Educated business owner on need to adhere to internal and external due dates identified on monthly reminders.
1/19/18	NY	Deficiency Notice	Did not provide evidence of providing annual notice to enrollees.	Reminded business owners of contractual requirements and timeframes related to member notifications.
1/19/18	NY	Deficiency Notice	Did not consistently assess non-dual enrollees as eligible for nursing facility level of care.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/19/18	NY	Deficiency Notice	Did not consistently advise enrollees of the voluntary benefit of Consumer Directed Personal Assistance Services upon enrollment or notify them in writing of the patient centered services plan.	Reminded business owners of contractual requirements and timeframes related to member notifications.
1/19/18	NY	Deficiency Notice	Did not routinely provide universal assessments within the required timeframes.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/19/18	NY	Deficiency Notice	Some patient centered services plans lacked sufficient detail and did not provide a back-up plan in the event that regular services are unavailable.	Held team meeting and/or focused provider training to address need to adhere to contractual standards and the detail expected in care plans. Increased oversight monitoring.
1/19/18	NY	Deficiency Notice	Did not routinely send written acknowledgement or determination notices to enrollees.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/19/18	TN	Fine	Failure to comply with pickup and delivery standards for one member.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.
1/18/18	TN	CAP	In Q4 2017, provider data file did not meet accuracy requirement for telephone numbers.	The CAP includes activities to improve provider telephone accuracy in the provider enrollment file, including continued work with data vendors, and continued regular provider visits to validate each element on the provider file.
1/17/18	IN	Fine	In Q1 and Q2 2017, did not meet the metric for timely processing of prior authorization requests.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.
1/17/18	IN	Fine	In Q1 2017, did not meet the metric for performing a health needs screening on new members.	Held team meeting to address need to adhere to contractual standards and monitor system alerts of upcoming due dates. Increased oversight monitoring.

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Date	State	Type	Description	Response/Plan of Correction
1/17/18	IN	Fine	Did not meet the average speed of answer metric for some programs in Q1 and Q2 2017.	Identified root cause of performance variance and implemented process improvements, including updates to real-time workforce management tool alerts.
1/17/18	IN	Fine	For Q1 2017, did not meet the call abandonment metric of 5%.	Identified root cause of performance variance and implemented process improvements, including updates to real-time workforce management tool alerts.
1/17/18	IN	Fine	Did not meet the 100% metric for resolving member appeals within 30 days in one program during Q1 and Q2 2017.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
1/17/18	IN	Fine	Did not meet the 100% metric for resolving member appeals within 30 days in one program during Q2 2017.	Addressed need to adhere to contractual standards and monitor system alerts of upcoming due dates during team meeting. Increased management monitoring of upcoming due dates.
1/17/18	IN	Fine	In Q1 2017, did not meet the metric for returning 100% of provider calls received after-hours within one business day.	Identified root cause of performance variance and implemented process improvements, including updates to real-time workforce management tool alerts.
1/16/18	TN	Fine	Failure to comply with pickup and delivery standards for two members.	Reviewed contractual standards with vendor. Increased vendor oversight/monitoring, with formal corrective action taken when necessary due to continued poor performance.

Medicare and Federal Programs Affiliate Regulatory Actions Audit Findings

Audit findings for affiliates operating Medicare and federal programs for audits conducted within the last two years, January 16, 2018 through January 15, 2020.

Report Date	State	Type of Audit	Findings	Response/Plan of Correction
12/17/19	TX	Actuary Bid Audit	CY2020 CMS Bid Audits for H2593 and R4487. Findings across several areas, including inadequate supporting documentation, inaccurate out-of-network percentages, incorrect PBP to BPT mapping, reported low-income membership, and financial reporting and forecasting, such as projected claims cost, risk score forecast using inaccurate projection, and did not make appropriate adjustments.	Executed a careful review of the audit findings and recommendations and provided a response to the draft report.
9/23/19	Multiple	CMS Financial Audit	This 2017 CMS Financial Audit covered 28 contracts. Findings across several areas, including potentially overstated PDE data reported to CMS, inability to provide adequate supporting documentation, claims system configuration problem, and discrepancies in DIR between the plan and the PBM.	Created and executed work plan to address findings.
6/18/19	NJ	External Quality Review	2019 NJ FIDE SNP Annual Program Review of CY 2018. Findings included a medical record gap missing follow-up care information, and deficiencies noted in appointment availability and after-hours access. Minor deficiencies noted in hospitals and dental/specialty dental data.	Created and executed work plan to address findings.
1/17/18	Multiple	CMS Compliance Review	This 2017 CMS Anthem Program Audit covered 38 contracts. Findings across several areas, including conducting initial health risk assessments and annual reassessments, care coordination documentation, grievance and appeal process deficiencies, and applying unapproved UM practices for pharmacy formulary.	Created and executed work plan to address findings.

Other Actions

Disclosure of other actions received by affiliates operating Medicare and federal programs within the last two years, January 16, 2018 through January 15, 2020.

Date	State	Type	Description	Response/Plan of Correction
7/19/19	Multiple	Notice of Non-Compliance (NONC)	Did not send enrollment cancellation notifications within the required timeframes.	Took action to prevent a recurrence.
6/20/19	Multiple	NONC	Inaccurate processing of Medicare Part D claims resulted in incorrect cost sharing for Medicare beneficiaries.	Took action to prevent a recurrence.

Date	State	Type	Description	Response/Plan of Correction
5/16/19	Multiple	NONC	Failure to meet the CMS standard for average hold time/disconnect rate during Q1 2019 Call Center Timeliness Study.	Took action to prevent a recurrence.
4/17/19	GA, NM, WA	Ad Hoc CAP	Low Summary Star Rating.	Developed and executed CAP to resolve deficiencies.
4/5/19	MO, VA	NONC	Did not successfully complete automated true out-of-pocket balance transfer transactions within the established timeframes for Q1 2019.	Took action to prevent a recurrence.
2/20/19	FL	NONC	Failure to meet the CMS standard for the disconnect percentage rate during Q4 2018 monitoring.	Took action to prevent a recurrence.
2/8/19	CA, OH, WI, NY	NONC	Failure to submit enhanced formulary files as required for CMS' Part D Transition Monitoring Program Analysis.	Took action to prevent a recurrence.
2/5/19	Multiple	NONC	Failure to send timely written notifications of coverage determinations	Took action to prevent a recurrence.
10/18/18	TX	NONC	Did not meet MMP Part D call center interpreter availability standard.	Took action to prevent a recurrence.
9/11/18	NY	NONC	Failure to issue written notices to enrollees impacted by the termination of contracted providers within the required timeframes.	Took action to prevent a recurrence.
9/7/18	Multiple	NONC	Failure to download enrollment request via the Medicare Online Enrollment Center (OEC) within the CMS-required timeframe	Took action to prevent a recurrence.
7/23/18	FL	NONC	Did not report 2017 pharmacy rewards and incentives program data on or before the deadline.	Took action to prevent a recurrence.
7/23/18	FL	NONC	Did not report 2017 pharmacy access data on or before the deadline.	Took action to prevent a recurrence.
6/18/18	FL	NONC	Failure to ensure accurate claim information printed in the Part C Explanation of Benefits (EOBs).	Took action to prevent a recurrence.
5/9/18	Multiple	Civil Money Penalty	A May 2017 CMS audit of 2014/2015 Medicare financial information found enrollees charged incorrect co-payments for medical services.	Paid monetary sanction.
5/4/18	AZ	NONC	Did not download enrollment requests via the Medicare Online Enrollment Center within the required timeframe.	Took action to prevent a recurrence.
4/16/18	CA, CO	NONC	Did not successfully complete automated true out-of-pocket balance transfer transactions within the established timeframes.	Took action to prevent a recurrence.
4/13/18	FL	NONC	Failure to ensure timely upload of Actual Mail Dates for the Contract Year (CY) 2018 Annual Notice of Change and/or Evidence of Coverage (ANOC/EOC) documents.	Took action to prevent a recurrence.
3/29/18	AZ	NONC	Failure to meet Q1 2018 call center monitoring timeliness standards for enrollee customer service and/or pharmacy technical help desk phone lines.	Took action to prevent a recurrence.

Supplemental Document 3.4-1b: Medicare and Federal Programs Affiliate Regulatory Actions

Date	State	Type	Description	Response/Plan of Correction
2/28/18	AZ, CA, CO, NV, VA	NONC	Did not provide timely written notification of confirmation of enrollment to members between March 31, 2017 and June 3, 2017.	Took action to prevent a recurrence.
2/28/18	AZ, CA, CO, GA, VA	NONC	Non-compliance with CY 2018 Part D formulary submission.	Took action to prevent a recurrence.
2/23/18	AZ, CA	NONC	Failure to submit complete and accurate final bid.	Took action to prevent a recurrence.
2/20/18	AZ, CA, CO, NV, VA	NONC	Self-disclosed failure to generate complete and accurate EOBs for February 2017 claims.	Took action to prevent a recurrence.
1/19/18	Multiple	Ad Hoc CAP	Non-compliance with CY 2017 Part D requirements for accurate reporting of Medicare Plan Finder data.	Developed and executed CAP to resolve deficiencies.

5. References

The State may conduct reference checks to verify and validate the past performance of the Vendor and its proposed subcontractors.

5.1 Vendor (Prime) References Form

Include at least three (3) references from clients served within the last three (3) years that demonstrate the Vendor's ability to perform the scope of work described in this RFP. The Vendor should provide three (3) different clients in order to demonstrate its experience.

The Vendor should include client description, contract dates, and contact information (customer points of contact, addresses, telephone numbers, and email addresses). The Vendor should explain whether it performed the work as a prime contractor or as a subcontractor. The Vendor should provide their response as part of their bid in accordance with the template below. The Vendor may add additional Reference Tables as necessary.

Vendor References

Table 8: Vendor References

Vendor Information		
Vendor Name: AMERIGROUP Maryland, Inc. (Amerigroup Maryland)	Contact Name:	Vincent Ancona
	Contact Phone:	410-981-4001
Customer Information		
Customer Organization: Maryland Department of Health	Contact Name:	Jill Spector
	Contact Title:	Director, HealthChoice and Acute Care Administration
Customer Address: 201 W. Preston Street, Baltimore, MD 21201	Contact Phone:	410-767-5248
	Contact Email:	jill.spector@maryland.gov
Project Information		
Total Vendor Staff:	156 staff	
Project Objectives: HealthChoice, which began in 1997, is Maryland's statewide mandatory managed care program. HealthChoice provides health care to most Medicaid members and covers 1.2 million residents. Eligible Medicaid recipients enroll in the MCO of their choice and select a PCP to oversee their medical care. The Maryland Department of Health evaluates MCOs on six key performance areas: • Access to Care • Doctor Communication and Service • Keeping Kids Healthy • Care for Kids with Chronic Illness • Taking Care of Women • Care for Adults with Chronic Illness		
Project Description: As a HealthChoice MCO for more than 20 years, Amerigroup Maryland is responsible for the provision of physical health, care management, long-term care, vision, and pharmacy services for the following covered populations: TANF, CHIP, ABD, and Medicaid Expansion. Amerigroup Maryland covers more than 279,000 members, including 35,599 uninsured children under age 19 under the state's CHIP program. HealthChoice covers a broad array of services, including doctor visits, well-child checkups, immunizations, prescription drugs, x-ray and lab, urgent care, emergency (including when out of state), hospital, well women care, prenatal and postpartum care, family planning and birth control (no pharmacy copays), home health, and vision exam and glasses (children under 21). Amerigroup Maryland's scope of work includes benefit administration, care management, community and stakeholder engagement, member services, enrollment and disenrollment, network development and maintenance, provider services, quality management, claims processing, encounter data submission, program integrity, reporting and data analytics, regulatory compliance, financial management, and maintaining secure and flexible information systems.		
Vendor's Involvement: Amerigroup Maryland began serving HealthChoice members in 1999 and serves members statewide, covering all 24 counties, including the six counties designated as rural. Amerigroup Maryland is the state's second largest MCO, the largest in three counties (Baltimore, Montgomery, and Prince George's), and the second largest in seven counties, including one designated as rural.		

Although behavioral health services are carved out in Maryland, the health plan has developed a collaborative working relationship with the state's BH provider and is able to gain access to valuable data, including discharge summaries, for members active in care management.

Integration with the regional **Health Information Exchange** that serves Maryland and the District of Columbia is a key part of Amerigroup Maryland's operations. They have been sharing data with the Chesapeake Regional Information System for our Patients (CRISP) since October 2013, using bi-directional data feeds and access to CRISP's online services, such as Encounter Notification Service Proactive Management of Patient Transitions (ENS PROMPT), to support near real-time hospitalization notification. Additionally, they use CRISP to research members' utilization, contact information, and clinical notes, as needed. Amerigroup Maryland has many examples where notifications from CRISP increased their ability to promptly contact or meet with members, including making outreach calls within 48 hours after the care team learns of members with recent ER use or unscheduled inpatient admissions. Amerigroup Maryland encourages providers to participate and share data with CRISP, including coaching them on available services and the best ways to use CRISP data to improve the health and well-being of their patients.

In 2016, the Maryland Department of Health started a two-year pilot program with the **National Diabetes Prevention Program** (DPP) for Medicaid members at high risk for type 2 diabetes. The DPP is an evidence-based intervention designed to prevent or delay the onset of type 2 diabetes through a lifestyle change program that uses a CDC-approved curriculum focused on eating healthier, being physically active, and improving coping skills. Amerigroup Maryland partnered with a national DPP provider to offer the one-year virtual program (weekly classes for four months, followed by monthly classes) and provided participants with a fitness tracker and scale.

Amerigroup Maryland had the largest number of participants in the pilot. Amerigroup Maryland analyzed claims history to identify at-risk members and used Health Coaches to conduct outreach to explain the program and enroll members. Retention strategies were an important part of the pilot, employed by both the MCOs and the DPP provider to remove barriers and encourage continued participation. The success of the pilot led the state to make the DPP a covered benefit beginning in September 2019. Amerigroup Maryland is working closely with the state and the other MCOs to operationalize the program, including engaging PCPs as DPP providers to supplement the virtual providers, screening protocol, referral and enrollment processes, and program delivery. Additionally, the program seeks to align diabetes prevention goals with population health objectives. Amerigroup Maryland continues to deliver meaningful value through provider collaborations and engagement, enhanced affordability through cost of care and care management, and innovative solutions for a better, more personalized health care experience that drives better health outcomes for our members. Two new initiatives focus on the health of children in Baltimore and include working closely with the Baltimore City Health Department.

Amerigroup Maryland is the only MCO participating in the Baltimore City Health Department **Lead Collaborative**. The program targets children under age 7 and includes environmental and medical home visits (in-home and telephonic) conducted by trained staff who provide health education on topics including lead, nutrition, child supervision, good housekeeping, and clinic compliance.

Amerigroup Maryland uses data sharing with the Baltimore City Health Department to help identify children with **uncontrolled asthma** who would benefit from home assessments, education, and case management referrals. Amerigroup Maryland provides care management and home assessments for children with uncontrolled asthma, as well as supply kits to reduce asthma triggers in the home.

Project Benefits: Amerigroup Maryland has achieved great success with quality initiatives, with 16 measures above the 90th percentile and 14 above the 75th percentile in measurement year 2018 (HEDIS 2019). Specific results include:

- Adolescent Well-care Visits: 73.73/90th percentile
- Well-child Visits in the

- First Fifteen Months of Life (6+ visits): 70.45/75th percentile
 - Third, Fourth, Fifth, and Sixth Year of Life: 87.50/90th percentile
- Children and Adolescents Access to PCP
 - Age 12 to 24 months: 97.30/75th percentile
 - Age 25 months to 6 years: 93.54/90th percentile
 - Age 7 to 11 years: 95.85/90th percentile
- Prenatal and Postpartum Care — Postpartum Care: 77.86/90th percentile
- Adult BMI Assessment: 94.16/75th percentile
- Cervical Cancer Screening: 67.88/75th percentile

Amerigroup Maryland also benefits members and providers through strong operations, as demonstrated by 2019 statistics for claims processing, member call centers, and member appeals. Key statistics include:

- Claims Processing — 2,887,516 claims
 - 93.4% of claims received electronically
 - Average turnaround time of 6.6 days
 - 97.6% paid within 20 days
- Member Call Center — 243,971 calls
 - 23 second average speed of answer
 - 1.74% abandonment rate
 - 87.08% of calls answered within 30 seconds
- Member Appeals
 - 490 standard member appeals in an average of nine days (requirement is 30 days)
 - 53 expedited member appeals in an average of two days (requirement is 72 hours)

Key Personnel

Name: Vincent Ancona	Role: Chief Executive, ultimate authority over contract performance
Name: Kevin Criswell	Role: Chief Financial Officer, oversees all budget and accounting systems
Name: Dr. Bradley Jackson	Role: Medical Director, licensed Maryland physician actively involved in all major clinical programs
Name: Sameria Cornish	Role: Compliance Officer, responsible for general adherence with contract requirements
Name: Raquel Samson	Role: Network Development Director, oversees development of compliant provider network
Name: Marvin Council	Role: Quality Director, oversees quality management program's daily activities
Name: Lori Hammond	Role: Member Services Director, oversees team that serves as central contact point for members

Project Measurements:

Projected Membership of Vendor's Contract: 270,000	Actual Membership of Vendor's Contract: 278,978
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	Current contract: 1/2020 Original contract: 6/1/1999	To:	Current contract: 12/2020
Actual Start and Completion Dates:	From:	Current contract: 1/2020	To:	Current contract: 12/2020
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: Amerigroup Maryland has been performing this work as the prime contractor since 1999.				

Table 8: Vendor References

Vendor Information		
Vendor Name: Amerigroup Iowa, Inc. (Amerigroup Iowa)	Contact Name:	Jeffrey Jones
	Contact Phone:	515-221-7699
Customer Information		
Customer Organization: Iowa Department of Human Services	Contact Name:	Mike Randol
	Contact Title:	Iowa Medicaid Director
Customer Address: 611 5 th Avenue, Des Moines, IA 50315	Contact Phone:	515-256-4640
	Contact Email:	mrandol@dhs.state.ia.us
Project Information		
Total Vendor Staff:	522 staff	
Project Objectives: The Iowa Department of Human Services transitioned from fee-for-service to a statewide risk-based managed care model on April 1, 2016. A majority of services are included in the program, Iowa Health Link, including LTSS, BH, and pharmacy. Iowa MCOs also cover the state's CHIP program, Healthy and Well Kids in Iowa, also known as <i>hawk-i</i>. Iowa Health Link and <i>hawk-i</i> cover more than 600,000 individuals. Iowa's managed care program has an overarching goal to improve the health of Iowa Medicaid members. Some of the goals the program seeks to accomplish include: • Promoting appropriate utilization of services • Reducing health care costs while improving quality through increasing provider participation in accountable care organizations, and reducing the rate of potentially preventable readmissions and potentially preventable ER visits • Making sure transitions of care do not have adverse effects • Promoting the use and interoperability of Health Information Technology between providers, MCOs, and the Medicaid agency Project Description: Amerigroup Iowa has been an Iowa Health Link and <i>hawk-i</i> MCO since the program transitioned to manage care in 2016. Amerigroup Iowa is responsible for the provision of physical health, BH, care management, long-term care, LTSS, vision, pharmacy, and non-emergency medical transportation (NEMT) services for the following covered populations: TANF, CHIP, and Medicaid expansion. Amerigroup Iowa's scope of work includes benefit administration, care management, community and stakeholder engagement, member services, enrollment and disenrollment, network development and maintenance, provider services, quality management, claims processing, encounter data submission, program integrity, reporting and data analytics, regulatory compliance, financial management, and maintaining secure and flexible information systems. Operating statewide in a state that is 79.8% rural, Amerigroup Iowa currently serves more than 384,000 members, including almost 37,000 children under the state's CHIP program. Amerigroup Iowa is the largest MCO in the state, with 60% market share. Amerigroup Iowa is playing a lead role with the state in the implementation of Electronic Visit Verification. Vendor's Involvement: Amerigroup Iowa's membership has steadily increased since beginning operations almost four years ago, rising from 44,607 at go-live to 384,154 at the end of 2019. During the		

2019 open choice period, members making an active choice picked Amerigroup Iowa more than 80% of the time. Throughout the rise in membership, Amerigroup Iowa has remained a dedicated partner to the state and been able to maintain consistent performance in operational metrics and quality scores.

In July of 2019, an MCO exited the Iowa Medicaid program and as a result, Amerigroup Iowa transitioned approximately 200,000 additional members into their plan, working closely with the state to make sure continuity of care of the new members remained intact. To support the transition, Amerigroup Iowa took deliberate action by executing a business associate agreement to allow open communication directly with the exiting MCO to help with the transition of high-risk members. They also worked with Iowa Medicaid to put together public notices and FAQs. The strong partnership between Amerigroup Iowa and the Iowa state Medicaid agency made the transition successful and minimized disruption to members.

Amerigroup Iowa is focused on implementing and operating programs that drive positive results and highlight a number of key accomplishments in their support of the state's goal to improve the health of Iowa Medicaid members. Some of these include the following:

- **Increasing BH Services.** In 2018, Amerigroup Iowa reduced mental health and substance use disorder inpatient usage by 13.5% while increasing subacute inpatient usage by 3.2%, meaning they got the level of care right more often. They also increased outpatient mental health services by 9% and other mental health services by 8% — enhancing member access to the full array of BH services. In addition, outpatient substance use disorder services increased, offsetting a corresponding decrease in inpatient mental health services.
- **Improving Chronic Care.** Amerigroup Iowa identified members with a qualifying condition, reached out one-on-one, and offered them access to more robust and expanded benefits. Due to this outreach, their ratio of members using this expanded benefit was up 15% in 2018.
- **Returning Members to Communities.** Amerigroup Iowa's community-based Care Managers have helped 115 members move from a facility back to the community by talking to members about options and offering a VAS for community reintegration.

Reducing the *inappropriate use of hospital ERs* has been a focus of the Iowa HealthLink program since its inception in 2016. Amerigroup Iowa's in-house Integrated Case Management team focuses on outreach to members identified in utilization data reports as being frequent ER users. The outreach is showing some promising results; in the first nine months of 2019, repeat utilization was down by 9.44%. Case managers use specific training and a quick-reference guide on the topic of "rapid readmission" to ER services as they make telephone calls to members. On the calls, case managers discuss available alternative services (such as urgent care centers and the member's PCP) and follow-up with educational brochures.

Recently, Amerigroup Iowa launched three pilots to address SDOH domains: housing, nutrition, and employment. Our affiliate is excited about the impact of these pilots and will continue to identify and implement initiatives that can have a positive impact on the lives of their members.

Additionally, Amerigroup Iowa is committed to investing in the health of Iowans. In 2019, \$368,622 in non-taxpayer foundation dollars were invested in Iowa community groups in support of childhood obesity and youth health, immunizations, food insecurity, BH, heart disease, decreasing low birth weight babies, and disaster relief.

Project Benefits: Amerigroup Iowa has achieved great success with quality initiatives, with 32 measures above the 90th percentile and 28 above the 75th percentile in measurement year 2018 (HEDIS 2019). Specific results include:

- Adults' Access to Preventive/Ambulatory Health Services Total: 87.24/90th percentile
- Childhood Immunization Status — 9 measures above the 75th percentile
- Children and Adolescents Access to PCP
 - Age 25 months to 6 years: 90.64/75th percentile
 - Age 12 to 19 years: 92.47/75th percentile

- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment
 - Initiation Total: 70.94/90th percentile
 - Engage Total: 26.06/90th percentile
 - Adult BMI Assessment: 96.84/90th percentile
 - Controlling High Blood Pressure: 69.59/75th percentile
- Amerigroup Iowa also benefits members and providers through strong operations, as demonstrated by 2019 statistics for claims processing and member and provider call centers. Key statistics include:
- Claims Processing — 6,251,894 claims
 - 96.7% of claims received electronically
 - Average turnaround time of 7.8 days
 - 95.4% paid within 20 days
 - Member Call Center — 259,635 calls
 - 27 second average speed of answer
 - 2.26% abandonment rate
 - 86.14% of calls answered within 30 seconds
 - Provider Call Center — 213,590 calls
 - 31 second average speed of answer
 - 1.43% abandonment rate
 - 85.76% of calls answered within 30 seconds

Key Personnel

Name: Jeffrey Jones	Role: Chief Executive, ultimate authority over contract performance
Name: Dennis Petersen	Role: Chief Financial Officer, oversees all budget and accounting systems
Name: Dr. Leslie Schechtman	Role: Medical Director, licensed physician actively involved in all major clinical programs
Name: Martha Crist	Role: Compliance Officer, responsible for general adherence with contract requirements
Name: Ebony Gilbert	Role: Network Development Director, oversees development of compliant provider network
Name: Amy Kutchen	Role: Quality Director, oversees quality management program's daily activities
Name: James Thomas	Role: Member Services Director, oversees team that serves as central contact point for members

Project Measurements:

Projected Membership of Vendor's Contract: 185,000	Actual Membership of Vendor's Contract: 384,154
Reason(s) for Change in Membership: In July 2019, an MCO exited the market and Amerigroup Iowa transitioned approximately 200,000 additional members into their plan (both through assignments and through member choice).	
Estimated Start and Completion Dates:	From: 4/1/2016 To: 3/31/2021

				May be extended for one additional two-year term
Actual Start and Completion Dates:	From:	4/1/2016	To:	3/31/2021 May be extended for one additional two-year term
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: Amerigroup Iowa has been performing this work as the prime contractor since 2016.				

Table 8: Vendor References

Vendor Information		
Vendor Name: Community Care Health Plan of Nevada Inc. dba Anthem Blue Cross and Blue Shield Healthcare Solutions	Contact Name:	Lisa Bogard
	Contact Phone:	702-545-9842
Customer Information		
Customer Organization: Nevada Division of Health Care Financing and Policy (DHCFP)	Contact Name:	Cody Phinney
	Contact Title:	Deputy Administrator
Customer Address: 1000 E. Williams Street, Suite 100 Carson City, NV 89701	Contact Phone:	775-684-3735
	Contact Email:	c.phinney@dhcfp.nv.gov
Project Information		
Total Vendor Staff:	74 staff	
Project Objectives: The mission of the Nevada Division of Health Care Financing and Policy and the Nevada Medicaid and Nevada Check Up (CHIP) programs is to: • Provide quality health care services to low-income Nevadans in the most efficient manner • Promote equal access to health care at an affordable cost to the taxpayers of Nevada • Restrain the growth of health care costs • Review Medicaid and other state health care programs to maximize potential federal revenue In the managed care program, their mission is to improve the health of Nevadans by: • Emphasizing preventive care, early intervention, appropriate utilization, and quality care • Enhancing continuity of care through integrated medical, behavioral, and social care • Ensuring a medical home for Medicaid and Nevada Check Up recipients • Ensuring that each recipient can access high-quality, comprehensive health care services within their service area Project Description: In Nevada, Medicaid services for recipients living in urban Clark and Washoe counties are delivered by one of three MCOs. In addition to the provision of covered benefits, MCOs are responsible for health screenings, applicable health needs assessments, ongoing care management, and network development. Anthem Blue Cross and Blue Shield Healthcare Solutions has been serving Nevada Medicaid members in Clark and Washoe counties since 2009. Our Nevada affiliate is responsible for the provision of physical health, BH, care management, LTC, vision, and pharmacy services for the TANF, CHIP, and Medicaid expansion populations. Our Nevada affiliate's scope of work includes benefit administration, care management, community/stakeholder engagement, member services, enrollment and disenrollment, network development and maintenance, provider services, quality management, claims processing, encounter data submission, program integrity, reporting and data analytics, regulatory compliance, financial management, and maintaining secure and flexible information systems. Vendor's Involvement: Anthem Blue Cross and Blue Shield Healthcare Solutions serves 193,748 members, including 8,919 children under the Nevada Check Up program. Anthem Blue Cross and Blue Shield Healthcare Solutions operates a number of innovative solutions to improve access to care and improve members' health outcomes, support self-management, and address unmet SDOH. Descriptions of a few of these programs follows:		

- **Housing.** Our Nevada affiliate executes a multi-pronged strategy based on the drivers of chronic hospitalization and the underlying needs of homeless members. The strategy focuses on engaging members wherever they are living and while in the hospital, providing an array of targeted care coordination and case management activities to meet their health and service needs. With services provided to 2,600 members, results show reductions in ER visits and inpatient admissions of more than 60% each, along with an increase in outpatient services of 57%. Program components include:
 - **Care management** to support members during inpatient stays and to connect members to the community and provider resources upon discharge
 - Navigation specialist to meet with members bedside to identify social needs prior to discharge, employing an extensive community resource database and tracking patient engagement and outreach activities
 - Through partnerships with providers and community-based organizations, coordinate appropriate placement in short-term or long-term housing
 - A mobile shower unit that provides weekly hygiene support in high-density homeless areas. In addition, their partner, Clean the World, donates clean clothes.
- **Education and Food.** Partnership with Create a Change and Title I Schools in Clark County to teach students how to grow their own vegetables. The vegetables are then donated back into the community.

Our Nevada affiliate was the only MCO participating in the **Pathway Forward** pilot program that began in September 2018 to transition inmates back into the community by providing job placement, housing, and health and wellness resources. In collaboration with the corrections department, our affiliate found a link between escalating recidivism and the barriers formerly incarcerated individuals face when trying to reintegrate into society and comply with parole requirements. Many individuals do not have anywhere to go or anyone to help them upon release, fueling homelessness and creating challenges that lead to acts of desperation, violations of parole, and a return to incarceration.

The Pathway Forward program's goals are to reduce recidivism, provide family reunification, and establish financial self-sufficiency. To achieve these goals, our affiliate built relationships with service providers to help coordinate short-term housing, transportation, and other wraparound services, including therapy, medical, psychiatric, and case management. Our affiliate fully funded many of the services critical to the program's success, including housing and intensive case management.

- Twelve months of outcomes data demonstrate the program's overwhelming success, including:
- Within 24 hours of release, all participants received food support, phones, hygiene kits, and clothing, as well as bus passes, bridge housing, and help accessing identification materials.
 - All participants accepted mentorship and engaged in efforts to create social support networks, reunify with family, and achieve gainful employment.
 - All able-bodied participants enrolled in employment training and job assistance programs and approximately 76% achieved gainful employment.
 - Of the 90 individuals participating in the program since its inception, only four have returned to prison.

In September, 2019, Anthem Blue Cross and Blue Shield Healthcare Solutions launched a no-cost Interpersonal Violence Reduction program to target, engage, and serve members who are victims of intimate and interpersonal violence. Outreach and enrollment includes telephonic and in-person outreach to locate and enroll members, including in-person case finding in high-need communities where gangs and violence are prevalent. The program delivers tech-enabled interventions that include content, methods, and methodologies to address behavioral, medical, and social needs specific to the reduction of intimate and interpersonal violence. The program also focuses on addressing trauma, including generational trauma, developed over years of being victims of violence.

Anthem Blue Cross and Blue Shield Healthcare Solutions is continuing to implement new programs to support their Nevada Medicaid and Nevada Check Up members.

Project Benefits: Anthem Blue Cross and Blue Shield Healthcare Solutions has achieved great success with quality initiatives, with six measures above the 90th percentile and 12 above the 75th percentile in measurement year 2018 (HEDIS 2019). Specific results include:

- Medication Management for People with Asthma — 51-64: 60.18/75th percentile
- Immunizations for Adolescents:
 - MENIN: 92.70/90th percentile
 - HPV: 47.69/75th percentile
 - Combo 2: 45.74/75th percentile
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents — three measures, Total, 6–11, and 12–17: 0.00/90th percentile (reverse measure where lower rate indicates better performance)
- Children and Adolescents Access to PCP
 - Age 12 to 24 months: 97.30/75th percentile
 - Age 25 months to 6 years: 93.54/90th percentile
 - Age 7 to 11 years: 95.85/90th percentile
- Follow-up Care for Children Prescribed ADHD Medication-C&M Phase: 68.75/75th percentile
- Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment Initiation — measures at the 75th percentile

Anthem Blue Cross and Blue Shield Healthcare Solutions also benefits members and providers through strong operations, as demonstrated by 2019 statistics for claims processing and member and provider call centers. Key statistics include:

- Claims Processing — 2,572,831 claims
 - 95.4% of claims received electronically
 - Average turnaround time of 5.9 days
 - 98.9% paid within 20 days
- Member Call Center — 168,681 calls
 - 29 second average speed of answer
- 1.46% abandonment rate
- Provider Call Center — 117,191 calls
 - 53 second average speed of answer
 - 2.31% abandonment rate

Key Personnel

Name: Lisa Bogard	Role: Chief Executive, ultimate authority over contract performance
Name: David Hsieh	Role: Chief Financial Officer, oversees all budget and accounting systems
Name: Dr. Lisa Thompson	Role: Medical Director, licensed physician actively involved in all major clinical programs
Name: Sheri Starcher	Role: Compliance Officer, responsible for general adherence with contract requirements
Name: Jacquie Owens	Role: Network Development VP, oversees development of compliant provider network
Name: Lisa Werlech	Role: Quality Director, oversees quality management program's daily activities
Name: Charles Barrios	Role: Member Services Director, oversees team that serves as central contact point for members

Project Measurements:				
Projected Membership of Vendor's Contract: 190,000		Actual Membership of Vendor's Contract: 193,748		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	Current contract: 7/1/2017 Original contract: 2/1/2009	To:	Current contract: 6/30/2021
Actual Start and Completion Dates:	From:	Current contract: 7/1/2017 Original contract: 2/1/2009	To:	Current contract: 6/30/2021
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Vendor performed the work as a subcontractor, the Vendor should describe the scope of subcontracted activities: Anthem Blue Cross and Blue Shield Healthcare Solutions has been performing this work as the prime contractor since 2009.				

5.2 Subcontractor References (If Applicable)

If the Vendor's proposal includes the use of subcontractor(s), provide three (3) references for each subcontractor. The Vendor should provide their response as part of their bid in accordance with the template below. The Vendor may add additional Reference Tables as necessary. The State prefers references that demonstrate where the prime and subcontractors have worked together in the past.

Table 9: Subcontractor References

Anthem Reference #1

Subcontractor Information		
Vendor Name: Anthem, Inc., operating through our affiliate, Amerigroup Partnership Plan, LLC (Anthem)	Contact Name:	Michael Hofer
	Contact Phone:	716-445-5256
Customer Information		
Customer Organization: HealthNow New York, Inc. dba BlueCross BlueShield of Western New York (HealthNow)	Contact Name:	Jared Gross
	Contact Title:	Senior Vice President
Customer Address: 257 West Genesee Street, Buffalo, NY 14202-2657	Contact Phone:	716-887-8619
	Contact Email:	Gross.Jared@healthnow.org
Project Information		
Total Vendor Staff:	56	
Project Objectives: HealthNow is an MCO for the New York Medicaid Managed Care and Child Health Plus programs serving TANF, ABD, and CHIP populations.		
Project Description: Amerigroup Partnership Plan, LLC, an affiliate of Anthem, provides administrative support to HealthNow for medical services under the New York Medicaid Managed Care and Child Health Plus programs.		
Vendor's Involvement: Amerigroup Partnership Plan, LLC began supporting members on November 1, 2016 as a subcontractor to HealthNow for their Medicaid Managed Care and Child Health Plus contracts. It provides technical infrastructure, administrative services, operational support, and support for health plan management. Specific responsibilities include: • Network development and management • Member enrollment data maintenance • Member and provider call center operations • Claims processing • Encounter data submission • Medical management, including utilization, care, and disease management • Grievance and appeal processing and reporting • Program integrity, including Special Investigations Unit • Compliance, regulatory, and management reporting		
Project Benefits: In 2019, Amerigroup Partnership Plan, LLC demonstrated strong performance across claims processing, member and provider call centers, and member appeals areas. • Claims Processing — 509,421 claims ▪ Average turnaround time of 9.8 days ▪ 81.27% auto-adjudication rate		

97.54% paid within 30 days 89.31% received electronically - Member Call Center — 29,903 calls 60 second average speed of answer 3.2% abandonment rate - Provider Call Center — 19,537 calls 130 second average speed of answer 5.1% abandonment rate			
Key Personnel			
Name: Michael Hofer		Role: Chief Executive, ultimate authority over contract performance	
Name: Daniel Maciejewski		Role: Operations, oversees all program operations and compliance with contract requirements	
Name: Dr. James Poss		Role: Medical Director, licensed physician actively involved in all major clinical programs	
Name: Michele LoPorto		Role: Compliance Officer, responsible for general adherence with contract requirements	
Project Measurements:			
Projected Membership of Vendor's Contract: 40,000		Actual Membership of Vendor's Contract: 51,474	
Reason(s) for Change in Membership: HealthNow has continued to gain members over time.			
Estimated Start and Completion Dates:	From:	11/2016	To: 09/2021
Actual Start and Completion Dates:	From:	11/2016	To: 09/2021
Reason(s) for Difference Between Estimated and Actual Dates: N/A			
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Anthem, Inc., operating through our affiliate, Amerigroup Partnership Plan, LLC (Anthem) provides service to HealthNow as a subcontractor to its contract with the New York Department of Health. The scope of subcontracted activities includes providing technical infrastructure, administrative services, operational support, and support for health plan management.			

Table 9: Subcontractor References
Anthem Reference #2

Subcontractor Information		
Vendor Name: Anthem, Inc., operating through our affiliate, Anthem Partnership Holding Company, LLC (Anthem)	Contact Name:	Frank Clepper
	Contact Phone:	913-563-1613
Customer Information		
Customer Organization: Physician Health Plan Partners (PHP)	Contact Name:	Ken Nielsen
	Contact Title:	President and CEO
Customer Address: 1125 17 th St., Suite 1000, Denver, CO 80202	Contact Phone:	720-612-6612
	Contact Email:	Ken.Nielsen@phpmcs.com
Project Information		
Total Vendor Staff:	34	
Project Objectives: The Accountable Care Collaborative (ACC) Program is the core of Colorado's state Medicaid program known as Health First Colorado. The fundamental premise of the ACC through Health First Colorado is that regional communities are in the best position to make changes that will cost-effectively optimize health and quality of care for all members.		
Project Description: Anthem and PHP formed an equal joint venture in 2018 as Colorado Community Health Alliance (CCHA) serving as the Regional Accountable Entity (RAE) for Health First Colorado Regions 6 and 7. Key responsibilities for RAEs include overseeing both primary care and BH services as well as adjusting how services are reimbursed. Anthem is responsible for administering the capitated BH benefit for CCHA as the RAE.		
Vendor's Involvement: Anthem, Inc., operating through our affiliate, Anthem Partnership Holding Company, LLC (Anthem) provides support to CCHA for BH services under the Health First Colorado program through technical infrastructure, administrative services, operational support, and support for health plan management. Specific responsibilities include: • Network development and management • Member and provider call center operations • Claims processing • Encounter data submission • Medical management, including utilization and care management • Grievance and appeal processing and reporting • Program integrity, including Special Investigations Unit • Compliance, regulatory, and management reporting		

Project Benefits: In 2019, Anthem demonstrated strong performance across claims processing and provider call centers. Key Statistics include:

- Claims Processing — 842,601 claims
 - 94.8% of claims received electronically
 - Average turnaround time of 7.6 days
 - 97.7% paid within 20 days
 - 94.9% paid within 14 days
- Member Call Center — 2,073 calls
 - 94.9% paid within 14 days
 - 0 second average speed of answer
 - 0.86% abandonment rate
 - 98.9% of calls answered within 30 seconds

Key Personnel

Name: Frank Clepper	Role: Chief Executive, ultimate authority over contract performance
Name: Patrick Fox	Role: Medical Director, licensed Colorado physician actively involved in all major clinical health programs
Name: Darren Lish	Role: Medical Director, licensed Colorado physician actively involved in all major clinical health programs
Name: Gelissa Garcia Diaz	Role: Behavioral Health Director, ultimate authority over BH program's daily activities
Name: Abigail Roa Justiniano	Role: Compliance Officer, responsible for general adherence with contract requirements

Project Measurements:

Projected Membership of Vendor's Contract: 296,000	Actual Membership of Vendor's Contract: 312,428
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Reason(s) for Change in Membership: CCHA has continued to gain members over time.

Estimated Start and Completion Dates:	From:	7/2018	To:	6/2020
Actual Start and Completion Dates:	From:	7/2018	To:	6/2020

Reason(s) for Difference Between Estimated and Actual dates: N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:



Anthem, Inc., operating through our affiliate, Anthem Partnership Holding Company, LLC (Anthem) provides support to CCHA for BH services under the Health First Colorado program through technical infrastructure, administrative services, operational support, and support for health plan management.

Table 9: Subcontractor References
Anthem Reference #3

Subcontractor Information		
Vendor Name: Anthem, Inc.	Contact Name:	Felicia Norwood, Executive Vice President and President, Government Business Division
	Contact Phone:	800-331-1476
Customer Information		
Customer Organization: Maryland Department of Health	Contact Name:	Jill Spector
	Contact Title:	Director, HealthChoice and Acute Care Administration
Customer Address: 201 W. Preston Street, Baltimore, MD 21201	Contact Phone:	410-767-5248
	Contact Email:	jill.spector@maryland.gov
Project Information		
Total Vendor Staff:	156 staff	
Project Objectives: AMERIGROUP Maryland, Inc. (Amerigroup Maryland) is an MCO for Maryland's statewide mandatory managed care program, HealthChoice, which began in 1997. HealthChoice provides health care to most Medicaid recipients and covers 1.2 million residents. Eligible Medicaid recipients enroll in the MCO of their choice and select a PCP to oversee their medical care.		
Project Description: Anthem, Inc. provides administrative support to Amerigroup Maryland, for medical services under the Maryland HealthChoice program.		
Vendor's Involvement: Anthem, Inc. supports Amerigroup Maryland as a subcontractor to their HealthChoice contract. It provides technical infrastructure, administrative services, operational support, and support for health plan management. Specific responsibilities include: • Network development and management • Member enrollment data maintenance • Member and provider call center operations • Claims processing • Encounter data submission • Medical management, including utilization, care, and disease management • Grievance and appeal processing and reporting • Program integrity, including Special Investigations Unit • Compliance, regulatory, and management reporting		
Project Benefits: In 2019, Anthem, Inc. demonstrated strong performance across claims processing, member and provider call centers, and member appeals areas. Key statistics include: • Claims Processing — 2,887,516 claims ▪ 93.4% of claims received electronically ▪ Average turnaround time of 6.6 days ▪ 97.6% paid within 20 days		

- Member Call Center — 243,971 calls 23 second average speed of answer 1.74% abandonment rate 87.08% of calls answered within 30 seconds - Member Appeals 490 standard member appeals in an average of nine days (requirement is 30 days) 53 expedited member appeals in an average of two days (requirement is 72 hours)				
Key Personnel				
Name: Vincent Ancona		Role: Chief Executive, ultimate authority over contract performance		
Name: Kevin Criswell		Role: Chief Financial Officer, oversees all budget and accounting systems		
Name: Dr. Bradley Jackson		Role: Medical Director, licensed Maryland physician actively involved in all major clinical programs		
Name: Sameria Cornish		Role: Compliance Officer, responsible for general adherence with contract requirements		
Name: Raquel Samson		Role: Network Development Director, oversees development of compliant provider network		
Name: Marvin Council		Role: Quality Director, oversees quality management program's daily activities		
Name: Lori Hammond		Role: Member Services Director, oversees team that serves as central contact point for members		
Project Measurements:				
Projected Membership of Vendor's Contract: 270,000		Actual Membership of Vendor's Contract: 278,978		
Reason(s) for Change in Membership: Amerigroup Maryland has continued to gain members over time.				
Estimated Start and Completion Dates:	From:	Current contract: 1/2020 Original contract: 6/1/1999	To:	Current contract: 12/2020
Actual Start and Completion Dates:	From:	Current contract: 1/2020	To:	Current contract: 12/2020
Reason(s) for Difference Between Estimated and Actual Dates: N/A				

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Anthem, Inc. provides service to Amerigroup Maryland as a subcontractor to its contract with the Maryland Department of Health. The scope of subcontracted activities includes providing technical infrastructure, administrative services, operational support, and support for health plan management.

Table 9: Subcontractor References

AMR Reference #1

Subcontractor Information		
Vendor Name: Advanced Medical Reviewers, LLC (AMR)	Contact Name:	Amanda Markle
	Contact Phone:	310-907-9395
Customer Information		
Customer Organization: Kern Health Systems	Contact Name:	Deborah Murr
	Contact Title:	Senior Director of Health Services
Customer Address: 9700 Stockdale Highway, Bakersfield, CA 93311	Contact Phone:	661-664-5141
	Contact Email:	deborah.murr@khs-net.com
Project Information		
Total Vendor Staff:	Approximately 75	
Project Objectives: AMR coordinates advisory peer reviews regarding medical necessity and experimental/investigational treatment to assist in Kern Health Systems benefit determination process.		
Project Description: AMR's panel of physician and allied health professionals review medical records to make recommendations related to care.		
Vendor's Involvement: AMR provides medical review services to Kern Health Systems. Various physician specialists review cases to make recommendations on questions related to medical necessity, treatment plans, experimental/investigational, and more.		
Project Benefits: • Capability to handle quick turnaround times • Wide range of specialists • Ability to rapidly scale increased volume		
Key Personnel		
Name: Douglas Hayward	Role: Chief Executive Officer	
Project Measurements:		
Projected Membership of Vendor's Contract: 30,000	Actual Membership of Vendor's Contract: 30,000	
Reason(s) for Change in Membership: N/A		

Estimated Start and Completion Dates:	From:	04/2018	To: Ongoing
Actual Start and Completion Dates:	From:	04/2018	To: Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A			
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: AMR provides medical peer review services.			

Table 9: Subcontractor References

AMR Reference #2

Subcontractor Information		
Vendor Name: Advanced Medical Reviewers, LLC (AMR)	Contact Name:	Amanda Markle
	Contact Phone:	310-907-9395
Customer Information		
Customer Organization: Allegiance Benefit Plan Management, Inc.	Contact Name:	Jeannie Anderson
	Contact Title:	Medical Review Manager
Customer Address: 2806 South Garfield Street, Missoula, MT 59801	Contact Phone:	406-721-2222 x3325
	Contact Email:	jeannie.anderson@askallegiance.com
Project Information		
Total Vendor Staff:	Approximately 75	
Project Objectives: AMR coordinates advisory peer reviews regarding medical necessity and experimental/investigational treatment to assist its customer in the customer's benefit determination process.		
Project Description: AMR's panel of physician and allied health professionals review medical records to make recommendations related to care.		
Vendor's Involvement: AMR provides medical review services to Allegiance Benefit Plan Management, Inc. Various physician specialists review cases to make recommendations on questions related to medical necessity, treatment plans, experimental/investigational, and more.		
Project Benefits: • State and specialty matched physicians • Independent assessments • Efficient, secure technology		
Key Personnel		
Name: Dirk Visser	Role: Chief Executive Officer	
Project Measurements:		
Projected Membership of Vendor's Contract: 25,000	Actual Membership of Vendor's Contract: 25,000	
Reason(s) for change in membership: N/A		

Estimated Start and Completion Dates:	From:	07/2016	To: Ongoing
Actual Start and Completion Dates:	From:	07/2016	To: Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A			
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: AMR provides medical peer review services.			

Table 9: Subcontractor References

AMR Reference #3

Subcontractor Information		
Vendor Name: Advanced Medical Reviewers, LLC (AMR)	Contact Name:	Amanda Markle
	Contact Phone:	310-907-9395
Customer Information		
Customer Organization: St. Francis Hospital	Contact Name:	Melissa Berry
	Contact Title:	Quality Management
Customer Address: 1 Saint Francis Drive Greenville, SC 29601-3955	Contact Phone:	864-255-1549
	Contact Email:	melissa_berry@bshsi.org
Project Information		
Total Vendor Staff:	Approximately 75	
Project Objectives: AMR coordinates advisory peer reviews regarding quality of care.		
Project Description: AMR's physician reviewers conduct advisory independent peer reviews regarding the treating physician's quality of care.		
Vendor's Involvement: AMR's physician reviewers give feedback on another clinician's medical appropriateness, level of care, and quality, as an independent, unbiased third party.		
Project Benefits: • Increase quality • Independent, unbiased review • Wide range of specialists and subspecialists		
Key Personnel		
Name: Matthew Caldwell	Role: President	
Project Measurements:		
Projected Membership of Vendor's Contract: N/A — client is a hospital	Actual Membership of Vendor's Contract: N/A	
Reason(s) for Change in Membership: N/A		

Estimated Start and Completion Dates:	From:	02/2012	To:	Ongoing
Actual Start and Completion Dates:	From:	02/2012	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: AMR provides medical peer review services.				

Table 9: Subcontractor References

Exela Reference #1

Subcontractor Information			
Vendor Name: Exela Technologies, Inc. (Exela)	Contact Name:	Christy Hudson	
	Contact Phone:	303-249-1268	
Customer Information			
Customer Organization: Midlands Choice, Inc.	Contact Name:	Greta Vaught	
	Contact Title:	President & CEO	
Customer Address: 8420 West Dodge Road, Suite 210, Omaha, NE 68114-3492	Contact Phone:	402-390-1589	
	Contact Email:	gvaught@midlandschoice.com	
Project Information			
Total Vendor Staff:	7		
Project Objectives: For providers and multiple clients, utilize technology to streamline front-end processes and reduce cost.			
Project Description: Claims front-end services for claims submission to include provider portal.			
Vendor's Involvement: For providers and multiple clients, utilize technology to streamline front-end processes and reduce cost.			
Project Benefits: Provider portal innovation implemented, increased efficiency, and reduced cost.			
Key Personnel			
Name: Trudy Knapp-Rhodes		Role: Business Analyst	
Project Measurements:			
Projected Membership of Vendor's Contract: N/A — Anticipated 35,000 based on annual contract claims volume		Actual Membership of Vendor's Contract: N/A — Anticipated 35,000 based on annual contract claims volume	
Reason(s) for Change in Membership: N/A			
Estimated Start and Completion Dates:	From:	09/2006	To: Ongoing
Actual Start and Completion	From:	09/2006	To: Ongoing

Dates:				
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: For providers and multiple clients, utilize technology to streamline front-end processes and reduce cost.				

Table 9: Subcontractor References

Exela Reference #2

Subcontractor Information		
Vendor Name: Exela Technologies, Inc. (Exela)	Contact Name:	Christy Hudson
	Contact Phone:	303-249-1268
Customer Information		
Customer Organization: Blue Cross and Blue Shield of North Carolina	Contact Name:	Kentreal Farrar
	Contact Title:	Manager, CGSO Vendor Services Delivery
Customer Address: 5901 Chapel Hill Road, Durham, NC 27707	Contact Phone:	919-765-2801
	Contact Email:	Kentreal.farrar@bcbsnc.com
Project Information		
Total Vendor Staff:	82	
Project Objectives: Exela processes health care claims in front-end scope from data capture to output data files in standard format. They utilize portal technology for customer staff to review incomplete documents or verify information in exception queues. Once the customer has confirmed and updated claim data points, claims are released back into the workflow to deliver output in standard format. Exela processes health care claims in adjudication scope directly in customer mainframe applications via secure connections for the Medicare Advantage and Medicare Supplemental lines of business.		
Project Description: Claims data capture services utilizing portal technology for exception handling. Adjudication in customer systems.		
Vendor's Involvement: Provides data capture, exception handling, and adjudication services.		
Project Benefits: • Better member outcomes and increased efficiency with exception handling in data capture process • Reduce cost in both data capture and adjudication		
Key Personnel		
Name: Mary Wynne	Role: Vendor Manager	
Name: Betsy Harris	Role: Business Analyst	
Project Measurements:		
Projected Membership of Vendor's Contract:	Actual Membership of Vendor's Contract:	

N/A — Anticipated 1.5 million based on annual contract claims volume		N/A — Anticipated 1.5 million based on annual contract claims volume	
Reason(s) for Change in Membership: N/A			
Estimated Start and Completion Dates:	From:	12/2012	To: N/A
Actual Start and Completion Dates:	From:	12/2012	To: Present
Reason(s) for Difference Between Estimated and Actual Dates: N/A			
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: Provides data capture, exception handling, and adjudication services.			

Table 9: Subcontractor References

Exela Reference #3

Subcontractor Information		
Vendor Name: Exela Technologies, Inc. (Exela)	Contact Name:	Christy Hudson
	Contact Phone:	303-249-1268
Customer Information		
Customer Organization: Health Plan Holdings, Inc.	Contact Name:	Vicki Jackson
	Contact Title:	Manager
Customer Address: 780 Brooksedge Plaza Drive, Westerville, OH 43081	Contact Phone:	614-212-7065
	Contact Email:	vicki.jackson@harringtonhealth.com
Project Information		
Total Vendor Staff:	10	
Project Objectives: Exela processes health care claims from mailroom services to output files in standard format. They utilize technology to streamline manual invention and introduced claims submission portal for customer service and claims processing staff to submit claims electronically.		
Project Description: Claims front-end services for claims submission to include document submission portal for customer staff.		
Vendor's Involvement: Claims front-end processing (mailroom, optical character recognition, electronic document submission portal).		
Project Benefits: • Document electronic document submission portal innovation implemented • Increase efficiency • Reduction in cost		
Key Personnel		
Name: Eric Uhl	Role: Business Analyst	
Project Measurements:		
Projected Membership of Vendor's Contract: N/A — Anticipated 195,000 based on annual contract claims volume	Actual Membership of Vendor's Contract: N/A — Anticipated 195,000 based on annual contract claims volume	
Reason(s) for Change in Membership: N/A		

Estimated Start and Completion Dates:	From:	06/2011	To:	Ongoing
Actual Start and Completion Dates:	From:	06/2011	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: N/A				

Table 9: Subcontractor References

IngenioRx Reference #1

Subcontractor Information		
Vendor Name: IngenioRx, Inc. (IngenioRx)	Contact Name:	Angela Thomas
	Contact Phone:	317-517-9758
Customer Information		
Customer Organization: Lexington Fayette County Urban Government	Contact Name:	John Maxell
	Contact Title:	HR Director
Customer Address: 200 East Main Street, Lexington, KY 40507	Contact Phone:	859-258-3033
	Contact Email:	Jmaxell2@lexingtonky.gov
Project Information		
Total Vendor Staff:	Approximately 1623 employees for all lines of business (LOBs) at time of the project	
Project Objectives: Transition of Pharmacy Benefit Partner services to IngenioRx. IngenioRx administers and delivers a full suite of pharmacy benefit management services, including: • Claim adjudication • Best-in-class pharmacy network • Account management • Formulary management • Price transparency • Benefits management • Medical and pharmacy integration • Searchable formulary and searchable pharmacy network tools • 24/7 enrollee call center staffed with pharmacy specialists • Prior authorization, including electronic PA • Rebate administration • Mail order pharmacy • Specialty pharmacy management • Reporting and analytics • Clinical services, including formulary design, point-of-service (POS) edits, Drug Utilization Management edits, and clinical programs addressing BH, physical health, and medication management		
Project Description: The project included a joint project management team with representatives from IngenioRx and from the Lexington Fayette County Urban Government office, as well as a Transition Steering Committee and a comprehensive project plan. The project plan tracked key milestones, decisions, risks, and mitigation plans for each of the multiple work streams, including Benefits, Eligibility, Claims, Clinical, and Operational Readiness. In March 2018, we began general testing of the pharmacy benefit plan and had completed satisfactory testing of the benefit and clinical processes prior to transition. In January 2019, we		

began parallel testing, which continued until transition. We conducted a full end-to-end validation of business processes and continued testing until the May 1, 2019 Operational Start Date to confirm claims adjudicated properly and timely and to provide a seamless, uninterrupted member experience. As we approached transition, we communicated regularly with the Lexington Fayette County Urban Government office. In addition, we provided reports and participated in on-site Readiness Reviews, as needed and/or required by the Lexington Fayette County Urban Government office. We assembled a team of 400 at the IngenioRx headquarters to support the seamless go-live transition to IngenioRx.

Vendor's Involvement:

All Pharmacy Benefit Partner-related services were addressed and accounted for on this project, including network development and maintenance, system testing and delivery, formulary and benefit programming, claims testing, claims processing, call center management, medical and pharmacy integration, clinical programs, reporting, and prior authorization.

Project Benefits:

- Enhanced member experience with 24/7 call center with a second level support by pharmacy experts and warm transfers to Member Services for medical questions
- Connect customer service center with account management team to efficiently resolve issues
- Decreased pharmacy spend seen in first month with IngenioRx
- Enhanced Pharmacy Service Model for members receiving specialty medications
- Seamless transition to IngenioRx

Key Personnel

Name: Angela Thomas	Role: Senior Pharmacy Account Manager, IngenioRx
Name: Lynn Lundy	Role: Account Manager Consultant, Anthem BCBS KY

Project Measurements:

Projected Membership of Vendor's Contract: Approximately 3,000 subscribers (approximately 6,000 members)	Actual Membership of Vendor's Contract: Approximately 6,000 members transitioned to IngenioRx on 5/1/19
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Reason(s) for Change in Membership: N/A

Estimated Start and Completion Dates:	From:	1/1/2018	To:	4/30/2019
Actual Start and Completion Dates:	From:	1/1/2018	To:	4/30/2019

Reason(s) for Difference Between Estimated and Actual Dates:
N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

All Pharmacy Benefit Partner-related services were performed, including network development and maintenance, system testing and delivery, formulary and benefit programming, claims testing, claims

processing, call center management, clinical programs, reporting and analytics, regulatory compliance, rebate administration, specialty pharmacy management, mail order pharmacy, and prior authorization.

Since the transition to IngenioRx on 5/1/19, IngenioRx has grown to approximately 1,770 employees and is currently managing the pharmacy benefits for over 6,000 Lexington Fayette County Urban Government members.

Table 9: Subcontractor References

IngenioRx Reference #2

Subcontractor Information		
Vendor Name: IngenioRx, Inc. (IngenioRx)	Contact Name:	Mi Jung Lim
	Contact Phone:	571-205-2806
Customer Information		
Customer Organization: AMERIGROUP Maryland, Inc. (Amerigroup Maryland)	Contact Name:	Vincent Ancona
	Contact Title:	Chief Executive
Customer Address: 7550 Teague Road, Suite 500, Hanover, MD 21076	Contact Phone:	410-981-4001
	Contact Email:	vincent.ancona@amerigroup.com
Project Information		
Total Vendor Staff:	Approximately 1623 employees for all LOBs at time of the project	
Project Objectives: Transition of Pharmacy Benefit Partner services to IngenioRx. IngenioRx administers and delivers a full suite of pharmacy benefit management services, including: • Claim adjudication • Best-in-class pharmacy network • Account management • Formulary management • Benefits management • Medical and pharmacy integration • Medicaid regulatory compliance • Anthem managed Preferred Drug List (PDL) support • Searchable formulary and searchable pharmacy network tools • 24/7 enrollee call center staffed with pharmacy specialists • Prior authorization, including electronic PA • Rebate administration • Mail order pharmacy • Specialty pharmacy management • Real-time reporting and analytics • Clinical services, including formulary design, POS edits, Drug Utilization Management edits, and clinical programs addressing BH, physical health, and medication management		
Project Description: The project included a joint project management team with representatives from IngenioRx and the Amerigroup Maryland, as well as a Transition Steering Committee and a comprehensive project plan. The project plan tracked key milestones, decisions, risks, and mitigation plans for each of the multiple work streams, including Benefits, Eligibility, Claims, Clinical, and Operational Readiness, as well as a dedicated Medicaid event verification to confirm compliance with all state and federal requirements. In March 2018, IngenioRx began general testing of the pharmacy benefit plan and had completed		

satisfactory testing of the benefit and clinical processes prior to transition. In January 2019, IngenioRx began parallel testing which continued until transition. IngenioRx conducted a full end-to-end validation of business processes and continued testing until the May 1, 2019 Operational Start Date to confirm claims adjudicated properly and timely and to provide a seamless, uninterrupted member experience. As IngenioRx approached transition, IngenioRx communicated regularly with the Amerigroup Maryland and the Maryland Department of Health. In addition, IngenioRx provided reports and participated in on-site Readiness Reviews, as needed and/or required by Amerigroup Maryland or the Maryland Department of Health. IngenioRx assembled a team of 400 at the IngenioRx Headquarters to support the seamless go-live transition to IngenioRx.

Vendor's Involvement:

All Pharmacy Benefit Partner-related services were addressed and accounted for on this project, including network development and maintenance, system testing and delivery, claims testing, claims processing, call center management, medical and pharmacy integration, clinical programs, reporting, and prior authorization.

Project Benefits:

- Enhanced member experience with 24/7 call center with a second level support by pharmacy experts and warm transfers to Member Services for medical questions
- Connect customer service center with pharmacy account management team to efficiently resolve issues
- Seamless transition to IngenioRx
- Decreased pharmacy spend seen in first month with IngenioRx — projected savings in 2019 (May–December) is \$1.49 million

Key Personnel

Name: Mi Jung Lim

Role: Pharmacy Account Manager

Project Measurements:

Projected Membership of Vendor's Contract:
Approximately 276,000 pharmacy lives

Actual Membership of Vendor's Contract:
Approximately 276,000 pharmacy lives transitioned to IngenioRx on May 1, 2019

Reason(s) for Change in Membership: N/A

Estimated Start and Completion Dates:

From: 1/1/2018

To: 4/30/2019

Actual Start and Completion Dates:

From: 1/1/2018

To: 4/30/2019

Reason(s) for Difference Between Estimated and Actual Dates:

N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

All Pharmacy Benefit Partner-related services were performed, including network development and maintenance, system testing and delivery, formulary and benefit programming, claims testing and processing, call center management, clinical programs and services, reporting and analytics, regulatory compliance, rebate administration, specialty pharmacy management, mail order pharmacy, and prior authorization.

Since the transition to IngenioRx on 5/1/19, IngenioRx has grown to approximately 1,770 employees and is currently managing the pharmacy benefits for approximately 272,000 Amerigroup Maryland Medicaid members.

Table 9: Subcontractor References

IngenioRx Reference #3

Subcontractor Information		
Vendor Name: IngenioRx, Inc. (IngenioRx)	Contact Name:	Kelly Switzer
	Contact Phone:	785-260-1959
Customer Information		
Customer Organization: AMERIGROUP Texas, Inc. (Amerigroup Texas)	Contact Name:	Patrick Sturdivant
	Contact Title:	Chief Executive
Customer Address: 2505 North Highway 360, Suite 300, Grand Prairie, TX 75050	Contact Phone:	806-632-1087
	Contact Email:	patrick.sturdivant@anthem.com
Project Information		
Total Vendor Staff:	Approximately 1,623 employees for all LOBs at time of the project	
Project Objectives: Transition of Pharmacy Benefit Partner services to IngenioRx. IngenioRx administers and delivers a full suite of pharmacy benefit management services, including: • Claim adjudication • Best-in-class pharmacy network • Account management • Formulary management • Benefits management • Medical and pharmacy integration • Medicaid regulatory compliance • Anthem managed PDL support • Searchable formulary and searchable pharmacy network tools • 24/7 enrollee call center staffed with pharmacy specialists • Prior authorization including electronic PA • Rebate administration • Mail order pharmacy • Specialty pharmacy management • Real-time reporting and analytics • Clinical services, including formulary design, POS edits, Drug Utilization Management edits, and clinical programs addressing BH, physical health, and medication management		
Project Description: The project included a joint project management team with representatives from IngenioRx and Amerigroup Texas, as well as a Transition Steering Committee and a comprehensive project plan. The project plan tracked key milestones, decisions, risks, and mitigation plans for each of the multiple work streams, including Benefits, Eligibility, Claims, Clinical, and Operational Readiness, as well as a dedicated Medicaid event verification to confirm compliance with all state and federal requirements. In March 2018, we began general testing of the pharmacy benefit plan and had completed satisfactory		

testing of the benefit and clinical processes prior to transition. In January 2019, we began parallel testing which continued until transition. We conducted a full end-to-end validation of business processes and continued testing until the October 1, 2019 Operational Start Date to confirm claims adjudicated properly and timely and to provide a seamless, uninterrupted member experience. As we approached transition, we communicated regularly with the Amerigroup Texas and the state agency. In addition, we provided reports and participated in on-site Readiness Reviews, as needed and/or required by Amerigroup Texas or the state agency. We assembled a team of 400 at the IngenioRx Headquarters to support the seamless go-live transition to IngenioRx.

Vendor's Involvement:

All Pharmacy Benefit Partner-related services were addressed and accounted for on this project including network development and maintenance, system testing and delivery, claims testing, claims processing, call center management, medical and pharmacy integration, clinical programs, reporting, and prior authorization.

Project Benefits:

- Enhanced member experience with 24/7 call center and average net promoter score of 70% achieved
- Connect customer service center with pharmacy account management team to efficiently resolve issues
- Decreased pharmacy spend seen in first month with IngenioRx
- Flawless transition to IngenioRx

Key Personnel

Name: Kelly Switzer

Role: Pharmacy Director

Project Measurements:

Projected Membership of Vendor's Contract:
Approximately 746,000 pharmacy lives

Actual Membership of Vendor's Contract:
Approximately 746,000 pharmacy lives transitioned to IngenioRx on October 1, 2019

Reason(s) for Change in Membership: N/A

Estimated Start and Completion Dates:	From:	1/1/2018	To:	9/30/2019
Actual Start and Completion Dates:	From:	1/1/2018	To:	4/30/2019

Reason(s) for Difference Between Estimated and Actual Dates:
N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

All Pharmacy Benefit Partner-related services were performed, including network development and maintenance, system testing and delivery, formulary and benefit programming, claims testing, claims processing, call center management, clinical programs, reporting and analytics, regulatory compliance, rebate administration, specialty pharmacy management, mail order pharmacy, and prior authorization.

Since the transition to IngenioRx on 10/1/19, IngenioRx has grown to approximately 1,770 employees and is currently managing the pharmacy benefits for over 774,000 Amerigroup Texas Medicaid members.

Table 9: Subcontractor References

SKYGEN Reference #1

Subcontractor Information		
Vendor Name: SKYGEN USA, LLC (SKYGEN)	Contact Name:	Mark Dasek
	Contact Phone:	262-946-4537
Customer Information		
Customer Organization: Horizon Blue Cross Blue Shield New Jersey (Horizon)	Contact Name:	Dr. Fred DiOrio, DMD
	Contact Title:	Dental Director
Customer Address: 1427 Wyckoff Road Farmingdale, NJ 07727	Contact Phone:	732-256-5485
	Contact Email:	fred_diorio@horizonnjhealth.com
Project Information		
Total Vendor Staff:	Approximately 600	
Project Objectives: SKYGEN USA provides administrative dental services for Horizon's Medicaid members.		
Project Description: SKYGEN performs all services necessary to administer the dental benefit to Horizon, including implementation, network development, provider relations, credentialing, member services, member outreach, quality, utilization management, appeals and grievances, and reporting. In addition to policies and procedures that proactively assure members receive appropriate services and treatment, SKYGEN has built sophisticated reporting and analytics into their dental benefits software system, the Enterprise System. This system allows them to run reports designed specifically for Medicaid dental programs that monitor utilization and member outcomes. Using this data, they create interventions, outreach initiatives, and educational campaigns as appropriate for Horizon.		
Vendor's Involvement: SKYGEN has managed Horizon's Medicaid members since 2012, with a focus on holistic program integrity and stewardship. To address Horizon's most immediate needs, they used a combination of data analytics, fee schedule analysis, and geo-access reporting to analyze costs. SKYGEN is delegated to perform the following activities for the dental program: • Provider recruitment, credentialing, education, and retention • Authorizations • Utilization review and management • Claims processing and provider payment • Call center services • Reporting • Member services • Quality assurance • Complaints, grievances, and appeals		

• FWA				
Project Benefits:				
For Horizon, SKYGEN reduced their PMPM costs, resulting in significant saving while achieving over 80% provider satisfaction from 2015 to 2017. They also consulted with Horizon to improve their providers' performance and helped protect nearly one million members by reducing and preventing FWA.				
Key Personnel				
Name: Mark Dasek		Role: Relationship Manager		
Name: Arica Buretta		Role: Service Manager		
Name: Nicole Martins		Role: Account Manager		
Name: Lynn Kern		Role: Director of Claims Administration		
Name: Marcel Tetzlaff		Role: Vice President, Provider Experience and Dental Benefits Management		
Name: Kyle Koltz		Role: Senior VP Third Party Administration Operations		
Project Measurements:				
Projected Membership of Vendor's Contract: 847,000		Actual Membership of Vendor's Contract: 847,000		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	12/2012	To:	Ongoing
Actual Start and Completion Dates:	From:	12/2012	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:				
All services SKYGEN performs on behalf of Horizon are performed as a subcontractor. This includes provider recruitment, credentialing, education, and retention; authorizations; utilization review and management; claims processing and provider payment; call center services; reporting; member services; quality assurance; complaints, grievances, and appeals; and FWA monitoring.				

Table 9: Subcontractor References

SKYGEN Reference #2

Subcontractor Information		
Vendor Name: SKYGEN USA, LLC (SKYGEN)	Contact Name:	Mark Dasek
	Contact Phone:	262-946-4537
Customer Information		
Customer Organization: United Concordia Dental (United Concordia)	Contact Name:	Daniel J. Wright
	Contact Title:	SVP Government Business & CFO
Customer Address: 4401 Deer Path Road Harrisburg, PA 17110	Contact Phone:	717-260-7182
	Contact Email:	daniel.wright@highmark.com
Project Information		
Total Vendor Staff:	Approximately 600	
Project Objectives: SKYGEN USA provides administrative dental services for United Concordia's Medicaid members.		
Project Description: SKYGEN is a dental administrative services organization. They perform all services necessary to administer the dental benefit to United Concordia in Pennsylvania, Ohio, Kentucky, North Carolina, and West Virginia, including implementation, member services, quality, and reporting. In addition to policies and procedures that proactively assure members receive appropriate services and treatment, SKYGEN has built sophisticated reporting and analytics into their dental benefits software system, the Enterprise System. SKYGEN's system allows them to run reports designed specifically for Medicaid dental programs that monitor utilization and member outcomes.		
Vendor's Involvement: SKYGEN has been the dental administrator managing United Concordia's Medicaid members since 2012, currently totaling nearly 400,000 members. SKYGEN USA performs the following activities for United Concordia: • Authorizations • Claims processing and provider payment • Reporting • Member services • Quality assurance		
Project Benefits: SKYGEN USA has effectively managed the dental benefit program for United Concordia, creating efficiencies, working to increase provider and member satisfaction, and improving automated claims processing. Project benefits include improving access to care, reducing program overhead, containing benefit costs, and safeguarding patients.		

Key Personnel			
Name: Mark Dasek		Role: Relationship Manager	
Name: Arica Buretta		Role: Service Manager	
Name: Cheryl Lightheart		Role: Account Manager	
Name: Lynn Kern		Role: Director of Claims Administration	
Name: Kyle Koltz		Role: Senior VP Third Party Administration Operations	
Project Measurements:			
Projected Membership of Vendor's Contract: 396,000		Actual Membership of Vendor's Contract: 396,000	
Reason(s) for Change in Membership: N/A			
Estimated Start and Completion Dates:	From:	04/2012	To: Ongoing
Actual Start and Completion Dates:	From:	04/2012	To: Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A			
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: All services SKYGEN performs on behalf of United Concordia Dental are performed as a subcontractor. This includes authorizations, claims processing, provider payment, reporting, member services, and quality assurance.			

Table 9: Subcontractor References

SKYGEN Reference #3

Subcontractor Information		
Vendor Name: SKYGEN USA, LLC (SKYGEN)	Contact Name:	Mark Dasek
	Contact Phone:	262-946-4537
Customer Information		
Customer Organization: Commonwealth Care Alliance	Contact Name:	Jessica Vida
	Contact Title:	Director of Dental, OTC Ancillary Programs
Customer Address: 30 Winter Street Boston, MA 02108	Contact Phone:	617-426-0600 x1001
	Contact Email:	jmedeiros@commonwealthcare.org
Project Information		
Total Vendor Staff:	Approximately 600	
Project Objectives: SKYGEN provides administrative dental services for Commonwealth Care Alliance's 31,000 Medicaid members.		
Project Description: SKYGEN is a dental administrative services organization. They perform all services necessary to administer the dental benefit to Commonwealth Care Alliance in Massachusetts, including implementation, claims processing, provider payment, reporting, call center, authorizations, quality assurance, complaints, appeals, and grievances.		
Vendor's Involvement: SKYGEN has been the dental administrator managing Commonwealth Care Alliance's Medicaid members since 2014. SKYGEN performs the following activities for Commonwealth Care Alliance: • Authorizations • Claims processing and provider payment • Reporting • Member services • Quality assurance		
Project Benefits: SKYGEN USA has effectively managed the dental benefit program for Commonwealth Care Alliance, creating efficiencies, working to increase provider and member satisfaction, and improving automated claims processing. Project benefits include improved access to care, reduced program overhead, containing benefit costs, and safeguarding patients.		

Key Personnel				
Name: Mark Dasek		Role: Relationship Manager		
Name: Crystal Seng		Role: Service Manager		
Name: Autumn Stockton		Role: Account Manager		
Name: Lynn Kern		Role: Director of Claims Administration		
Name: Kyle Koltz		Role: Senior VP Third Party Administration Operations		
Project Measurements:				
Projected Membership of Vendor's Contract: 31,000		Actual Membership of Vendor's Contract: 31,000		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	06/2014	To:	Ongoing
Actual Start and Completion Dates:	From:	06/2014	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: All services SKYGEN performs on behalf of Commonwealth Care Alliance are performed as a subcontractor. This includes claims processing; provider payment; reporting; authorizations; quality assurance; call center; and complaints, grievances, and appeals.				

Table 9: Subcontractor References
SPH Reference #1

Subcontractor Information		
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Contact Name:	Midge Coker
	Contact Phone:	404-394-9156
Customer Information		
Customer Organization: Alameda Alliance for Health	Contact Name:	Dr. Sanjay Bhatt
	Contact Title:	Quality Improvement Medical Director
Customer Address: 1240 South Loop Road, Alameda, CA 94502	Contact Phone:	510-747-6152
	Contact Email:	sbhatt@alamedaalliance.org
Project Information		
Total Vendor Staff:	5	
Project Objectives: Conduct surveys to assess member and provider satisfaction.		
Project Description: Health risk assessment, CAHPS, provider access, provider satisfaction, and member satisfaction (clinician and group CAHPS) surveys.		
Vendor's Involvement: SPH provides survey administration services.		
Project Benefits: • Certification • Process improvement • Better member outcomes		
Key Personnel		
Name: Dr. Sanjay Bhatt	Role: Quality Improvement Medical Director	
Project Measurements:		
Projected Membership of Vendor's Contract: 260,554	Actual Membership of Vendor's Contract: 260,554	
Reason(s) for Change in Membership: N/A		

Estimated Start and Completion Dates:	From:	01/2012	To:	12/2019
Actual Start and Completion Dates:	From:	01/2012	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: SPH is not a subcontractor for this client.				

Table 9: Subcontractor References

SPH Reference #2

Subcontractor Information			
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Contact Name:	Midge Coker	
	Contact Phone:	404-394-9156	
Customer Information			
Customer Organization: Blue Shield Promise Health Plan (Previously Care1st Health Plan)	Contact Name:	Norma Perez	
	Contact Title:	Senior Quality Improvement Accreditation Project Manager	
Customer Address: 601 Potrero Grande Drive, Monterey Park, CA 91755	Contact Phone:	323-827-6627	
	Contact Email:	Norma.Perez@blueshieldca.com	
Project Information			
Total Vendor Staff:	5		
Project Objectives: Conduct surveys to assess member and provider satisfaction.			
Project Description: Clinician and group CAHPS, provider satisfaction, CAHPS 5.0H, prescription adherence outreach, Medicare CAHPS, HOS, call center satisfaction, Medicare CAHPS drill down surveys, and care management and disease management satisfaction surveys.			
Vendor's Involvement: SPH Analytics provides survey administration services.			
Project Benefits:			
• Certification • Process improvement • Better member outcomes			
Key Personnel			
Name: Norma Perez		Role: Senior Quality Improvement Accreditation Project Manager	
Project Measurements:			
Projected Membership of Vendor's Contract: 3,377,207		Actual Membership of Vendor's Contract: 3,377,207	
Reason(s) for Change in Membership: N/A			
Estimated Start and Completion Dates:	From:	01/2012	To: 12/2019
Actual Start and Completion	From:	01/2012	To: Ongoing

Dates:				
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: SPH is not a subcontractor for this client.				

Table 9: Subcontractor References

SPH Reference #3

Subcontractor Information			
Vendor Name: Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Contact Name:	Midge Coker	
	Contact Phone:	404-394-9156	
Customer Information			
Customer Organization: El Paso First Health Plans Inc.	Contact Name:	Edgar Martinez	
	Contact Title:	Director of Member Services	
Customer Address: 1145 Westmoreland Drive, El Paso, TX 79925	Contact Phone:	915-532-3778 x1064	
	Contact Email:	edmartinez@elpasohealth.com	
Project Information			
Total Vendor Staff:	5		
Project Objectives: Conduct surveys to assess member and provider satisfaction.			
Project Description: Commercial adult CAHPS, Medicaid adult CAHPS (STAR adult), Medicaid child (CHIP child and Medicaid), and provider satisfaction.			
Vendor's Involvement: SPH provides survey administration services.			
Project Benefits: • Certification • Process improvement • Better member outcomes			
Key Personnel			
Name: Edgar Martinez, MBA		Role: Director of Member Services	
Project Measurements:			
Projected Membership of Vendor's Contract: 71,846		Actual Membership of Vendor's Contract: 71,846	
Reason(s) for Change in Membership: N/A			
Estimated Start and Completion Dates:	From:	01/2015	To: 12/2019

Actual Start and Completion Dates:	From:	01/2015	To:	Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: SPH is not a subcontractor for this client.				

Table 9: Subcontractor References

VSP Reference #1

Subcontractor Information					
Vendor Name: Vision Service Plan Insurance Company (VSP)	<table border="1"> <tr> <td>Contact Name:</td> <td>Annie Mayo</td> </tr> <tr> <td>Contact Phone:</td> <td>336-995-8417</td> </tr> </table>	Contact Name:	Annie Mayo	Contact Phone:	336-995-8417
Contact Name:	Annie Mayo				
Contact Phone:	336-995-8417				
Customer Information					
Customer Organization: Aetna Better Health of Ohio	<table border="1"> <tr> <td>Contact Name:</td> <td>Matt Koblenz</td> </tr> <tr> <td>Contact Title:</td> <td>Vendor Manager</td> </tr> </table>	Contact Name:	Matt Koblenz	Contact Title:	Vendor Manager
Contact Name:	Matt Koblenz				
Contact Title:	Vendor Manager				
Customer Address: 7400 West Campus Road, New Albany, OH 43054	<table border="1"> <tr> <td>Contact Phone:</td> <td>614-254-4681</td> </tr> <tr> <td>Contact Email:</td> <td>Koblensm@aetna.com</td> </tr> </table>	Contact Phone:	614-254-4681	Contact Email:	Koblensm@aetna.com
Contact Phone:	614-254-4681				
Contact Email:	Koblensm@aetna.com				
Project Information					
Total Vendor Staff:	2,600				
Project Objectives: Provide high-quality routine vision care services to members. Provide various reports on the customer's overall performance.					
Project Description: Maintain claims and provider systems to allow the customer's network of providers to obtain coverage information and submit claims for routine vision services.					
Vendor's Involvement: VSP provides network support, development (as needed) and credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and any reporting specified in the agreement.					
Project Benefits: • Provide highest level of routine vision care to members • Capture member health information for reporting to the state for wellness initiatives • Streamline benefit delivery system for ease of the member and provider interactions					
Key Personnel					
Name: Gary Bach	Role: Manager, Health and Government Markets				
Name: Natasha Strickner	Role: Program Manager				
Project Measurements:					
Projected Membership of Vendor's Contract: 30,000	Actual Membership of Vendor's Contract: 30,000				

Reason(s) for Change in Membership: N/A			
Estimated Start and Completion Dates:	From:	06/2014	To: Ongoing
Actual Start and Completion Dates:	From:	06/2014	To: Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A			
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: VSP provides network support, development (as needed), credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and all reporting identified in the contract.			

Table 9: Subcontractor References

VSP Reference #2

Subcontractor Information	
Vendor Name: Vision Service Plan Insurance Company (VSP)	Contact Name: Annie Mayo
	Contact Phone: 336-995-8417
Customer Information	
Customer Organization: BlueChoice HealthPlan of South Carolina	Contact Name: Scott Timmons
	Contact Title: Sr. Director Provider Networks
Customer Address: 4101 Percival Road, Columbia, SC 29229	Contact Phone: 803-264-2068
	Contact Email: Scott.Timmons@bluechoicesc.com
Project Information	
Total Vendor Staff:	2,600
Project Objectives: Provide high-quality routine vision care services to members. Provide various reports on the customer's overall performance.	
Project Description: Maintain claims and provider systems to allow the customer's network of providers to obtain coverage information and submit claims for routine vision services.	
Vendor's Involvement: VSP provides network support, development (as needed) and credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and any reporting specified in the agreement.	
Project Benefits: • Provide highest level of routine vision care to members • Capture member health information for reporting to the state for wellness initiatives • Streamline benefit delivery system for ease of the member and provider interactions	
Key Personnel	
Name: Gary Bach	Role: Manager, Health and Government Markets
Name: Natasha Strickner	Role: Program Manager
Project Measurements:	
Projected Membership of Vendor's Contract: 125,000	Actual Membership of Vendor's Contract: 125,000
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	07/2010	To: Ongoing
Actual Start and Completion Dates:	From:	07/2010	To: Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A			
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: VSP provides network support, development (as needed), credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and all reporting identified in the contract.			

Table 9: Subcontractor References

VSP Reference #3

Subcontractor Information	
Vendor Name: VSP	Contact Name: Annie Mayo
	Contact Phone: 336-995-8417
Customer Information	
Customer Organization: Community Health Plan of Washington	Contact Name: Vicky Bruner
	Contact Title: Director, Marketplace Strategy
Customer Address: 1111 Third Avenue, Seattle, WA 98101	Contact Phone: 206-613-8811
	Contact Email: Vicky.Bruner@chpw.org
Project Information	
Total Vendor Staff:	2,600
Project Objectives: Provide high-quality routine vision care services to members. Provide various reports on the customer's overall performance.	
Project Description: Maintain claims and provider systems to allow the customer's network providers to obtain coverage information and submit claims for routine vision services.	
Vendor's Involvement: VSP provides network support, development (as needed) and credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and any reporting specified in the agreement.	
Project Benefits: • Provide highest level of routine vision care to members • Capture member health information for reporting to the state for wellness initiatives • Streamline benefit delivery system for ease of the member and provider interactions	
Key Personnel	
Name: Gary Bach	Role: Manager, Health and Government Markets
Name: Natasha Strickner	Role: Program Manager
Project Measurements:	
Projected Membership of Vendor's Contract: 500	Actual Membership of Vendor's Contract: 500

Reason(s) for Change in Membership: N/A			
Estimated Start and Completion Dates:	From:	01/2013	To: Ongoing
Actual Start and Completion Dates:	From:	01/2013	To: Ongoing
Reason(s) for Difference Between Estimated and Actual Dates: N/A			
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: VSP provides network support, development (as needed), credentialing/re-credentialing activities, claims processing, call center support (both member and provider), activities associated with member health and wellness, and all reporting identified in the contract.			

Table 9: Subcontractor References

Wipro Reference #1

Subcontractor Information		
Vendor Name: Wipro LLC (Wipro)	Contact Name:	Paul Andrews
	Contact Phone:	573-635-2434 x5216
Customer Information		
Customer Organization: Missouri Department of Social Services, MO HealthNet Division (MO HealthNet)	Contact Name:	Darin Hackmann
	Contact Title:	Medicaid Enterprise Systems Chief Information Officer
Customer Address: 615 Howerton Court, Jefferson City, MO 65109	Contact Phone:	573-751-7996
	Contact Email:	Darin.M.Hackmann@dss.mo.gov
Project Information		
Total Vendor Staff:	179	
Project Objectives: Provide quality Medicaid Management Information System (MMIS) support and comprehensive Fiscal Agent services, including call centers, document management, and fulfillment services.		
Project Description: This contract signifies the continuation of MMIS implementation and support and Fiscal Agent services Wipro has been providing to the state of Missouri since 1988. This contract facilitates the following project activities: • Provide and support the provider web portal, including enrollment, re-credentialing, and enhancements to support the elimination of FWA • Provide and support the eMOMED web portal, which facilitates online provider claims submission, status checks, and remittance advice statement requests • Provide call center services to program participants, health care service providers, clinical authorizations, and technical help • Process paper claims and attachments, image provider and participant correspondence, resolution of suspended claims, and data entry into the MMIS • Provide professional review services for prior authorization and precertification of services • Maintain and modify the MMIS utilizing the entire range of the system development life cycle • Provide an avenue for necessary system enhancements or modifications needed to assure efficient Medicaid program application and to address any regulatory changes		
Vendor's Involvement: Wipro serves as the prime contractor and provides system integration, project management services, and the full scope of the software development life cycle, as well as manages comprehensive Fiscal Agent services for the Missouri Medicaid program.		
Project Benefits: • Provide efficient and accurate provider enrollment processes		

- Assist the state in making sure FWA within the provider community is at a minimum
- Make sure eligible citizens receive quality care
- Make sure providers receive payment timely and accurately
- Provide efficient avenues of communication regarding Medicaid claims, eligibility, and provider enrollment
- Make sure FWA is at a minimum within the Medicaid program
- Achieve and maintain state and federal regulatory compliance

Key Personnel

Name: Paul Andrews	Role: Account Manager
Name: Anita Mosley	Role: IT Director
Name: Mahesh Mullath	Role: Program Manager
Name: Pramod Govindan	Role: Security and Compliance

Project Measurements:

Projected Membership of Vendor's Contract: More than one million	Actual Membership of Vendor's Contract: More than one million
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Reason(s) for Change in Membership: N/A

Estimated Start and Completion Dates:	From: 09/2007	To: 06/2014
Actual Start and Completion Dates:	From: 09/2007	To: 06/2020

Reason(s) for Difference Between Estimated and Actual Dates:

The contract has had various amendments, including extensions for services rendered, maintenance and operations, and modifications required to achieve compliance with Medicaid regulation changes.

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

N/A

Table 9: Subcontractor References

Wipro Reference #2

Subcontractor Information		
Vendor Name: Wipro LLC (Wipro)	Contact Name:	Anuj Kumar
	Contact Phone:	573-353-0482
Customer Information		
Customer Organization: Change Healthcare (CHC)	Contact Name:	Greg Kirsch
Customer Address: 3055 Lebanon Pike, Suite 1000, Nashville, TN 37214	Contact Title:	Senior Director, IT Research & Development
	Contact Phone:	615-932-3000
	Contact Email:	gkirsch@changehealthcare.com
Project Information		
Total Vendor Staff:	1,899	
Project Objectives: The goal of this strategic partnership is to establish CHC as a true integrated health care technology enabler, driving organizational capacity and agility as well as delivering enhanced value to customers. Wipro helps enable business and process transformation tools for CHC and their customers through customer engagement platforms that introduce emerging capabilities, including digital, robotic process automation and artificial intelligence, enterprise resource planning (ERP) consolidation, streamlined health care management and customer relationship management systems, and modernization of customized cloud solutions with industry-leading information security frameworks.		
Project Description: CHC engaged Wipro to significantly decrease costs by providing functions using lower priced resources and by transforming processes. CHC seeks a flexible relationship that takes advantage of evolving technologies, including automation, as well as to change platforms or methods of service delivery.		
Vendor's Involvement: The engagement between Wipro and CHC encompasses multiple services lines over the 10-year contractual agreement including infrastructure services, application development, business process services, and joint Wipro/CHC health care technology products.		
Project Benefits: ▪ Engagement/Project Ramp-up. Wipro sourced and on-boarded 1,899 dedicated resources across six countries, fulfilling requirements for more than 20 projects. ▪ Information Security. To facilitate quick ramp-up, Wipro enabled and equipped 10 PHI-compliant delivery centers across three continents, certifying 1,700+ seats with health care industry-specific information and physical security controls in less than 12 months.		

- **IT Service Desk.** Migrated global support for all CHC IT Service Desk functions to Wipro centralized operations in offshore markets with premiere technical talent.
- **Payer Print Business.** Transitioned print services to Wipro, leveraging backend horsepower for application development to enable CHC's patient billing and payment solution.
- **Member Engagement.** Through due diligence and capability showcasing, Wipro earned the trust of CHC's largest payer customer, establishing and providing advocate and coordination services, including member outreach, eligibility and enrollment, and patient scheduling.

Key Personnel

Name: Anuj Kumar	Role: VP Health, Account Manager
Name: Vishal Saxena	Role: Technology, IT Program Leader
Name: Jennifer Crum	Role: Enterprise Program Leader
Name: Tushar Behera	Role: Operations Client Partner

Project Measurements:

Projected Membership of Vendor's Contract: N/A	Actual Membership of Vendor's Contract: N/A
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Reason(s) for Change in Membership: N/A

Estimated Start and Completion Dates:	From: 02/2018	To: 02/2028
Actual Start and Completion Dates:	From: 02/2018	To: 02/2028

Reason(s) for Difference Between Estimated and Actual Dates:
N/A

If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:

Wipro provides the following activities to CHC:

- Client/Customer-facing services, such as call center, back office, and technology infrastructure services
- Transition of CHC corporate financial systems from multiple disparate legacy platforms to the target Oracle platform
- Credentialing verification automation and transformation for both payers and providers

Table 9: Subcontractor References

Wipro Reference #3

Subcontractor Information		
Vendor Name: Wipro LLC (Wipro)	Contact Name:	Bonet Lobo
	Contact Phone:	678-314-2822
Customer Information		
Customer Organization: Best Buy Co., Inc.	Contact Name:	Sherrell Christenson
	Contact Title:	Director, Contact Strategy and Partner Management
Customer Address: 7601 Penn Avenue South, Richfield, MN 55423	Contact Phone:	612-291-8001
	Contact Email:	Sherrell.Christenson@bestbuy.com
Project Information		
Total Vendor Staff:	More than 900	
Project Objectives: The goal of this strategic partnership is to establish Best Buy as a true integrated technology enabler, driving organizational capacity and agility, as well as delivering enhanced value to Best Buy's customers. Wipro helps enable business and process transformation tools for Best Buy and their customers through customer engagement platforms that introduce emerging capabilities, including digital, robotic process automation and artificial intelligence, ERP consolidation, streamlined customer relationship management systems, and modernization of customized cloud solutions with industry-leading information security frameworks.		
Project Description: Best Buy contracted Wipro to significantly decrease costs by providing functions using lower priced resources and transforming processes. Best Buy seeks a flexible relationship that takes advantage of evolving technologies, including automation, as well as changing platforms or methods of service delivery.		
Vendor's Involvement: The engagement between Wipro and Best Buy encompasses multiple services lines over the eight-year agreement, including infrastructure services, application development, business process services, and joint Wipro/Best Buy technology products.		
Project Benefits: • Browse and Sell, post-purchase support, billing and renewal, total tech support, and fraud detection management • Repair, delivery, installation, and post-purchase support for notebooks, desktops, tablets, home theater, mobile, etc. • Committed transformation benefits through Lean and Six Sigma projects		

Key Personnel				
Name: Bonet Lobo		Role: Director — Client Partner		
Name: Shekar Saraf		Role: Operations Lead		
Project Measurements:				
Projected Membership of Vendor's Contract:		Actual Membership of Vendor's Contract:		
N/A		N/A		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	02/2012	To:	02/2020
Actual Start and Completion Dates:	From:	02/2012	To:	02/2020
Reason(s) for Difference Between Estimated and Actual Dates:				
N/A				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities:				
N/A				

6. Financial Stability

The Vendor should provide the following components for this section:

6.1 Dun & Bradstreet (D&B) Ratings

The Vendor should provide the industry standard Dun & Bradstreet (D&B) ratings that indicate its financial strength and creditworthiness, assigned to most U.S. and Canadian companies (and some companies of other nationalities) by the U.S. firm D&B. These ratings are based on a company's worth and composite credit appraisal. Additional information is given in credit reports (published by D&B) that contain the company's financial statements and credit payment history.

The Vendor should provide the following D&B measures:

- PAYDEX
- Commercial Credit Score Percentile (Delinquency Predictor)
- Financial Stress Score
- D&B Viability Rating
- Bankruptcy Found
- D&B Rating

Dun & Bradstreet Ratings

UniCare has maintained compliance with State and federal financial stability requirements since our initial contract start in 2003. We maintain compliance through sustaining a high net worth and exceeding solvency requirements. We will continue our commitment to full transparency and provide DHHR, BMS, and the West Virginia Offices of the Insurance Commissioner with required and requested financial information. We remain steadfast in our commitment to improving the health and well-being of our members while ensuring financial stability.

In Table 3.6-1, we provide the requested Dun & Bradstreet (D&B) measures for UniCare, as well as our ultimate parent company, Anthem, Inc. We will provide copies of D&B ratings reports upon request.

Upon review of our D&B rating, please note that D&B indicates they have not received a sufficient sample of payment experiences to establish a current PAYDEX score for UniCare. UniCare's

Commercial Credit Score Percentile rating (Delinquency Predictor) of 79 means that we are in a

classification of companies where only 2.5% have incidence of delinquent payment. Similarly, for our Financial Stress Score of 33, less than 1% of companies (0.84%) given this score are at risk for severe financial stress. For UniCare's Viability Score of 6 in D&B's Viability Rating, of the businesses given this rank, only 13% have the probability of becoming no longer viable.

As discussed later in our response to Section 6.2, Anthem commits to providing UniCare with any necessary financial backing.

Table 3.6-1. UniCare and Anthem, Inc. D&B Ratings

D&B Measure	UniCare Rating	Anthem, Inc. Rating
PAYDEX	Not available	75 (Paying 8 days past due)
Commercial Credit Score Percentile (Delinquency Predictor)	79 (Low to Moderate Risk of severe payment delinquency)	81 (Low to Moderate Risk of severe payment delinquency)
Financial Stress Score	33 (Moderate to High Risk of severe financial stress)	31 (Moderate to High Risk of severe financial stress)
D&B Viability Rating	6 – Viability Score 4 – Portfolio Comparison A – Data Depth Indicator Z – Company Profile	4 – Viability Score 6 – Portfolio Comparison A – Data Depth Indicator G – Company Profile
Bankruptcy Found	None	None
D&B Rating	ER3 (100-499 employees)	ER1 (1,000 or more employees)

Additional UniCare Rating

To further demonstrate UniCare's sound financial position, we provide our ratings from AM Best. Our rating was re-affirmed with an effective date of November 7, 2019, and we will provide a copy upon request. Table 3.6-2 provides UniCare's current AM Best rating information, along with a description of the insight these ratings provide.

AM Best is a recognized indicator of insurer financial strength and creditworthiness. As the world's first credit rating agency (founded in 1899), AM Best is the only global credit rating agency with a focus on the insurance sector.

Table 3.6-2. UniCare Ratings from AM Best Indicate a Strong Financial Position

AM Best Rating Indicator	UniCare Rating	Description
Financial Strength Rating	A- Outlook: Stable	Excellent rating of the ability to meet ongoing insurance obligations
Issuer Credit Rating	A- Outlook: Stable	Excellent rating of the ability to meet ongoing senior (long-term basis) financial obligations

6.2 Financial Capacity

The Vendor should supply evidence of financial stability sufficient to demonstrate reasonable stability and solvency appropriate to the requirements of this procurement. The Vendor should provide their response as part of their bid in accordance with the template below.

Please list credit references that can verify the financial standing of your company.

Financial Capacity: Evidence of Financial Stability

UniCare has been financially stable and dependable over the past 17 years and has shown the capacity for growth necessary to successfully partner with DHHR. We have remained well-funded throughout our time serving West Virginia members. We anticipate funding capital requirements through income from operations; however, we have additional support and backing from our ultimate parent company, Anthem, a Fortune 50 company. Anthem will continue to provide unconditional financial support to UniCare through ongoing financial monitoring and any needed capital contributions. This puts us in an extremely strong position to continue supporting MHT programs.

UniCare maintains a COA with the West Virginia Offices of the Insurance Commissioner. We have been licensed and in good standing since beginning operations, including compliance with all financial requirements.

As of December 31, 2018, UniCare's statutory net worth exceeds the West Virginia Offices of the Insurance Commissioner requirement of 200% of the Authorized Control Level (ACL), and demonstrates a strong financial position with a Risk-Based Capital (RBC) ratio of 563.6%. Our audited 2019 financial statement will be available in early March, and we will provide a copy upon request.

As shown in our net worth analysis in Table 3.6-3, UniCare had \$55 million more than the State's requirement of 200% of ACL at the end of 2018. In other terms, *UniCare held 2.8 times the required capital*. As of September 30, 2019 (the end of quarter three), our capital reserves had increased by more than \$18 million, to \$103,832,170. This clearly demonstrates the strong financial capacity of UniCare to continue to serve MHT members.

Table 3.6-3. UniCare Continues to Exceed State Statutory Net Worth Requirements

Net Worth Analysis — Measure	UniCare Value	Description
Values as of 12/31/2018		
Total Adjusted Capital — 12/31/2018	\$ 85,279,052	Per 2018 Annual NAIC filing
ACL RBC	\$ 15,131,994	Per 2018 Annual NAIC filing
RBC Ratio Against ACL	563.6%	Total Adjusted Capital — 12/31/2018 divided by ACL RBC
200% of ACL (State adopted RBC)	\$ 30,131,994	State adopted RBC = 2 times ACL RBC
Excess over 200% of ACL Requirement — \$	\$ 55,015,064	Total Adjusted Capital minus 200% of ACL
Values as of 9/30/2019		
Total Adjusted Capital — 9/30/2019	\$ 103,832,170	Per 9/30/2019 Quarterly NAIC filing
Increase in Capital Reserves from 12/31/2018	\$ 18,553,118	Total Adjusted Capital (9/30/2019) minus Total Adjusted Capital (12/31/2018)

Additionally, Anthem provides UniCare with any necessary financial backing through access to capital markets, and we are able to leverage Anthem's financial strength and resources. In 2018, Anthem's combined ACL RBC ratio across its insurance and HMO operating subsidiaries was on average approximately 523%, which is 2.6 times federal and State requirements. As of September 30, 2019, Anthem held \$3.0 billion in cash and investments.

We are not aware of any impending changes in financial structure and position that could adversely impact our ability to administer MHT programs, and we comply with all statutory requirements pertaining to net worth, surplus and solvency, or our ability to pay debts generally as they come due.

Ongoing Process to Review Financial Position

Anthem's Treasury team actively monitors expected statutory capital for UniCare and other affiliates on a monthly basis, evaluating actual capital against forecasts. The process uses internal Generally Accepted

Accounting Principles (GAAP) earnings forecasts that are further adjusted for Statutory Accounting Principles to project statutory net income. The process incorporates a target capital amount that is above the capital requirement set by the West Virginia Offices of the Insurance Commissioner. This excess in capital helps insulate UniCare from monthly fluctuations in operating results.

Each month, Treasury assesses UniCare's capital against the forecast to identify potential deficits against the target capital amount. If necessary to maintain capital requirements, Anthem will contribute capital to UniCare. In this event, Treasury will notify our CEO, Tadd Haynes, and our CFO, Kevin Dean, so they are fully apprised of the assessment and the capital infusion.

Credit References

Anthem is one of the nation's leading health benefits companies and provides UniCare with the ability to leverage its financial strength and resources through access to its capital markets. In addition to its own available funds and investments, Anthem has senior revolving credit facilities totaling \$3.5 billion, including a \$2.5 billion 5-Year Facility with a maturity date of June 2024, and a \$1 billion 364-Day Facility with a maturity date of June 2020. There were no amounts outstanding under the 5-Year Facility or the 364-Day Facility at any time during 2019. These credit lines could be used, if necessary, to help provide liquidity to our West Virginia operations.

Anthem is a member, through certain subsidiaries, known as the Subsidiary Credit Facilities, with separate lenders for general corporate purposes. These Subsidiary Credit Facilities provide combined credit up to \$600 million. As of September 30, 2019, \$150 million was outstanding under the Subsidiary Credit Facilities.

Table 3.6-4 shows the credit amount, outstanding amount, and available amount on these senior revolving and Subsidiary Credit Facilities.

Table 3.6-4. Anthem Provides UniCare with Access to Credit Facilities

Credit Line Description	Credit Amount (in Billions)	Outstanding — as of 9/30/19 (in Billions)	Available (in Billions)
Senior Revolving: 5-Year Credit Facility	\$ 2.5	\$ 0.0	\$ 2.5
Senior Revolving: 364-Day Credit Facility	\$ 1.0	\$ 0.0	\$ 1.0
Subsidiary Credit Facilities: 364-Day	\$ 0.6	\$ 0.2	\$ 0.5
Total	\$ 4.1	\$ 0.2	\$ 4.0

Additionally, Anthem is a member, through certain subsidiaries, of the Federal Home Loan Bank of Indianapolis, the Federal Home Loan Bank of Cincinnati, and the Federal Home Loan Bank of Atlanta, or collectively, the FHLBs. As a member, Anthem has the ability to obtain short-term cash advances, subject to certain minimum collateral requirements. As of September 30, 2019, \$560 million, with a fixed interest rate of 1.990%, was outstanding under the short-term FHLB borrowings.

We provide the requested credit references in Table 10.

Table 10: Credit References

INSTITUTION	ADDRESS	PHONE NUMBER
Bank of America Merrill Lynch (UniCare bank account)	4361 Irwin Simpson Road Mason, Ohio 45040	888-715-1000
Chase Bank (UniCare bank account)	4 New York Plaza, 13 th Floor New York, New York 10004	212-623-9321
Bank of America Merrill Lynch (Anthem line of credit)	100 North Tryon Street Charlotte, North Carolina 28255	980-387-5915
Charleston Area Medical Center Jeff Sandene, Executive Vice President, CFO	501 Morris Street Charleston, West Virginia 25301	304-388-7603

ATTACHMENT 4: PROJECT ORGANIZATION AND STAFFING APPROACH

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

For ease of formatting and evaluation, **Attachment 4: Project Organization and Staffing Approach** provides the required outline for the Vendor's response to staffing. The Vendor's response to the following should not exceed 25 pages, excluding organizational charts, the forms provided in this Attachment, and any supplemental documentation requested as part of the submission.

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

1. Initial Staffing Plan

As part of the Vendor's bid response, the Vendor should provide an Initial Staffing Plan. In addition to the requirements described in **Attachment 5: Mandatory Requirements** and **Appendix 1: Detailed Specifications**, the Vendor's narrative description of its proposed Initial Staffing Plan should include the following:

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

- An organizational chart showing how subcontractor(s), excluding direct-care providers, will be managed within the Vendor's West Virginia organizational structure, including the primary individuals at the Vendor's organization and at each subcontractor organization responsible for overseeing such subcontract. This information may be included in the West Virginia organizational chart listed previously or as a separate organizational chart(s).
- A brief narrative explaining the submitted organizational charts, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the Vendor's proposed management of the Vendor program(s).
- A narrative describing tools and processes used to screen available staff to fill positions.
- A narrative describing the process for replacing key staff within defined timeframes, and procedures for backfilling key staff during any transition.
- A hiring plan for administration of the contract awarded through this solicitation.
- Information on how Vendor staffing numbers will reflect adequate access to service populations indicated in this solicitation.
- Information on any additional training or materials—including, but not limited to, the content, methods, and timeframe to initiate and complete training—the Vendor will provide to the Contract Liaison/MHT Administrator to support enrollment.
- Subcontractor Monitoring Plan
 - If the Vendor retains a subcontractor for claims processing, dental benefit management (DBM), behavioral health management, utilization management, or network development, describe activities and monitoring tools for each subcontractor.
 - Provide sample subcontractor agreements for review. The successful Vendors will submit finalized agreements to the Department for approval prior to implementation.
 - If contracting with a benefits manager, provide a separate listing/table of benefit manager vs. Vendor functions in administering the benefits (e.g., provider recruitment, member and provider calls, utilization management, provider education).
 - Identify types of reports/data the subcontractor will provide to the Vendor to help manage medical benefits or other benefits. Indicate the overall content of reports and the frequency with which they will be provided to the Vendor. Please provide sample reports where available.
 - Provide a description of how the Vendor will use reports/data from each subcontractor to ensure appropriate vendor oversight and member access/satisfaction/continuity of care.

- Identify the frequency of contact/status calls with each subcontractor upon go-live and on an ongoing basis.
- Describe a plan that will be followed in the event that a subcontractor does not fulfill its contract or service obligations, including, but not limited to, details on any corrective action plan processes.
- Describe the Vendor's contingency plan in the event that the Vendor or a subcontractor terminates its contract, including plans to identify another subcontractor and transition steps that would take place to ensure uninterrupted member access.
- Describe whether each subcontractor is an affiliate of the Vendor or an unrelated third party.

UniCare's Staffing Plan

UniCare has developed a locally-based leadership team and staff structure to fulfill program requirements. UniCare's key staff are led by our Chief Executive Officer (CEO) Tadd Haynes. Tadd guides our West Virginia operations and leads the administration and coordination of our services. Tadd will continue in this role, with authority over our day-to-day operations and Contract administration.

Our staffing plan blends our strong local team with the administrative proficiency of Anthem back-office functions. At the core of our organizational structure is our whole person care model (Figure 4.1-2) that aligns with DHHR's goals.

Over the last year, UniCare has reviewed our current organizational structure, specifically with the feedback from each of our stakeholders, and as a result, identified a number of opportunities to deploy new, innovative programs and resources so that collectively, we can work together to transform health care delivery in West Virginia. Our proposed project team reflects the skills and qualifications paramount to accomplishing Contract requirements. ***Based in our Charleston office with geographic reach throughout the State, our locally-based key leadership maintains full accountability and autonomy for making service delivery and administrative decisions for every aspect of our operations and performance.***

UniCare has a well-established infrastructure in Charleston. We plan to hire additional employees to raise the bar on the quality of our programs to serve members, including CHIP members. For example:

- We are establishing a West Virginia-based call center, staffed with experienced representatives with the skill set and local knowledge to address our members' and providers' complex needs. Our call center will be comprised of 12 associates and located in our Charleston office.
- To support our field-based staff, we will add a satellite office in Morgantown. This second office will allow us to widen our footprint and positively impact the Morgantown economy.

Proposed Project Team Functional Responsibilities and Reporting

Requirements

Our locally based employees oversee and manage functional areas outlined under the proposed Contract. Our key health plan leadership report directly to our **CEO, Tadd Haynes**, who leads from our Charleston office. They align our goals with the State's; develop and oversee operations; and make sure we continue to provide the services to address the needs of our members, providers, and DHHR.

Compliance and Program Integrity

Our West Virginia-based **Compliance Officer, Richard Chapman**, leads the efforts in implementing and overseeing our Compliance Program to meet State, federal, and contractual requirements. Richard works with our locally based interim **Program Integrity Lead, Rick Leveck**, and **MHT Regulatory Manager, Amber Nary**, who are dedicated to fostering ethics and compliance; preventing, detecting, and investigating fraud, waste, and abuse (FWA); and communicating regularly with DHHR. The Compliance Officer, along with key staff, makes sure Anthem's support services functions comply with the contract.

Operations

Operations Director, Megan Lombard oversees our operational support services team; oversees and manages all major data transactions, such as claims payment, processing of enrollment and encounter files; and supports accurate and timely data exchange with the State. She stays in daily contact with our **Contract Liaison/MHT Administrator, Barbara Wessels**, who operates from our Charleston office. Our ultimate parent company, Anthem, Inc. (Anthem), provides centrally delivered services to complement our local resources. These Anthem supports include claims processing, enrollment processing, encounter data management, and information technology. These functions are fully accountable to our local leadership team, and work with Megan to assure coordinated processes.

Community Engagement

Our Community Engagement team is led by our locally-based ***Community Engagement Director, Natalie Robinson***, who will oversee development of our education, training, and outreach strategy, including delivery of customized training to various audiences in different formats. These Community Engagement Representatives will be strategically positioned throughout West Virginia to identify local training needs, collaborate with local subject matter experts, and provide trainings in local forums.

Provider Services

Our locally-based Provider Services team is led by ***Network Development Director, Terri Roush***. Her team includes ***Provider Services Director, Elizabeth Daniel*** and ***Network Relations Manager, Misty Kegl***, as well as Provider Network Managers, Patient Centered Care Consultants (PC3s), and Network Relations Consultants responsible for network development, contracting, payment strategies, provider collaboration, demographics and directories, and provider communications. The team provides technical assistance, training, support, resources, and tools to focus on member care. Terri also oversees our PC3s who support providers in complying with federal and State regulations and assist in resolving issues.

Member Services

Our newly created West Virginia call center staff will report to our ***Member Services Director, Richard Grooms***, who is based in our Charleston office. The team will have immediate access to our local care and case management teams, operations department, clinical staff, and provider relations team. These member services representatives will be familiar with the local community, including the barriers members may be facing and the local resources available.

We will continue to draw on our national resources to help callers with more administrative tasks, such as simple PCP changes. This will allow our West Virginia call center to focus on providing more high-

touch and specialized service to our members and providers. Should these administrative calls become more complex, our national resources will quickly warm transfer callers to the local West Virginia team. These national resources will provide our members and providers critical support during business continuity events, such as the tornado that left our office without power in June 2019.

Whole Person Care Management

Clinical Leadership. Our locally based, West Virginia-licensed interim *Medical Director, Sanjoydeb Mukherjee, MD* and our *Behavioral Health Medical Director, Jorge Cortina, MD*, direct UniCare's clinical activities and medical management programs and oversees UniCare's clinical leadership team. Together, they oversee the development of UniCare's clinical practice guidelines, review potential quality of care problems, and direct our clinical management programs.

Dental Director Jarrell Martin

As a native West Virginian and dentist, my passion is for helping members and their families. It is a pleasure to serve my community and see their eagerness to engage in their health. I have seen the barriers and hardships families face when it comes to care. I believe it is incumbent upon us to advocate for members and help to get them the care they need through collaboration with providers and bringing whole-person care to the forefront.

We have made the decision to bring the key staff role of *Dental Director* in house with the hiring of Charleston-based *Jarrell Martin, II, DDS*; we will not be using a subcontractor to fill this role. He will work with our Medical Directors to increase access to comprehensive dental care. Bringing this position in house will allow us to quickly operationalize dental functions and to quickly pivot when needs arise. Additionally we are adding a *Pharmacy Director* to collaborate across our clinical and care management departments, including in the management of prescription medications.

Integrated Care Management. Our *Director of Integrated Care Management Vicky Gallaher, RN-BSN* directs our local care and medical management components, including collaborative initiatives to deliver population-based Care Coordination. Vicky's team of resources includes *Care Management Directors, Anita Blackburn, RN, CCM; and Ryan Kinder, RN-BSN; and Medical Management*

Director, Angela Hobbs, RN-BSN. Our integrated Care Management team is locally-based.

The Integrated Care Management Team comprises Nurse Care Managers, Licensed Behavioral Health Care Managers, Peer Support Specialists, Behavioral Health Specialists, Health Coaches, Community Health Workers (CHW), and Community Paramedics (CP). Trained in Person-Centered Thinking®, trauma-informed practices, and social determinants of health, the team has expertise in maternal health and children with medically complex needs, behavioral health and substance use disorder, home health services, and children with specialized health care needs. Our care management team is multidisciplinary, trained in management of co-morbid conditions, and supported by our UM, QM, and community outreach teams with *staff based in every corner of West Virginia.*

Population Health. Our integrated whole person model incorporates population health management and care coordination interventions. Going above and beyond the goals and objectives of DHHR, we are proposing over 15 new population health staff, including a



Director of Population Health Management, Public Health Manager, Population Health Engagement Leader, Population Health Reporting and Analytics, Public Health Strategy Leader, Public Health Coordinators, Community Navigators, and Liaisons for Housing, Employment, and Transportation.

Our Population Health Team partners with public health and community partners to identify social determinants of health that impact how UniCare members can improve their health.

Quality Management

Quality Director Victoria Warner, MPH, LPN, CMCN, leads our locally-based Quality Management team. This team provides effective monitoring, reporting, and analysis and plays a critical role in helping us achieve high quality measure scores. They also provide health education to members and families, providers, and community partners. The team works to close crucial gaps and conducts clinical quality

interventions. They are responsible for overseeing NCQA compliance, as well as grievances and appeals. The team reports through the Quality Improvement Committee.

Quality Management (QM) Member Liaisons handle issues causing member dissatisfaction and disengagement from care. This team will log member issues and complaints, find commonalities, and coordinate internally and externally to solve systemic root problems. The team will collaborate with the MHT Member Advocate and UniCare's Quality Management team.

Clinical Quality Program Consultants support providers to improve effectiveness and efficiencies. They analyze quality metrics and reports for care opportunities and support practice implementation of care coordination and care management. They collaborate with the PC3 team and actively support providers and practice teams on office-based care delivery interventions. Our QM Liaisons and Clinical Quality Program Consultants ultimately report to our Quality Director.

Organizational Chart

Our organizational charts (Figures 4.1-1 and 4.1-2) illustrate our company structure and local lines of authority and Figure 4.1-3 represents a subcontractor chart, which shows leadership responsible for their oversight. Our charts outline the location of each position, functions performed at the local level, and the reporting relationships across functions and subcontractor staff. All our key staff are based in our Charleston office. The location and contact information of our key staff is 200 Association Drive, Suite 200, Charleston, West Virginia 25311, and the phone is 888-611-9958.

Figure 4.1-1. UniCare's Organizational Chart

West Virginia Mountain Health Trust Organizational Chart

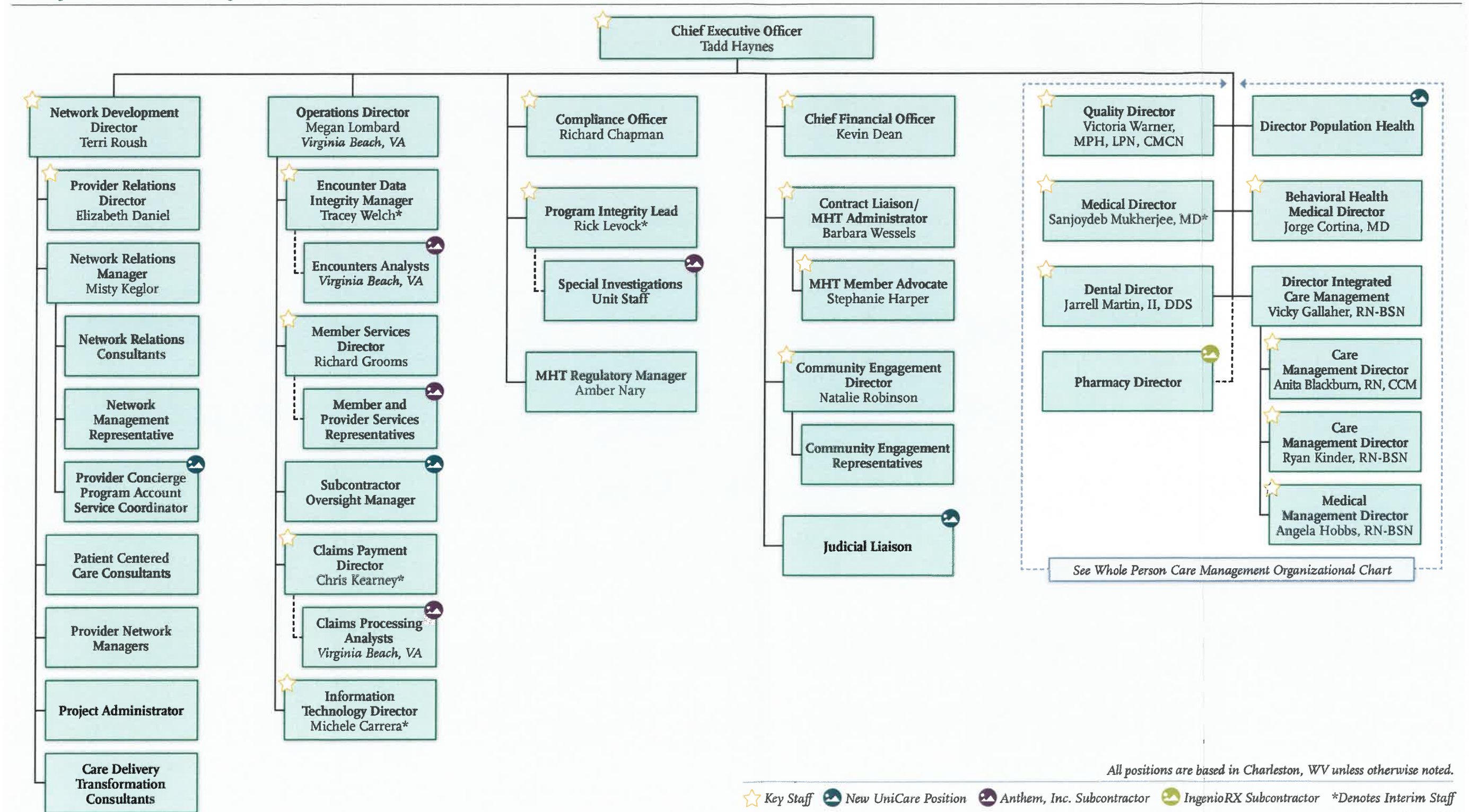


Figure 4.1-2. UniCare's Whole Person Care Management Organizational Chart

West Virginia Mountain Health Trust Whole Person Care Management Organizational Chart

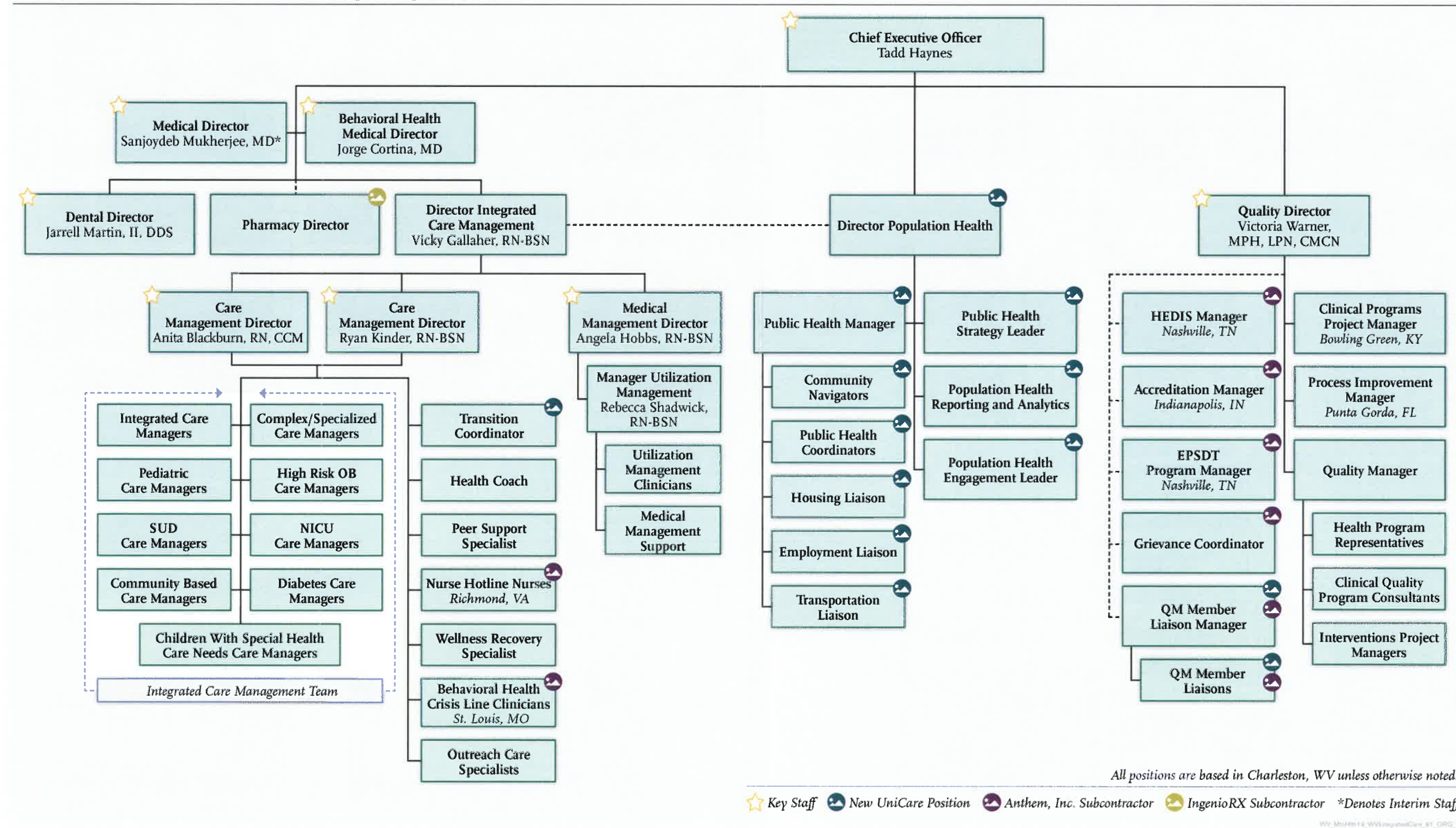
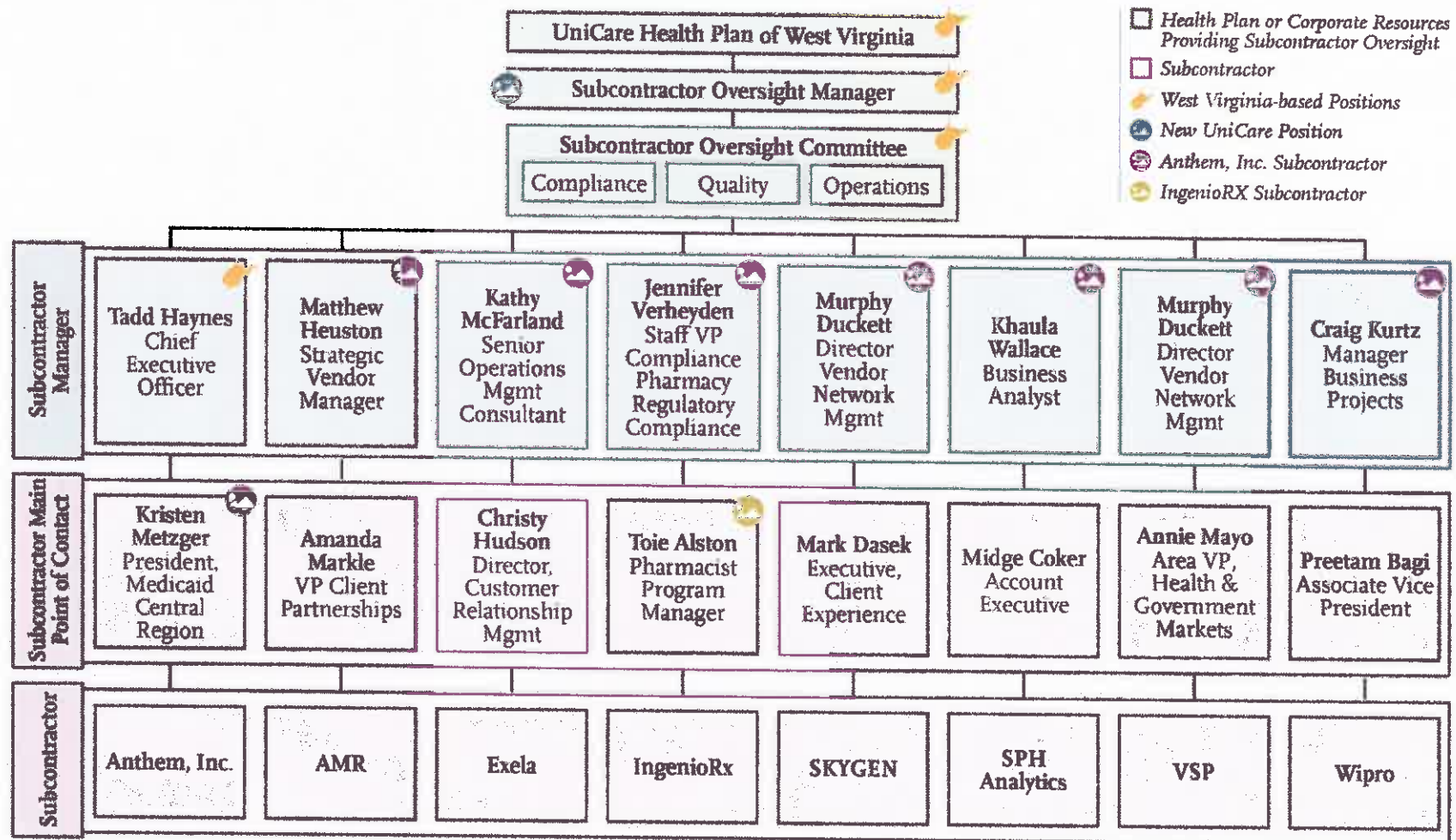


Figure 4.1-3. UniCare's Subcontractor Management and Oversight Structure

Unicare Health Plan of West Virginia – Unicare Subcontractor Management and Oversight Structure



Tools and Processes to Screen Available Staff to Fill Positions

We have already begun the hiring process for the over 65 additional employees. When new staffing positions are needed, we begin with determining the skills and qualifications required by each position. We vet candidates to make sure they have required credentials, education, and experience. To create job descriptions, we outline necessary credentials and combination of education and experience in accordance with Contract requirements. Our recruiting approach includes advertising media, social media marketing strategies, association outreach, job fairs, word-of-mouth, colleges and universities, and referrals.

Local Partnerships for Medical Directors

To better leverage academic resources to address local challenges, we are exploring partnerships with the West Virginia School of Osteopathic Medicine to have their faculty members serve as Associate Medical Directors for UniCare. These Associate Medical Directors would serve as thought leaders in developing the next iteration of specialty care models for pediatrics and substance use disorders; and their perspectives will be invaluable in developing innovative payer/provider collaborative solutions for West Virginia health care.

We have an internal pipeline of leadership talent to execute our business strategies, minimize disruption when replacing personnel, and invest in our leadership to fill vacant roles. Having a strong pipeline of talent helps us screen and fill critical leadership positions with individuals who have the necessary skills to take our company into the future. Figure 4.1-4 highlights our process and standard timelines for hiring.

The recruiting and onboarding of permanent key staff to replace interim will be prioritized. In line with Figure 4.1-4, we will prioritize our hiring efforts and aim to hire interim staff within 7 weeks of posting. To assist us in finding qualified individuals, we will consider taking our search outside of Charleston to every corner of West Virginia or even nationwide. We will consider using a recruitment agency that specializes in attracting healthcare leadership. We will offer current employees referral bonuses for any candidate they refer to, and is hired. We will also consider sign-on bonuses for hired staff and may also consider relocation packages for some positions.

Figure 4.1-4. Talent Acquisition Hiring Timelines

Talent Acquisition Hiring Timelines

Category	Week																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Interim and Key Staff	Post, source, screen, interview, offer, and accept							Notice 14 Days		Training Determined by department										
Operations	Post, source, screen, interview, offer, and accept Allow approximately 6 weeks to recruit for group hires over 10. For every 5 additional FTEs, add one week of recruiting time.							Notice 14 Days		Training Determined by department										
Clinical	Post, source, screen, interview, offer, and accept Allow approximately 10 weeks to recruit for group hires over 10. *Recommend staggered hiring/starts for >20 FTEs							Notice 30 Days							Training Determined by department					
☐ Recruiting/Interviewing/Selection ☐ Employer Notice ☐ Training																				

We prefer to hire locally, which includes recruiting from local universities. We attend career fairs at Marshall University, West Virginia University, University of Charleston, and West Virginia State University. In September 2019, *we partnered with both Marshall University and the West Virginia Autism Training Center on Disability Mentoring Day to promote career development for students and job-seekers with disabilities* and provided them with \$7,500 in funding. We also partnered with the West Virginia Autism Training Center at Marshall University in 2018, and with West Virginia State University and the Statewide Independent Living Council from 2015 to 2017 to make Disability Mentoring Day a reality. Additional examples of our partnerships include United States Business Leadership Network; UNCF; National Association on Disability, Easterseals; Job Accommodation Network; MindShift; VeteranRecruiting; HirePurpose; Hiring Our Heroes; Military Spouse Corporate Career Network; Out & Equal; Hispanic Association on Corporate Responsibility; and Diversity Best Practices.

Interested applicants can apply through our online application system. We conduct phone interviews for those who meet job requirements. We select the top candidates for in-person interviews conducted by a

combination of peer employees, the manager, and Human Resources staff. After interviewing, we select the top candidate based on their relevance of experience and organizational fit. Finally, we make an offer. If the candidate accepts the offer, they undergo an extensive background check prior to starting.

As part of standard hiring and screening, our Human Resources team uses E-Verify to conduct employment eligibility verification, along with background investigation through reference checks, confirmation of academic credentials and licensures, Social Security number trace, and investigation of criminal histories, which includes reviewing information from the Office of the Inspector General's exclusion database and national sex offender's registry check. We perform the screening after an offer of employment is accepted and prior to employment, and periodically thereafter. We apply the same standards and accountability for our subcontractors' hired staff. When selecting subcontractors, our Procurement Department conducts extensive review of State and federal lists of providers currently debarred by State or federal government, as well as State licensing and certification requirements, including review of regulatory compliance history, registrations, exclusions, terminations, sanctions, corrective action plans, and associated performance improvement plans.

Replacing Key Staff and Backfilling Key Staff During a Transition

We focus on retaining key staff by providing on-the-job training, coaching, and mentorship. The success of our operations depends on qualified key staff as well as flexible policies and processes to facilitate contingency plans for filling open positions. We meet DHHR's requirements and replace any key staff position within 30 days after a position is vacant, using the following strategies:

- Identifying at least one backup for each key staff position
- Re-allocating work assignments and mobilizing backups quickly to deliver needed services
- Training managers to provide the same services as their functional employees

- Identifying employees at our parent company and affiliates who can provide backup temporarily
- Immediately posting the position and deploying our recruiting strategies to identify and hire a permanent replacement as quickly as possible

Using cross-trained local staff, we transition functions. We can also temporarily fill vacant positions with trained employees from our national offices or affiliate health plans in nearby states, if necessary. Another successful recruiting strategy is tapping into our network of colleagues and the relationships we build with organizations.

Hiring Plan for Administering the Contract Award

We have always been able to recruit and retain sufficient numbers of adequately trained staff to meet our Contract obligations. *Neither UniCare nor our affiliates have ever had an implementation delay as a result of inability to recruit staff.*

Our hiring plan includes a comprehensive onboarding and training plan. This plan provides all employees and subcontractors with training on West Virginia Medicaid programs, covered benefits and services, and populations served. We also make sure we provide necessary resources for them to acquire and develop skills and knowledge needed to perform their jobs and continuously meet our high excellence standards, ethical behavior, customer service, and timeliness.

UniCare Recognized as a Great Place to Work



UniCare was one of eleven West Virginia companies named a "Five-Diamond Employer" in 2019 by the State's Chamber of Commerce. This designation recognizes outstanding companies for their employee policies, continuing educational opportunities, community service participation, and empowerment of employees. All West Virginia Chamber member companies doing business in the Mountain State were eligible for the award.

Hiring Plan – Initial Onboarding and Training

Our UniCare Training Academy streamlines the development, delivery, and reporting of training into one easy-to-use system; and it incorporates multi-modal training and mechanisms for tracking, monitoring, and alerting, as well as reporting compliance and training completion. We provide regularly

updated required, regionally identified, culturally competent, and program-specific training. Our training includes a tailored curriculum to make sure our employees receive appropriate information and education.

Initial training consists of orientation and job- and department-specific training. We conduct initial training within one week of the employee's start date. It emphasizes the importance of diversity and inclusion, and acquaints new employees with our mission, philosophy, strategies, and programs. Our new hire training program includes courses covering a variety of topics, including our comprehensive compliance training that spans cultural competency, ethics, HIPAA, and communication skills. **On-the-job training** occurs during the first month of employment in a variety of settings (both online and in-person) to convey valuable information about West Virginia Medicaid and members we serve.

Ongoing training includes annual refresher courses and training to support programmatic changes, including cultural sensitivity and diversity, marketing, program integrity, compliance, cultural competency, ethics, and HIPAA and privacy training.

We encourage employees to pursue ongoing educational opportunities as well as specialized certifications. We also offer tuition reimbursement to encourage employees to advance their education.

Hiring Plan – Retaining Consistent Staffing Levels and Team Stability

UniCare has developed a thoughtful approach to employee retention. First and foremost, we have established a work place culture that enables our employees to be comfortable, welcomed, and engaged in their work environment. As highlighted in Figure 4.1-5, we have a multi-faceted retention strategy

I became Dad to my second child, a son, in February of last year. Thanks to UniCare's employee benefits, I was able to take four weeks of paid leave to help my family transition into our new life. My son had complications and was readmitted to the hospital. Because of the paid leave, I was able to be there to care for him — taking him to follow-up visits, putting him down for naps, and soothing him. When my first child was born, I didn't work for UniCare and didn't receive the same paid leave. This benefit has allowed me to bond with my son differently than I did with my first child. Now all he wants is "Dada!"

Ryan Kinder, Care Management Director

comprised of work-life balance offerings, financial compensation, work place and culture initiatives, health and wellness programs, and professional development opportunities. Some of these programs are discussed in more detail below.

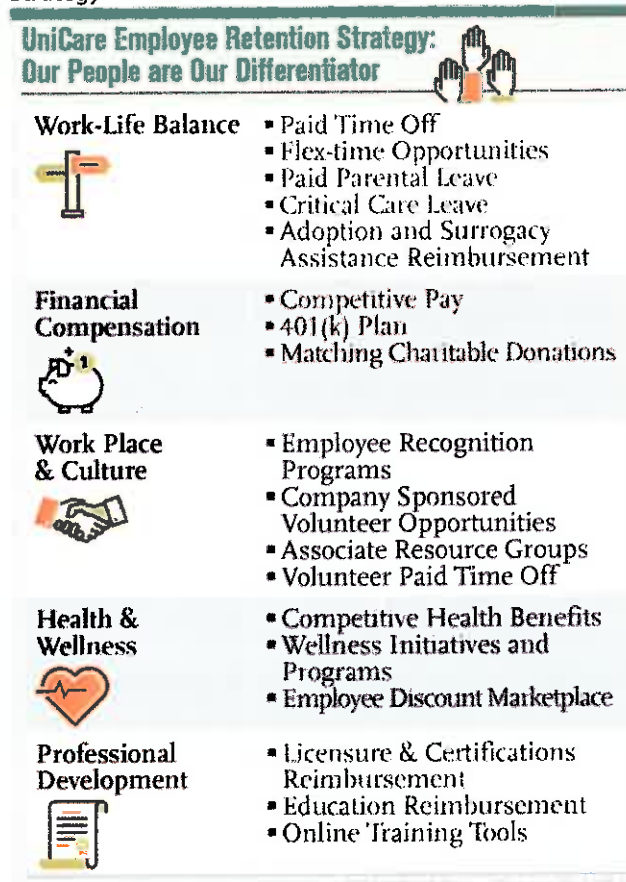
IMPACT Program: Recognizes employee performance, including monetary awards and paid time off (PTO). **Education Reimbursement:** Reimburses for eligible education expenses up to \$5,000 per calendar year with qualifying grades. **Certification Awards:** Offers monetary awards for completion of approved certifications. **Job-related Licensure Reimbursement:** Reimburses eligible employees the cost of fees required for license

renewals. **Support for Parents:** Offers new parents 100% paid leave; adoption assistance; a transition week of part-time work for new parents after the birth or adoption of a child. We also offer rewards and recognition programs to acknowledge longevity, professional growth, and exemplary job performance.

Ample Staffing Numbers to Serve Our West Virginia Members

Our local West Virginia team includes a majority of employees located in our Charleston office and in the field. *We fill positions based on where employees can serve most effectively, which means our member- and provider-facing employees and leadership will remain local.* We can flex projected headcount as staffing assumptions change. We will adjust staffing levels based on changes in volume and service

Figure 4.1-5. UniCare's Multi-faceted Employee Retention Strategy



delivery. We begin the process by staffing based on whether each position is fixed, variable, or semi-variable in relation to projected membership. Fixed positions, like Contract Administrator/Medicaid Liaison, do not vary by membership but support fixed deliverables, compliance, and management.

We will continually review our staffing levels and quality of service standards to determine whether we need additional employees to adequately support members, providers, and DHHR. Each manager and department will routinely review their specific responsibilities and determine their current capacity by monitoring changes in volume, membership, program updates, and service delivery. We recognize a locally-developed staff will best serve this population; however, our management will work closely with their counterparts in our affiliate health plans to share best practices, review new processes and programs, and determine whether global or systemic changes may offer opportunities to enhance service delivery locally and whether best practices will require additional staff. Based on that information, managers will refine existing staffing plans, identify additional resources that can be rapidly mobilized, continue to provide required training, and work with other departments to identify operational efficiencies.

Training or Materials for the Contract Liaison/MHT Administrator

We will supplement the initial and ongoing training described previously by providing additional support to the Contract Liaison/MHT Administrator, Barbara Wessels. Under the direction of our CEO, Tadd Haynes, Barbara has been serving our members and has built relationships with community stakeholders. Barbara will work collaboratively to stay abreast of West Virginia's health priorities and goals, as well as how to effectively respond to issues that arise across information systems and reporting, appeals, quality, member services, medical management, and more. She will also receive training and support to stay current on program requirements and updates, policies and processes for enrollment, and the evolving needs of our membership. Barbara will also be included in our team's monthly clinical

education rounds, and will receive training in Mental Health First Aid, human trafficking, trauma-informed care, social determinants of health, person-centered thinking, and poverty simulations to better understand and communicate with our members.

Approach to Subcontracting Services

Our approach to subcontracting services centers on identifying areas where DHHR, our members, and providers can be best served by subcontractors with specialized capabilities and whose core business represents a capability required by the State's Contract. We retain sole responsibility for fulfilling West Virginia Contract requirements. We are fully accountable for our subcontractors' performance through processes implemented to monitor, supervise, and enforce Contract compliance.

Activities and Tools to Monitor Subcontractors

We maintain a monitoring plan for the subcontractors listed below and will provide the plan within 10 business days upon request. We monitor subcontractors' performance on an ongoing basis, per 42 CFR §438.230, and have subcontractor screening processes and pre-delegation audits as defined in Mandatory Requirement MD012. Initial monitoring is conducted in the form of pre-delegation assessment, and prior to expanding or changing an existing subcontractor's delegated functions, responsibilities, and/or line of business, the same pre-delegation assessment process is followed with annual audits conducted thereafter.

We screen subcontractors prior to onboarding. We collect the Disclosure of Ownership (DOO) form

Closed-Loop Subcontractor Oversight and Monitoring Activities



prior to contracting, and require subcontractors provide us updated DOOs within 35 calendar days of any ownership or control changes. Prior to contracting and then monthly, we run the entity and the agents, owners, and managing employees through Bridger (a tool that integrates “watch lists” into a single platform). The tool screens for sanctions from state licensing bodies. Additionally, the West Virginia Medicaid Exhibit is incorporated into each MSA/SOW. Specifically, the Medicaid Exhibit includes language, directly from the West Virginia Medicaid contract, requiring subcontractors to adhere to the same requirements as the vendor.

When a subcontract change is requested by DHHR, or there is a change in State and federal regulations or our guidelines, our Procurement Division and the West Virginia Subcontractor Management Team amend subcontract agreements. Our Compliance Manager submits the amendment to DHHR for approval before dissemination to subcontractors. Subcontractors must sign off on changes and provide written documentation they received, acknowledged, and incorporated amendments. We are proposing eight subcontractors to provide services as listed in Table 4.1-1.

Table 4.1-1. Eight Subcontractors Will Provide Specialized Services Required by the Contract

Subcontractor Name	Services Provided by Subcontractor
Anthem, Inc. (Anthem)	Administrative services, including accounting and financial, human resources, leasing and property management, information technology, marketing, actuarial, member services (including eligibility and enrollment), provider contracting, claims administration services, clinical informatics, legal and regulatory
Advanced Medical Reviewers, LLC (AMR)	Utilization management, clinical chart reviews
Exela Technologies, Inc. (Exela)	Paper claims keying, provider correspondence, claims data capture services
IngenioRx, Inc. (IngenioRx)	Pharmacy Benefit Partner managing medical injectable/physician administered prior authorizations and obtaining approval for implementation of clinical programs
SKYGEN USA, LLC (SKYGEN)	Dental Benefits Manager
Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Access and availability provider surveys
Vision Service Plan Insurance Company (VSP)	Vision Benefits Manager
Wipro Limited (Wipro)	Manual adjudication and adjustments for professional, outpatient, and inpatient claims

Health Plan Level Oversight

UniCare benefits from a multi-level approach to subcontractor management that is overseen at the health plan level, but supported by national departments focused on subcontractor management. At the local level, our Subcontractor Oversight Committee meets at least monthly with member facing/direct services subcontractors. Also, our national Subcontractor Managers function as day-to-day liaisons to review performance reports. The Subcontractor Oversight Committee comprises UniCare representatives from Compliance, Quality, and Operations. *Additionally, we will hire a West Virginia-based Subcontractor Oversight Manager who will lead the Subcontractor Oversight Committee and expand its scope under the Program.* This West Virginia-based Subcontractor Oversight Manager will work collaboratively with all oversight committees and Subcontractor Managers to foster a successful oversight alliance between us, individual Subcontractor Managers, and national oversight committees. This individual will also participate in monthly meetings with the Delegate Operations Committee to discuss potential risk, compliance issues, changes to State or federal regulations, and auditing. Additionally, the West Virginia-based Subcontractor Oversight Manager will collaborate with national Subcontractor Managers to provide consistency in management and expectations by:

- Cultivating strong relationships with subcontractors
- Assist as needed with Program Integrity and Special Investigations Unit processes
- Managing operational issues of benefit managers
- Managing implementation of new subcontractors
- Conducting review of results from annual on-site audits of subcontractors
- Identifying and managing subcontractor quality of service and operational improvement projects

- Maintaining ongoing interaction with our quality team, at least monthly, and as often as needed to make sure clinical reporting is promptly relayed from subcontractors
- Facilitating subcontractor performance reviews via a Quarterly Oversight Management Report

Subcontractor Managers are responsible for management, oversight, and ongoing communication with each subcontractor. *Subcontractor Managers are assigned to subcontractors based on area of expertise.* They keep the Subcontractor Oversight Committee apprised of concerns with, or significant changes at, the subcontractor. This approach gives us overall responsibility for overseeing subcontractor performance. This responsibility and oversight, as described, assures the quality and timeliness of any work done by our subcontractors.

National Oversight Committees

National oversight committees provide an additional level of support to our program and regular communication between them and our West Virginia Oversight Team maintains focus on delivering high-quality services to our members. National oversight functions include:

- **The National Quality Improvement Committee** meets quarterly and reports any quality or compliance issues to local committees, including those related to subcontractors.
- **The Delegate/Vendor Oversight and Management Committee (DVOMC)** oversees subcontractors serving multiple health plans. It is responsible for compliance with State, federal, NCQA, CMS, and individual program requirements and standards, as well as other regulatory or accreditation standards. It reports to the National Quality Improvement Committee quarterly.
- **The Delegation Operations Committee (DOC)** meets monthly and includes representatives from UniCare, subcontractor account management, quality, legal, compliance, and other areas as needed. Reporting to the DVOMC quarterly, the DOC assesses oversight and compliance, monitors corrective

action plans (CAPs) (including recommending escalation), evaluates subcontractor performance, and makes recommendations to DVOMC on findings, as well as the use of audit tools. An example of how we interact and collaborate with this committee has been demonstrated through the use of reports provided by our vision benefits manager. This collaboration is detailed in the “Improving Subcontractor Performance and Results” section on the following page.

- **Joint Operations Committee (JOC)** meets quarterly to see that oversight and communication occurs between the national teams, health plans, and Compliance Officers. Agendas include national and health plan updates, delegate updates, delegated function report overview, market-specific issues, and collaborative project reports. The Subcontractor Managers’ report, includes meeting minutes and deficiencies, is sent to the DVOMC, and is available for annual State audit or internal audits.

Subcontractor Audits

At least annually, the Enterprise Delegation Oversight & Management (EDOM) department conducts oversight and monitoring audits to evaluate if subcontractors providing delegated functions:

- Are in compliance with contractual and applicable federal, state, and accreditation standards
- Are performing its contracted activities in a successful manner
- Need to implement corrective actions for non-compliance or unsatisfactory performance

The annual audit includes review of the subcontractor’s written policies and procedures and the performance of file review for documentation of compliance. EDOM communicates all oversight audit results to the Subcontractor Managers and key stakeholders, to include the West Virginia Subcontract Oversight Manager. In addition, EDOM provides all monitoring and evaluation of audit activities to the DVOMC. Account Managers and Business Owners provide notice to EDOM and engage in information sharing related to subcontractor performance status and pre-delegation and annual audit activities.

Standardized audit tools evaluate subcontractors pre-delegation and annually thereafter; audit tools are functional area- and product-specific, and based on contractual, federal, and State regulatory and accreditation standards. If a CAP is required, an Audit CAP Notification letter outlining deficiencies will be emailed to the Subcontractor. The subcontractor will submit a CAP with all action items completed within 30 calendar days of email receipt of their letter. For non-compliant CAPs or if a CAP is not received within a specified time frame, the issue will be escalated.

Enterprise Procurement Vendor Management teams also provide governance and oversight for AMR, Exela, and Wipro. Anthem Subcontractor Managers are responsible for the relationship and seeing the subcontractor is meeting contractual agreements, including service level agreements (SLAs), key performance indicators, and staffing commitments, and supports a model focusing on core functions:

- Strategic Governance
- Service Performance Management
- Subcontractor Transition Implementations
- Contract and Financial Management
- Risk and Compliance
- Issues and Dispute Management

Subcontractor Selection and Oversight Program Activities

We confirm subcontractors meet operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical standards. During our pre-delegation audit we examine their HIPAA privacy and security compliance, grievance and appeals history, operating procedures, staffing ratios, and financial viability. We audit for policies and training agendas, attendee lists, and proof training was conducted. We offer guidance on topics such as our policies and procedures; HIPAA; FWA avoidance and prevention; and cultural competency. When possible, we check credible subcontractor industry references.

We monitor subcontractor financial stability. We also monitor over- and under-utilization and adherence to complaint and grievance requirements. We tailor our oversight program to functions and services each subcontractor provides. We outline ongoing oversight in Table 4.1-2.

Table 4.1-2. Our Oversight Program Monitors Subcontractors Throughout the Life Cycle

Timing	Oversight Activities
Daily	Subcontractor Managers and subject matter experts work with subcontractors to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate performance concerns
Monthly	- Complete Performance Indicator dashboard on each subcontractor - Review performance against standards, including trends, and report submissions - Review performance with subcontractor, Subcontractor Managers, and West Virginia Oversight Team - DVOMC meeting to discuss approval of delegation, performance monitoring, CAPs, and terminations
Quarterly	- JOC Meetings to review performance metrics, HEDIS® and our specific initiatives, and CAPs - Meet with subcontractors to discuss performance and present issues, gaps, and concerns to the DVOMC plan - DVOMC reports to the National Quality Improvement Committee to discuss any quality issues with subcontractor performance - Report additions, terminations, CAPs, and risk to UniCare Compliance Committee
Annually	- Perform audit or annual review to confirm subcontractor meets operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements - Present audit findings to the DVOMC and the West Virginia Oversight Team

We customize a Performance Indicator Report for benefit managers. The Subcontractor Manager and subcontractor meet with the Oversight Team to review performance and discuss issues and solutions.

Sample Subcontractor Agreements

See Supplemental Document 4.1-1a for a sample Master Services Agreement. Supplemental Document 4.1-1b is the West Virginia Medicaid exhibit addressing provisions related to subcontractors as noted in the HIPAA Business Associate Agreement, which will be included in all of our subcontractor agreements.

Benefit Manager and UniCare Functions

Table 4.1-3 identifies our benefit manager subcontractors' functions and identifies which of these functions UniCare performs as the Vendor.

Table 4.1-3. Benefit Manager Subcontractor Functions and Vendor Functions

Function	Performed by SKYGEN (Benefit Manager)	Performed by VSP (Benefit Manager)	Performed by UniCare (Vendor)
Provider Recruitment	Yes	Yes	
Member and Provider Calls	Yes	Yes	Yes
Utilization Management	Yes		Yes
Provider Education	Yes	Yes	
Monitoring for FWA*			Yes
Member/Provider Grievances and Appeals	Yes		Yes

* Our Benefits Managers assist with monitoring FWA, and are required to report suspected instances to our Medicaid Special Investigations Unit team and assist as necessary with any investigations.

Subcontractor Reports and Data to Help UniCare Manage Benefits

We require subcontractors to submit two primary report types: data to fulfill regulatory reporting requirements and operational information to monitor performance. Subcontractor Managers maintain a schedule of due dates and follow up if they are late or submit incomplete or inaccurate data. We identify a report due date prior to the DHHR deadline to provide time for review. See Supplemental Documents 4.1-2a-d in which we provide samples of a Performance Indicator Report and GeoAccess® Map for both SKYGEN and VSP. The subset of reports in Table 4.1-4 includes those to verify appropriate subcontractor oversight and member access, satisfaction, and continuity of care (QU006).

Table 4.1-4. SKYGEN and VSP Routinely Provide UniCare with More than 20 Different Reports, Including Those Listed

SKYGEN Report	Frequency	How we use data to enable oversight and member access, satisfaction, and continuity of care	Does report help manage medical, social, or any other health benefit?
Appeal and Denial Letters	Quarterly	Monitors State and contract metrics and provides oversight of performance	Yes
Authorization Denial Report	Monthly	Monitors State and contract metrics and provides oversight of performance	Yes
Medicaid GeoAccess	Quarterly	Monitors member access to providers	Yes
Performance Indicator Report	Monthly	Monitors State and contract metrics and provides oversight of performance	Yes
Provider Satisfaction Survey	Annually	Monitors member access and satisfaction	Yes
VSP Reports			
Medicaid GeoAccess	Quarterly	Monitors member access to providers	Yes
Performance Indicator Report	Monthly	Monitors State and contract metrics and provides oversight of performance	Yes

Exchanging Information and Data

Data files will typically be sent using secure file transfer protocol or other secure protocol. Reports and other information will typically be sent through encrypted email or other secure methods. We document the schedule, format, and secure transmission method. If a file is late, an email alert notifies the Subcontractor Manager to obtain the reason for delay.

National Executive Dashboard

We monitor, track, and evaluate performance of all subcontractors, including Anthem, Inc., using the National Executive Dashboard (NED), a Tableau-based reporting tool that assembles key metrics visualizing performance against defined targets. All functional areas are represented in NED, including Claims Operations, Call Center, UM, and Enrollment. Each business owner is responsible for the performance and action plans for missed targets. NED provides leadership with a comprehensive status of operational performance by tracking and assimilating data used to inform mitigation strategies.

Leveraging Reports and Data to Assure Appropriate Oversight, Increase Member Access, Satisfaction, and Continuity of Care

We use reports to identify and address performance issues, such as a subcontractor falling short of a required SLA. In addition, we use data provided by benefit management subcontractors to enhance member care. In 2018, we sent more than 80,000 reminders to members to make dental appointments. In 2018, our representatives placed 270 reminder calls to members who had missed an annual dental visit. As illustrated in the first row of Table 4.1-5, this reporting contributed to our ability to outreach to members and improve Annual Dental Visit HEDIS measures by more than two points.

Table 4.1-5. HEDIS Score Improvements from 2018 to 2019

Measure	HEDIS 2018 (MY 2017)	HEDIS 2019 (MY 2018)
Annual Dental Visits for 2-20 year-olds	63.25	65.68
Dental Sealants for 6-9-year-olds	25.02	51.32

Improving Subcontractor Performance and Results

We use our Performance Indicator Report to monitor performance, track actions taken to improve it, set new targets, and drive positive results (see Supplemental Documents 4.1-2a and 4.1-2c). Written subcontractor agreements detail performance standards and actions taken to address them. If we identify

performance issues, we immediately apply a series of escalating interventions, including increased meeting frequency and data submission, development of an informal action plan, development of a CAP, financial penalties, and other sanctions. We view interventions as a process to improve performance and more closely collaborate with our subcontractors. The type of intervention depends varies depending on the severity of the issue and historical performance. We track and monitor all interventions. If interventions are unsuccessful, we consider termination and notify DHHR. Our approach is demonstrated through SKYGEN exceeding SLAs. During the past three years, they have:

- Assured members 100% access to a general practitioner within 30 minutes of their location
- Added more than 100 new providers to the network to support and improve member accessibility
- Answered 99% of member calls (live) within 30 seconds
- Processed 100% of clean claims in 30 days for in-network providers
- Processed 100% of out-of-network clean paper claims within 40 calendar days of receipt

Adhering to Member Complaint and Grievance Policies and Procedures

Our West Virginia-based team oversees the member complaint and grievance process. We instruct most subcontractors to forward member complaints and grievances to us. Our dental benefits manager (SKYGEN) addresses provider complaints and grievances. Our review of SKYGEN's Performance Indicator dashboard verifies their adherence to complaint and grievance requirements. The Subcontractor Manager and West Virginia UniCare Oversight Team promptly and thoroughly address any performance variances with our subcontractors.

Identifying Frequency of Calls with Each Subcontractor

Our subcontractor calls includes weekly implementation meetings and daily post go-live calls that eventually change to monthly, when the contact frequency reverts to the regular schedule, which includes:

A Monthly Operations Call: A touch base and review of monthly report summaries to make sure SLAs and contract requirements are being met. **A Quarterly JOC Meeting:** Review performance metrics and CAPs.

Ad hoc Meetings: Review detailed performance, monitor operational activities, and address broad scale issues. We are in contact with our Administrative Services subcontractors per the schedule dictated by any needs or issues that may arise. Our Subcontractor Oversight Committee, led by our Subcontractor Oversight Manager, receives regular input from the account managers who oversee their performance.

Addressing Subcontractors Unable to Fulfill Contract Obligations

We address performance or operational problems with escalating interventions, including increased meeting frequency and data submission, development of an informal action plan or a CAP, financial penalties, and other sanctions. If a CAP is needed, the Subcontractor Manager, our Oversight Team, and operational areas, work with the subcontractor to identify root cause, initiate corrective actions, and develop the CAP, which will include a timeline for correcting the deficiency, dashboards to review ongoing metrics, and regularly scheduled meetings to review progress.

Corrective Action Plan Process

The corrective action monitoring process ends when the subcontractor demonstrates ongoing compliance, typically for at least 90 days. The Subcontractor Manager works daily to identify and discuss early resolution of performance issues, before a problem arises. We supplement our account management structure with monthly performance reporting, quarterly reviews, and annual audits. If we continue delegation of a subcontractor with a CAP, they will submit a report for all noted deficiencies, which will include time frame for completion, follow-up evaluation, and deficiency resolution. The subcontractor must submit the remediated CAP within a specified time frame. Follow-up assessments are performed, in addition to the annual assessment. The subcontractor must agree to implement the CAP and resolve the

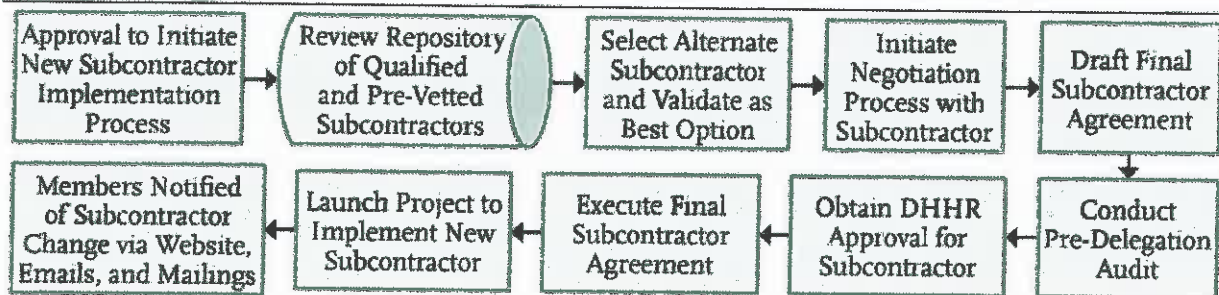
issue(s) within the determined time frame(s). The CAP response will be evaluated for acceptable resolution. The status of the ongoing CAP monitoring will be reported to the Committee monthly until resolved. A subcontractor with a score of Non-Compliance may be subject to escalation.

Contingency Plan if Subcontract Is Terminated

When a subcontractor is terminated, we quickly ramp up another from our repository, chosen based on their ability to provide continuing service. Those in our repository are pre-vetted for ability to perform work, including storage of all information, within the United States. We will provide DHHR written notice no later than five business days after receiving notice or giving notice of intent to terminate. We will work with DHHR to assure continuity of care by allowing members to receive services from their current provider up to 90 days. At least 90 calendar days before the effective date of a new subcontract, we will submit utilization review and claims processing subcontracts for approval. We will issue a subcontractor agreement detailing performance and compliance requirements, including responsibilities and data requirements. Our contingency plan includes tasks, customized for each subcontractor, so necessary functions continue. Figure 4.1-6 is our termination contingency and transition plan.

Figure 4.1-6. Our Contingency Plan Enables Seamless Transition Between Subcontractors

Steps to Transition Services to a New Subcontractor



Subcontractor Status as Affiliate or Unrelated Third Party

Six of our eight subcontractors are unrelated third parties. Anthem, Inc. and IngenioRx are affiliates of UniCare that also undergo rigorous monitoring and oversight.

Supplemental Document 4.1-1: Sample Subcontractor Agreements

Supplemental Document 4.1-1 includes the following:

- Supplemental Document 4.1-1a: Sample General Master Services Agreement
- Supplemental Document 4.1-1b: West Virginia Exhibit G of the Master Services Agreement

MASTER SERVICES AGREEMENT

This Master Services Agreement, by and between Anthem, Inc., an Indiana corporation ("Anthem"), and _____, a _____ corporation ("Supplier"), is entered into as of _____ (the "Effective Date").

In consideration of the covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the terms and conditions contained in this Agreement.

1. DEFINITIONS; INTERPRETATION.

Definitions. Capitalized terms used herein shall have the meanings ascribed to them in the body of this Agreement and/or in the Exhibits and other documents attached hereto, or as defined below. Terms other than those defined herein shall be given their plain English meaning and terms of art having specialized meanings in Supplier's industry shall be construed in accordance with industry standards. Unless the context otherwise requires, words importing the singular include the plural and vice-versa.

1.1. "Affiliate" means any entity controlling or controlled by or under common control with a Party, at the time of execution of the Agreement and any time thereafter, where "control" is defined as (a) the ownership of at least fifty percent (50%) of the equity or beneficial interest of such entity, or (b) any other entity with respect to which such Party has significant management or operational responsibility (even though such Party may own less than fifty percent (50%) of the equity of such entity).

1.2. "Agreement" means (a) the body of this Agreement, (b) any other Anthem policies and procedures, as may be modified from time to time, as set forth in Section 2, (c) any applicable Exhibits, and (d) any SOW that is entered into and signed by both Parties pursuant to this Agreement, as well as any SOW entered into subsequent to the Effective Date of the Agreement.

1.3. "Anthem Data" means, in or on any media or form of any kind: (i) all data or summarized data related to Anthem or its Affiliates, and all data indexing such data (regardless of whether or not owned by Anthem, generated or compiled by Anthem, or provided by Anthem's customers), including data that is in Anthem's or its Affiliates' databases or otherwise in Anthem's or its Affiliates' possession on the Effective Date or at any time from such date through the last day of the Term, all tapes of recorded conversations with Anthem's or its Affiliates' customers and all other information recorded by Supplier concerning Anthem's or its Affiliates' customers or the provision of the Services or Deliverables; and (ii) all other Anthem or its Affiliates' records, data, files, input materials, processed data, reports and forms that may be received, computed, developed, used, or stored by Supplier, or by any of Supplier's subcontractors, for Anthem or its Affiliates in the performance of Supplier's duties under the Agreement, but excluding in any event any internal data and information of Supplier and its subcontractors.

1.4. "Anthem IP" means (i) any IP made, conceived, developed, purchased, or licensed by Anthem or its Affiliates, or by third parties under contract to Anthem or its Affiliates, prior to the Effective Date of the applicable Statement of Work or PCWA, (ii) any IP provided by Anthem or its Affiliates or their respective agents to Supplier for incorporation into the Deliverables or use in connection with the Services (including any Anthem Data, images, programming, computer code, photographs, illustrations, graphics, audio clips, video clips and text), and (iii) any modifications or enhancements to the foregoing.

1.5. "Applicable Laws" shall mean all international, federal, state and local laws, statutes, ordinances, codes, rules, regulations, standards, orders (which are applicable to Anthem or Supplier),

licenses, or permits of any governmental entity or other authority that reasonably relate to performance under this Agreement in any applicable jurisdiction (whether within the United States or in any other country).

1.6. “BCP” has the meaning ascribed in Section 4.9.1.

1.7. “Confidential Information” has the meaning ascribed in Section 10.2.

1.8. “Custom IP” means IP made, conceived, or developed by Supplier or any subcontractor for Anthem or its Affiliates in creating the Deliverables or performing the Services. Except for the licenses granted herein, Custom IP does not include Supplier IP or Third-Party IP.

1.9. “Deliverable” or “Deliverables” means the tangible or intangible items produced by Supplier for Anthem or its Affiliates pursuant to a Statement of Work. Deliverables are a subset of Services and any reference to “Services” hereunder shall be deemed to include any Deliverables to be provided under an applicable Statement of Work. “Documentation,” is a subset of Deliverables and any reference to Deliverables shall be deemed to include reference to any related Documentation.

1.10. “Documentation” shall mean all manuals, descriptions, instructions or other materials, that are in existence or may come into existence during the period Supplier is providing Deliverables, Supplier-Provided Materials and/or Services hereunder and which describe the operation, maintenance, functionality and use of such Deliverables, Supplier-Provided Materials and/or Services, as applicable.

1.11. “Exhibit” or “Exhibits” shall include, when applicable, Exhibit A (Business Associate Agreement), Exhibit B (Medicare Advantage and Medicare Part D Regulatory Exhibit), Exhibit C (Federal Program Commercial Item Addendum), Exhibit D (Diversity Supplier Compliance Exhibit), Exhibit E (State Medicaid Attachments), Exhibit F (Required Information Security Controls), Exhibit G (Qualified Health Plan Regulatory Exhibit), or any other Exhibits attached hereto.

1.12. “Expenses” has the meaning ascribed in Section 3.1.

1.13. “Fees” has the meaning ascribed in Section 3.1.

1.14. “Force Majeure Event” has the meaning ascribed in Section 17.7.

1.15. “IP” means all concepts, inventions (whether or not protected under patent laws), works of authorship, information fixed in any tangible medium of expression (whether or not protected under copyright laws), moral rights, mask works, trademarks, trade names, trade dress, trade secrets, publicity rights, names, likenesses, know-how, ideas (whether or not protected under trade secret laws) and all other subject matter protected under patent (or which is not patented, but is subject matter that is protected under patent law), copyright, mask work, trademark, trade secret, or other laws, whether existing now or in the future, whether statutory or common law, in any jurisdiction in the world, for all media now known or later developed, including all new or useful art, combinations, discoveries, formulae, algorithms, specifications, manufacturing techniques, technical developments, systems, computer architecture, artwork, software, programming, applets, scripts, designs, processes and methods of doing business.

1.16. “Nonpublic Personal Financial Information” or “NPFI” shall have the same meaning as “Nonpublic Personal Information” in 15 USC, Subchapter I, Sec. 6801-6809, of the Gramm-Leach-Bliley Act. NPFI may also be referred to herein as “Personally Identifiable Information.”

1.17. “Party” means Anthem or Supplier; “Parties” means Anthem and Supplier.

1.18. “Protected Health Information” or “PHI” shall have the same meaning as the term “Protected Health Information” in 45 C.F.R. § 160.103, limited to the information created or received by Supplier from or on behalf of Anthem.

1.19. “Service Credits” has the meaning ascribed in Section 4.4.4.

1.20. “Service Levels” has the meaning ascribed in Section 4.4.1.

1.21. “Services” shall mean all services performed under the Agreement pursuant to a properly authorized and executed Statement of Work, together with any or all of the acts, services, tasks, subtasks, work, and/or Deliverables reasonably required to provide Anthem with such services in accordance with this Agreement, whether or not such inherent or implicit acts, services, tasks, subtasks, work and/or Deliverables are expressly identified in the Statement of Work (other than such acts, services, tasks and materials that Anthem or its representatives are responsible for providing as expressly listed in the applicable Statement of Work).

1.22. “Statement of Work” or “SOW” means the document, in the form provided by Anthem, describing the services, functions, responsibilities and projects to be performed thereunder, in accordance with this Agreement, and signed by authorized representatives of both Parties.

1.23. “Supplier IP” means IP made, conceived, developed, purchased, or licensed by Supplier or its Affiliates, or by third parties under contract to Supplier or its Affiliates, (i) prior to the effective date of the applicable Statement of Work or PCWA or (ii) independent of the Services, that, in case of both (i) and (ii) above: neither contains Anthem IP or any derivative works thereof; nor uses, includes or refers to Confidential Information of Anthem. For the avoidance of doubt, Supplier IP does not include Custom IP or any other Anthem IP.

1.24. “Supplier-Provided Materials” shall mean all materials, systems, goods, processes, and/or any other item, as applicable, provided by Supplier and delivered or made accessible to Anthem for Anthem’s use or benefit as identified in an Exhibit or SOW.

1.25. “Term” has the meaning ascribed in Section 7.1.

1.26. “Third-Party IP” means IP licensed, made, conceived, or developed by a third-party and used by Supplier in creating the Deliverables or performing the Services.

1.27. “Transferred Entity” has the meaning ascribed in Section 1.34.

1.28. Applicability of Definitions. The definitions contained in this Agreement shall apply to each SOW.

1.29. Requirement of a SOW; Order of Precedence. For each engagement under this Agreement, the Services to be performed by Supplier at Anthem’s request will be described in an SOW. Each SOW and each amendment thereto must be signed by both Parties and must state that it is made pursuant to this Agreement. Each SOW shall constitute a separate agreement which incorporates the terms and provisions of this Agreement. The provisions of this Agreement shall control over any conflicting provisions in an SOW or Exhibit, except to the extent the SOW or Exhibit indicates the clear intent of the parties that such conflicting term prevail over a term or condition of this Agreement. Notwithstanding the foregoing or any other provision of this Agreement to the contrary, in the event of any inconsistency or conflict between the terms and conditions of this Agreement and the terms and conditions of any of the

following Exhibits, if such Exhibits are attached to this Agreement, then the terms and conditions of the following specified Exhibits shall prevail over the terms and conditions of the main body of this Agreement or any SOW: Exhibit A (Business Associate Agreement), Exhibit B (Medicare Advantage and Medicare Part D Regulatory Exhibit), Exhibit C (Federal Program Commercial Item Addendum), Exhibit E (State Medicaid Attachments), Exhibit F (Required Information Security Controls), Exhibit G (Qualified Health Plan Regulatory Exhibit). An SOW or Exhibit may contain additional terms, provided that the terms do not conflict with the provisions of this Agreement.

1.30. Interpretation. The use of the terms “including,” “include” or “includes” shall in all cases herein mean “including without limitation,” “include without limitation” or “includes without limitation,” respectively.

1.31. Number and Gender. Words importing the singular include the plural and words importing the masculine include the feminine and vice versa where the context so requires.

1.32. No Primary Drafter. The Parties acknowledge and agree that they have mutually negotiated the terms and conditions of this Agreement and that any provision contained herein with respect to which an issue of interpretation or construction arises shall not be construed to the detriment of the drafter on the basis that such Party or its professional advisor was the drafter, but shall be construed according to the intent of the Parties as evidenced by the entire Agreement.

1.33. Anthem Affiliates. Supplier acknowledges and agrees that Anthem and all of its Affiliates (as they may exist during the term hereof) may all engage Supplier to perform Services and deliver Deliverables under this Agreement. In addition, Anthem Affiliates shall be entitled to receive the benefits of the Services and Deliverables under this Agreement; provided that they shall be deemed to be bound by the terms and conditions contained herein. In no event shall Anthem, Inc. be deemed or understood to administer or insure health care plans and/or health care delivery services.

1.34. Transferred Entities. In addition to Section 1.33 above, if any time during the Term Anthem sells or otherwise transfers ownership of a business unit or Affiliate (a “**Transferred Entity**”) using any Services or Supplier-Provided Materials or entitled to purchase Services or Supplier-Provided Materials hereunder, at Anthem’s option the Transferred Entity may continue to use or maintain the right to purchase such Supplier-Provided Materials and/or Services for a period not to exceed six (6) months, under the terms and conditions of this Agreement, provided such Transferred Entity signs an agreement with Supplier agreeing to be bound by the terms and conditions of this Agreement and Supplier shall cooperate with Anthem, the Transferred Entity and any new supplier in a transition to a new supplier’s products and/or services.

2. ANTHEM POLICIES AND PROCEDURES.

2.1 Sources. In addition to all other obligations contained herein, Supplier and its sub-contractors shall adhere to the then-current and applicable Anthem policies and procedures described in this Section and this Agreement. The policies and procedures are expressly referenced and incorporated into this Agreement and are either attached as exhibits to this Agreement and/or provided to Supplier via the web site addresses listed below (or any successor site or communication designated by Anthem).

Supplier Relations Webpage: <https://www.antheminc.com/Suppliers/index.htm>

(a) Supplier Code of Conduct

(b) Supplier Reimbursable Expense Guidelines

- (c) Procurement Process Technology and Electronic Signatures
- (d) Requirements for Onsite Personnel
- (e) Exhibit A: Business Associate Agreement (“BAA”)
- (f) Exhibit B: Medicare Advantage and Medicare Part D Regulatory Exhibit
- (g) Exhibit C: Federal Government Services Addendum for Commercial Items
- (h) Exhibit D: Diversity Supplier Compliance Exhibit
- (i) Exhibit E: State Medicaid Attachments
- (j) Exhibit F: Required Information Security Controls
- (k) Exhibit G: Qualified Health Plan Regulatory Exhibit

3. INVOICING AND PAYMENT; AUDIT.

3.1 Payment of Fees and Expenses. Supplier shall invoice Anthem for the fees as set forth in each SOW, as applicable (“**Fees**”). Except for (i) the Fees and (ii) expenses agreed to in an applicable SOW and incurred in accordance with this Agreement (“**Expenses**”), no other amounts shall be charged by Supplier or payable by Anthem. Anthem shall have the right of offset against amounts owed to it by Supplier. If a SOW specifies that Anthem is to pay Supplier’s Expenses for travel, meals and lodging, Anthem shall reimburse Supplier for actual, necessary and reasonable Expenses for: (a) travel by non-local Supplier personnel to a site specified by Anthem to perform services under a SOW; and (b) meals and lodging for such non-local personnel while performing such services. Such Expenses shall not under any circumstances include airfare other than coach. Anthem shall not be billed for travel time.

3.2 Anthem Invoice Requirements.

3.2.1 General. Supplier shall invoice Anthem for all Fees and, if applicable, Expenses via the Anthem Invoice online tool in accordance with the then current requirements at [Anthem, Inc. Policies](#) and [Procedures](#) (https://www.antheminc.com/wellpoint/groups/wellpoint/@wp_suppliers/documents/wlp_assets/pw_e226861.pdf) and as stated in the Procurement Process Technology and Electronic Signatures provisions therein. Supplier shall not charge Anthem for researching, reporting or correcting errors related to invoices. The invoice date shall not be earlier than the date on which Supplier is entitled to payment under the applicable SOW, or if not specified in the SOW, invoices may be issued monthly in arrears. Unless otherwise specified in a SOW, rates under a SOW or rate card Exhibit attached to this Agreement shall be fixed for the greater of (i) the initial term or (ii) five (5) years. Thereafter such rates shall not increase more often than annually and such increases shall not exceed the lesser of (i) the Consumer Price Index for All Urban Consumers (CPI-U): U. S. city average or (ii) three percent (3%) above the immediate prior rate. Supplier shall give Anthem at least ninety (90) days prior written notice of any increase in rate. Anthem shall not be responsible for any Fees or Expenses invoiced more than four (4) months after the close of the month to which such fees or expenses relate. Each such invoice shall contain sufficient detail to allow Anthem to identify all Services rendered.

3.2.2 Procurement Process Technology Fees. Supplier will be solely responsible for all expenses associated with transmitting and receiving documents via Anthem's Procurement Process Technology.

3.3 Payment by Anthem. Upon Acceptance of the Services, Deliverables and/or Supplier-Provided Materials in accordance with any acceptance criteria provided in this Agreement and in each applicable SOW and receipt of a correct and undisputed invoice, Anthem shall

(i) at its option either (a) pay Fees net fifteen (15) days; less a two percent (2%) discount on the invoiced amount or (b) pay Fees net ninety (90) days with no discount;

(ii) if applicable, pay Expenses net ninety (90) days with no discount; and

(iii) pay the amounts in accordance with Anthem's then-current payment policies (e.g. payment via ACH electronic payment to Supplier's financial institution per instructions in Anthem's ACH electronic payment form).

3.4 If Anthem disputes any invoiced amount, Anthem may withhold the disputed amount and will notify Supplier in detail as to the nature of the disputed charges and the reason for Anthem's disagreement. Supplier shall respond by providing documentation in reasonable detail for the disputed charges. The Parties shall make all reasonable attempts to resolve the dispute as amicably as possible within thirty (30) days. Invoices which are not sent via the Anthem Invoice online tool shall automatically be deemed to be in dispute until the invoice is resubmitted via such online tool.

3.5 Record Retention; Audits.

3.5.1 Billing Audits. Supplier shall maintain complete, accurate and detailed records regarding all amounts charged to Anthem under this Agreement. Supplier shall retain such records for no less than three (3) years from date of the invoice for such amount charged. Supplier shall allow Anthem and/or its authorized representatives to inspect and conduct audits on such records during normal business hours upon five (5) business days written notice. Supplier shall also impose a like requirement on any subcontractor who performs Services, directly or indirectly, to Anthem hereunder at a value of \$100,000 or more in any twelve (12) month period. If discrepancies or questions arise with respect to such records, Supplier shall preserve such records until an agreement is reached with Anthem regarding their disposition. Each Party shall bear its own expenses in conducting the audit and responding to information requests and Supplier shall not pass on such costs (including employee time, overhead, research, copying charges, professional fees, etc.) to Anthem. If an audit reveals that Supplier overcharged Anthem for any Fees, expenses or any other charges under this Agreement for any logically or readily identifiable component of a Service or chargeable material (as examples for illustrative purposes only: such as a greater than an agreed upon hourly rate for one or more personnel providing services, billing in excess of actual hours worked, miscalculation of actual amount of chargeable of supplies consumed, etc.), Supplier shall promptly reimburse Anthem in full for such overcharge(s). If such overcharges exceed five percent (5%) of the Fees, expenses or any other charges under this Agreement, Supplier shall also promptly reimburse Anthem for all reasonable internal and external audit expenses incurred by Anthem, including the reimbursement for any contingency fees paid by Anthem.

3.5.2 Performance Audits. Supplier agrees to make available (including providing copies of documents requested by Anthem auditors at no additional expense to Anthem) Supplier personnel and any and all books, records or other documents in its possession pertaining to the performance of its duties under this Agreement or applicable state and federal regulating authorities with jurisdiction over Anthem. The foregoing audit rights shall include when applicable, audits of (i) practices

and procedures, (ii) security practices and procedures, (iii) disaster recovery and backup procedures, and (iv) other areas necessary to enable Anthem to meet Applicable Laws applicable to the Services. Such audits and inspections may address Supplier's performance of the Services and compliance with the provisions of this Agreement. The auditors and other representatives of Anthem will be bound by confidentiality obligations related to Supplier Confidential Information no less restrictive than the confidentiality terms hereof.

3.5.3 SOC 1 and SOC 2 Audit Reports Supplier shall, at Supplier's expense, provide Anthem with a general (i.e., not Anthem-specific) Service Organization Control ("SOC") 2, Type II, AT section 101, report of Supplier annually. At a minimum, the SOC 2 report shall include a review of controls relevant to the Security Trust Service Principle, with additional Trust Service Principles potentially required based on the nature of the Services. To the extent that Supplier and Anthem agree that it is not feasible for Supplier to produce a SOC 2 report within the time period of the contract, Supplier agrees to develop a plan to obtain HiTRUST certification in accordance with Exhibit F – Required Information Security Controls. Additionally, if the nature of the Services includes transaction-processing, then Supplier shall also provide Anthem with a general (i.e., not Anthem-specific) SOC 1, Type II, Statement on Standards for Attestation Engagements, report of Supplier annually. Both the SOC 1 and SOC 2 report(s) of the third-party auditors will be solely for the use of Supplier and Anthem, its regulators and its independent accountants and will not be distributed or used by any other parties unless approved by Supplier, such approval not to be unreasonably withheld. If such report(s) include(s) any findings that Supplier fails to comply with the SOC 2 or SOC1/SSAE 16 requirements, or audit tests result in exceptions, Supplier agrees to remedy such noncompliance. Bridge letters covering the period from the end of the SOC 1 audit period through the end of Anthem's financial reporting period will also be provided by Supplier upon request by and without cost to Anthem. Supplier will comply with future guidance relating to SOC 2 (AT section 101) and SOC 1/SSAE 16 as issued by the AICPA, the Securities and Exchange Commission or the Public Company Accounting Oversight Board. Both Parties recognize that the report(s) of the third-party auditor do not constitute a certification or an attestation by Supplier under the Sarbanes-Oxley Act of 2002 or otherwise, but Supplier acknowledges that such report(s) may be relied upon by Anthem and Anthem's auditors as they deem appropriate. Supplier agrees to work collaboratively with Anthem to support alignment of Supplier's SOC 1 report with Anthem's financial reporting requirements.

3.5.4 Taxes. Anthem shall pay to Supplier all applicable sales or use taxes assessed by a government authority with respect to the Services and/or Supplier-Provided Materials provided by Supplier under this Agreement, provided that Supplier shall separately itemize such taxes on its invoice(s) to Anthem and that, upon request of Anthem, Supplier shall provide substantiation to Anthem confirming Supplier's reporting and remittance of such taxes to the appropriate government entity. To the extent Anthem has timely paid Supplier for any sales or use type tax, Supplier shall indemnify, defend, and hold Anthem harmless for any such tax, and any related penalties and interest arising from any failure of Supplier to timely report and remit such tax. Anthem shall not be liable for the payment of taxes imposed upon Supplier or upon Supplier's personnel resources, including state and federal income taxes, franchise taxes, Social Security taxes, welfare taxes, unemployment contributions, disability insurance, training taxes and any prepayments, estimated payments, reports, or withholdings required for such taxes. Any payment by Anthem of a Supplier tax obligation shall in no way affect or abrogate Supplier's obligations under this Agreement and shall not be construed as acceptance by Anthem of any Service or Supplier-Provided Materials or as a waiver of any of Anthem's rights.

4. SERVICES - GENERAL TERMS.

4.1 Services. During the Term of this Agreement, Supplier shall perform the Services, produce and deliver the Deliverables, as applicable, pursuant to this Agreement and written SOWs upon written request by Anthem or its Affiliates for such Services and Deliverables. Unless otherwise agreed to

in advance by Anthem in a properly executed Statement of Work, Supplier shall perform all Services in the United States and at no other location. Although the Parties have attempted in this Agreement (and the Parties agree to attempt in any Statement of Work) to delineate the specific services and functions to be provided by Supplier to Anthem and its Affiliates hereunder, the Parties acknowledge and agree that no such delineation could possibly be entirely exhaustive or complete and that some intended items may not be specifically identified. Accordingly, and notwithstanding anything to the contrary elsewhere in this Agreement or in any Statement of Work, Supplier's obligations hereunder shall include the performance of not only all of the Services and functions, and delivery of not only all of the Deliverables, that have been specifically delineated in this Agreement and in any Statements of Work, but also all of the incidental or related services and deliverables that are consistent with, and reasonably necessary to, the performance of any of the Services and functions, and delivery of the Deliverables, so delineated, except (i) services or functions for which Anthem expressly retains responsibility hereunder or (ii) services or functions expressly excluded from the Services, or subject to express qualifications or limitations of a Statement of Work.

4.2 No Minimum Commitment. Supplier understands Anthem makes no promises or representations whatsoever as to the amount of Services and/or Supplier-Provided Materials it will request during the term of this Agreement.

4.3 Non-Exclusivity. This Agreement is nonexclusive and does not grant Supplier an exclusive right to provide Anthem or its Affiliates with any kind of services, deliverables or products and Anthem and its Affiliates may use its own employees or other contractors to perform the same or similar Services or provide the same or similar Supplier-Provided Materials as are to be performed and/or provided by Supplier hereunder.

4.4 Performance Standards.

4.4.1 Supplier will perform the Services in accordance with the qualitative and quantitative standards set forth in the service level section of the applicable Statement of Work (the "Service Levels") if applicable. The Service Levels shall be applied as expressly provided in the applicable SOW.

4.4.2 Supplier will track, monitor, measure and report on its performance as against the Service Levels on a daily basis or as otherwise agreed between the parties in writing. Unless the applicable Statement of Work provides that Anthem will implement specific measurement and monitoring tools, Supplier shall implement the necessary measurement and monitoring tools and procedures required to accurately and timely monitor and report on Supplier's performance of the Services against the applicable Service Levels. Supplier shall maintain such measurement and monitoring tools and procedures throughout the Term.

4.4.3 Unless otherwise provided in the applicable Statement of Work, if during the course of any month (e.g., by reviewing daily performance data), Anthem becomes aware of adverse performance trends (e.g., trends indicating the Supplier may not meet the Service Level for the month), at Anthem's request Supplier will promptly prepare corrective action plans and with Anthem's approval, promptly implement such plans, even though the measurement period has not been completed and, accordingly, there has not yet been a Service Level default.

4.4.4 Supplier will provide Anthem credits against Supplier's charges if it fails to meet a Service Levels as provided in the Statement of Work ("***Service Credits***"). The specifics of the Service Levels and any possible related Service Credits will be listed in the applicable Statement of Work.

4.4.5 If Supplier fails to meet a Service Level, or if Anthem otherwise requests during a month due to adverse performance trends, Supplier will perform a root cause analysis to determine the cause of the failure, take such steps as are necessary to recover from such failure, develop for Anthem review and approval a plan outlining the steps Supplier will take to minimize to the extent possible the risk that such failure will reoccur and, with Anthem approval, implement such plan. In addition, Supplier will report to Anthem in writing regarding the cause of the failure and the steps taken by Supplier.

4.4.6 Where Supplier can establish to the reasonable satisfaction of Anthem that: (a) the root cause of its failure to achieve a Service Level was a factor outside of the reasonable control of Supplier, (b) Supplier is without fault in causing such factor, (c) Supplier would have achieved such Service Level but for such factor, and (d) Supplier used commercially reasonable efforts to (1) foresee and prevent the occurrence of such factor, and (2) perform and achieve that Service Level notwithstanding the presence and impact of such factor, then no Service Level Credit shall be assessed against Supplier for any resulting Service Level Default and Supplier shall otherwise be excused from achieving such Service Level for as long as the circumstances relating to such factor and preventing achievement of such Service Level prevail and Supplier continues to use its commercially reasonable efforts to prevent, overcome and mitigate the adverse effects of such factor to the extent required to achieve the applicable Service Level. For purposes of this provision, a failure of a subcontractor or Affiliate of Supplier shall not be treated as outside the control of Supplier except to the extent Supplier establishes to Anthem's reasonable satisfaction that the failure is the result of factors outside the control of both Supplier and the subcontractor or Affiliate. Notwithstanding the forgoing, the presence of such factor(s) determined by Anthem to be outside of the control of Supplier and/or its subcontractors or Affiliates shall not relieve Supplier of its business continuity and disaster recovery obligations set forth in Section 4.9.

4.5 Unauthorized Deliverable; Pre-Contract Work Authorization. Anthem will not be required to compensate Supplier for any work not described in a SOW, order form, or other appropriate writing signed by an authorized representative of Anthem, either as originally agreed to or as changed pursuant to the change control procedures set forth in Article 6 herein. An exception to the requirement of an executed SOW may be made if Anthem determines there is an urgent requirement to commence work and authorizes commencement of work before the finalization of a written SOW by way of a Pre-Contract Work Authorization ("*PCWA*") duly signed by Anthem; provided, however, that Anthem can terminate the PCWA at anytime if not satisfied with the progress being made toward finalization of a written SOW.

4.6 Cooperation with and Access by Third Parties. Anthem may from time to time hire outsourcers, subcontractors, consultants, or other third Parties ("Anthem Third-Party Contractors") to perform services or provide products relating to Anthem's business or the business of an Anthem Affiliate, and which may be integrated with the Services or Supplier-Provided Materials provided by Supplier hereunder (an "Integrated Project"). Supplier shall cooperate with and work in good faith with any Anthem Third-Party Contractor(s) as requested by Anthem. Such cooperation may include knowledge sharing of standards, policies, quality assurance and testing processes, as applicable, to ensure smooth deployment of Integrated Projects and/or the smooth and efficient transition of any Services (or component of Services) to, from, or among Anthem, Supplier and any Anthem Third Party Contractor. Moreover, nothing in the Agreement shall restrict access by such persons to the Services, Supplier-Provided Materials, and/or Deliverables, as applicable, as reasonably required for such Anthem Third Party Contractors to perform functions for and on behalf of Anthem or any Anthem Affiliate; and provided that such Anthem Third Party Contractors shall use or access the Supplier-Provided Materials and/or Services solely for Anthem's benefit and shall have agreed to confidentiality provisions no less restrictive than those contained in this Agreement, and Anthem shall remain responsible for such Anthem

Third Party Contractor's use or access to the Supplier-Provided Materials and/or Services in accordance with the terms of this Agreement.

4.7 Third-Party Software.

4.7.1 Clearance for Certain Anthem Provided Software. If Anthem will provide any software or access to software to Supplier, then before commencement of Supplier's Services (if specified on the applicable SOW) or before such software is accessed or used by Supplier (if the software is not specified on the applicable SOW), Anthem shall have the opportunity to ascertain whether it has the license rights to permit Supplier to access and use the third-party software needed for such Project. Anthem may cancel or postpone any specific work with Supplier (without any financial penalty and without such cancellation constituting a breach of contract by Anthem) if Anthem determines that it does not possess the needed license for Supplier to perform the Services for which such third-party software is needed. Unless explicitly provided for in a SOW, Supplier is responsible for any software, equipment, supplies, materials or other provisions it may need in performing Services or providing Deliverables.

4.7.2 Use of Anthem Provided Software. For each item of third-party software to which Anthem provides Supplier access or use of pursuant to a SOW, Supplier must de-install and return all such software to Anthem upon the expiration or termination of a SOW or at Anthem's request (and, at Anthem's request, provide an officer's written certification it has done so). Supplier may use or have access to such software only for the purpose of performing the applicable SOW and any other use is strictly prohibited. Supplier shall adhere to any third-party software license limitations when informed of, or provided with, those limitations, and shall indemnify, protect and defend Anthem for any misuse by Supplier or its personnel.

4.8 Disaster Avoidance. Upon the Effective Date, Supplier will create and maintain disaster avoidance procedures (e.g. fire detection, sprinkler systems, physical security) designed to safeguard Anthem's Data and the business continuity of the processes for which Supplier is responsible throughout the Term. These procedures will be subject to Anthem's review and approval as part of the agreed upon BCP. Supplier will be required to revise and maintain these procedures so that they are reasonably acceptable to Anthem throughout the Term.

4.9 Business Continuity Plans.

4.9.1 General. Supplier shall, at no additional cost, (i) within sixty(60) days of the Effective Date of this Agreement, develop a business continuity plan designed to safeguard the business continuity of Supplier's Services generally (the "General BCP"); (ii) within sixty(60) days of the Effective Date of an SOW under which Services will be provided, develop a business continuity plan designed to safeguard the business continuity of Supplier's Services under such SOW (an "SOW BCP"); and (iii) thereafter, maintain the General BCP and any applicable SOW BCP. The General BCP and any SOW BCP shall be referred to hereunder as a "**BCP**". Each such BCP shall be designed, utilizing Anthem's "Critical Path Curriculum" Methodology, to comply with the minimum requirements set forth herein and the Anthem Policies, including governance and oversight processes and procedures, in effect at the time the BCP is being submitted to Anthem. The BCP shall be subject to Anthem's review and approval. Such Supplier BCPs shall be implemented and resourced within ninety (90) days of approval of the BCP by Anthem. If the Parties have not mutually agreed on an SOW BCP within ninety (90) days of the SOW Effective Date, Anthem may terminate the applicable SOW upon written notice to Supplier without cause and Anthem shall not be responsible for any transition or wind down costs. Supplier shall revise each BCP as may be reasonably requested by Anthem from time to time throughout the Term. In the event of implementation of a BCP disruption response and recovery, Supplier shall not increase any costs or charges or charge Anthem or any Anthem Affiliate any fees in addition.

4.9.2 Business Continuity Plan Validation. After delivery of the BCP, the Parties shall conduct an initial exercise to validate that the applicable BCP will be able to meet the operational requirements of the business continuity strategy (including capacities and service quality) that will provide for the response to and recovery from the disruption event and the restoration of Services in accordance with the agreed upon recovery time objectives (“*RTOs*”) contained in the applicable BCP. Supplier will provide an exercise test plan and schedule to Anthem prior to the initial exercise and on completion of the exercise a summary of the results. Supplier will deliver an action plan to correct any material deficiencies found in its BCP within thirty (30) days of the completion of an exercise. Such action plan shall be designed to provide for mitigation of all material deficiencies within ninety (90) days of the completion of the exercise. Anthem reserves the right to observe or participate in any BCP exercise covering Services provided to Anthem on (i) Anthem’s internal environment, or (ii) Supplier environments solely dedicated to the performance of Services for Anthem. Anthem reserves the right to require full documentation for any BCP that covers the continuity of Services. Anthem reserves the right to require any changes to any BCP that covers the continuity of Services that, in Anthem’s commercially reasonable judgment, are necessary to comply with Anthem’s and its affiliates’ business continuity, risk and governance program requirements, regulatory requirements and accreditation requirements.

4.9.3 Business Impact Analysis. If requested by Anthem, Supplier will carry out a business impact analysis along with the Anthem BCP and business teams, utilizing Anthem’s “Critical Path Curriculum” Methodology. The objective would be to:

- A. Validate any existing assumptions on Services (take down to task and activity level, assess for regulatory, compliance, financial or customer impact) to understand the journey from now until solution identification
- B. Validate RTOs for the Services.
- C. Prioritize processes for recovery and required functional knowledge at an alternate site, taking into account the RTOs and then the importance of the applicable Service and its use to end users.

4.9.4 Restoration of Services. Supplier will provide business continuity, disaster recovery, and backup capabilities and facilities, through which Supplier will be able to perform its obligations hereunder (including service level agreements) with minimal disruptions or delays in accordance with the BCP. Supplier represents and warrants that it will comply with, provide, and fund the BCP. To the extent Services are impaired or disrupted due to an incident, Supplier agrees to execute recovery of the Services, in accordance with the applicable BCP. In the event Supplier does not restore the Services within such RTOs, Anthem may, at its option: (i) exercise any rights it may have to terminate under the Agreement; or (ii) either in-source or resource the Services that are disrupted (“step in rights”) and, in doing so, may take other action as is reasonably necessary to restore such disrupted Services. In the event that such failure to restore the Services gives Anthem the right to terminate for cause under the Agreement, Supplier shall have no further right to cure. In the event that such failure to restore the Services does not give Anthem the right to terminate for cause, Anthem may still terminate the SOW, without cause and Anthem shall not be responsible for transition or wind-down costs. Notwithstanding the foregoing, in the event Supplier does not restore the Services within thirty (30) days, Anthem may still exercise step-in rights at any time during the period that the Supplier fails to restore services in accordance with the applicable and approved BCP and included RTO(s) and, in doing so, may take other action as is reasonably necessary to restore such disrupted Services. Supplier shall cooperate fully with Anthem and its agents in the exercise of such step-in rights and provide reasonable assistance at no charge to Anthem to promptly restore such disrupted Services. Supplier shall not be entitled to receive any charges to the extent they relate to Services performed by Anthem and all costs associated with the exercise of such step-in rights. Such step-in rights shall continue until Supplier demonstrates to Anthem’s reasonable satisfaction that Supplier is able to resume performance of the Services with appropriate

mitigation in place designed to prevent further BCP failures for the Services. Such exercise of step-in rights shall not constitute a waiver by Anthem of any termination rights or rights to pursue a claim for damages arising out of the failure that led to the step-in rights being exercised. The foregoing does not limit Supplier's liability with respect to any default or non-performance by Supplier under the Agreement.

4.9.5 Without limiting the foregoing, Supplier covenants and agrees that it will restore Services to meet Service Levels in accordance with the BCP to support restoration of Service Levels within the RTOs set forth in applicable BCPs, but in no event shall a disruption of such services exceed thirty (30) days. Supplier agrees to cooperate with Anthem Third Party Contractors to restore Services, if and when appropriate.

4.9.6 If a business disruption will impact Services provided to Anthem, Supplier shall provide Anthem with timely notification and updates of the disruption, expected impact, expected duration, action plan and status. Supplier will ensure all Anthem Data in the possession or under the control of Supplier is backed up in accordance with agreed upon Service Levels, but in no event shall the off-site backup cycle of Anthem Data residing on Supplier's network exceed twenty-four hours.

4.9.7 Supplier shall consider and incorporate, where applicable and not limited to, the following areas when creating the BCP to be submitted for Anthem's review and approval:

- Scope and Severity of Disaster
- Disaster Response Team (DRT) roles and responsibilities
- Communications with media
- Identification of emergency services in each city
- Description of facilities at all locations
- DRT team members for each facility
- Alternate locations for each facility for the different disaster levels
- Plan review and update parameters
- Plan testing parameters
- Contact information
- Risk Mitigation for base infrastructure for various scenarios
- Diesel generator in data center
- UPS for critical equipment
- Fire detection and protection system
- Computer room
- Voice communication
- Transportation arrangement to and from the facility for employees
- Transportation arrangement between facilities in a city
- High uptime contracts for critical equipment
- All projects shall employ a system whereby backups are completed, at a minimum, every two (2) weeks, including both full and incremental backups and a validation that such backups of data were successfully made.
- Offsite storage of full backup is required. Supplier shall notify Anthem of the location of such offsite storage. Additional project-specific tape storage requirements may be addressed in the applicable Statement of Work.
- Document the decision tree for invocation, including basis points 1 to 4 above. This will include coordination with Anthem business continuity personnel as well as joint disaster recovery plans, as required to support the delivery continuity of the Services in accordance with this Agreement, including RTOs.

- Annually, as part of the test of the BCP, all processes are validated.

4.9.8 Supplier will meet with Anthem representatives to review said BCP. Supplier will make reasonable changes to said BCP as requested by Anthem. Supplier will maintain and test the BCP at regular intervals (no less frequently than annually), and will provide Anthem with documented results of the BCP tests that relate to the Services provided hereunder. In addition, Supplier will provide Anthem with sufficient notice to allow Anthem to participate in and/or monitor Supplier's BCP exercises for the Services. Supplier will promptly revise its BCP to conform to new governmental regulations, except that Supplier shall not increase any costs or charges without Anthem approval. If Supplier becomes aware that it is not in compliance with its BCP, Supplier will (a) notify Anthem in writing promptly, and (b) cure any such non-compliance within ten (10) calendar days thereafter. If the non-compliance cannot reasonably be cured within such period, Supplier will use commercially reasonable efforts to cure the non-compliance as soon as practicable. If such non-compliance results in risks unacceptable to Anthem, Anthem may: (i) terminate the applicable Statements of Work, without cause, upon written notice to Supplier, in accordance with the terms of the Agreement, and Anthem shall not be responsible for transition or wind-down costs; or (ii) at Anthem's option, exercise step-in rights for the Services that are disrupted and, in doing so, may take other action as is reasonably necessary to restore such disrupted Services.

4.9.9 Disaster Recovery Sites. Unless otherwise specified by Anthem, Supplier shall provide at least two (2) geographically diverse facilities from which Services may be performed so that, if a location from which Services are provided becomes unavailable (and subject to the applicable business continuity and disaster recovery provisions of this Agreement) and an alternate location is required in order to provide the Services, Supplier shall restore the Services at the secondary or backup sites, including staffing, at no additional charge to Anthem.

4.9.10 Training. Each Party shall train and have sole responsibility for training its own personnel on the Party's respective roles and responsibilities under the BCP. Supplier shall provide Anthem with a training status report and roles and responsibilities roster at least once every six (6) months or whenever there is a material change in key roles and responsibilities/staffing or skills readiness status. Key roles shall be identified in the BCP.

4.10 Acceptance and Training. Acceptance with respect to Services shall be as addressed in Section 4.10.1 and with respect to Deliverables shall be as set forth in Section 4.10.2.

4.10.1 Acceptance of Services. To the extent a SOW provides for Services:

(a) Preliminary Acceptance. Unless otherwise specified in a SOW, Anthem shall have ten (10) business days from the completion of each phase or milestone to test the Services relating thereto in order to determine whether such Services meet the standards and/or accomplish the objectives or other criteria for such Services as established in the applicable SOW ("Services Preliminary Acceptance Period"). In the event a SOW does not provide acceptance criteria, then the acceptance criteria shall be Anthem's reasonable satisfaction. If Anthem gives notice of non-Acceptance, (i) Anthem shall describe the reasons for non-Acceptance to Supplier in reasonable detail; (ii) Supplier shall have five (5) calendar days to re-perform the deficient Services at no cost to Anthem, until the applicable standards, objectives, milestones and/or other criteria are met to Anthem's reasonable satisfaction; and (iii) a ten (10) calendar day re-testing preliminary acceptance period shall begin.

(b) Final Acceptance; Multi-Phase Projects. Upon completion of all related Services for a particular project, (including upon completion of an intermediate phase of a project or entire project, as specified in a SOW), Anthem shall have fifteen (15) business days after completed

performance of the final phase of Services to test whether they meet the specifications set forth in the SOW ("Specifications"), in all material respects, (the "Services Final Acceptance Period"), unless a different time frame is specified in a SOW. The SOW shall identify any applicable preliminary and final acceptance milestones, deadlines or other criteria. The Services Final Acceptance Period shall not begin until any related Documentation, if any, has been delivered to Anthem. If Anthem gives notice of non-Acceptance, (i) Anthem shall describe the reasons for non-Acceptance to Supplier in reasonable detail; (ii) Supplier shall have fourteen (14) calendar days to re-perform the deficient Services at no cost to Anthem until the applicable standards, objectives, milestones and/or other criteria are met to Anthem's reasonable satisfaction; and (iii) the Services Final Acceptance Period shall begin again. In the event Supplier fails to re-perform a rejected Service to conform to the Specifications, as determined in Anthem's reasonable discretion, Anthem may terminate the applicable SOW immediately and receive from Supplier a refund of: (i) the fees previously paid to Supplier for the rejected Services; and (ii) the fees previously paid for all other Services which are materially affected by such non-conformity. If Services are deemed unacceptable despite efforts to correct deficiencies pursuant to the foregoing procedures, and the Parties fail to resolve the matter to their reasonable satisfaction, then either Party may submit the matter for dispute resolution pursuant to the procedures provided for in Article 16, Dispute Resolution. For Services and/or Deliverables performed and provided in multiple phases under a SOW, they shall be subject to final Acceptance testing under this paragraph, because such interim phases culminate in an integrated deployment or other solution, notwithstanding any preliminary acceptance that may have been determined during an intermediate phase of the project. To the extent a project involves Deliverables integrated with Services, then the foregoing testing, rejection and refund procedures and remedies shall include all related Deliverables.

4.10.2 Acceptance of Deliverables. To the extent a SOW provides for Deliverables, the SOW shall identify whether the Deliverable will be subject to Anthem review (a "Review Deliverable") or will be subject to Anthem testing (a "Test Deliverable"). Any reference to a "Deliverable" herein shall include reference to a Test Deliverable or a Review Deliverable, as the context requires.

(a) Preliminary Acceptance. Unless otherwise specified in the applicable SOW, Anthem shall have ten (10) calendar days after receipt to review each Review Deliverable or twenty (20) calendar days to test each Test Deliverable (or portions thereof if such Deliverable is to be delivered in portions as set forth in the applicable SOW) to determine whether it meets the Specifications (the "Preliminary Acceptance Period"). This Preliminary Acceptance Period shall not begin until the Documentation has been delivered to Anthem and the Deliverables are fully installed and operational as determined by the Parties. If Anthem gives notice of non-Acceptance, (i) Anthem shall describe the reasons for non-Acceptance to Supplier in reasonable detail; (ii) Supplier shall have five (5) calendar days to correct the Deliverable at no cost to Anthem; and (iii) the Preliminary Acceptance Period shall begin again.

(b) Final Acceptance; Multi-Phase Projects. Upon final delivery of all related Deliverables, (including upon completion of an intermediate phase of a project or entire project, as specified in a SOW), Anthem shall have ten (10) calendar days after receipt to review the Review Deliverables or thirty (30) calendar days to test the Test Deliverables to determine whether they meet the Specifications (the "***Deliverables Final Acceptance Period***"), unless a different time frame is specified in a SOW. This Deliverables Final Acceptance Period shall not begin until the Documentation has been delivered to Anthem and the Deliverables are fully installed and operational as determined by the Parties. If Anthem gives notice of non-Acceptance, (i) Anthem shall describe the reasons for non-Acceptance to Supplier in reasonable detail; (ii) Supplier shall have fourteen (14) calendar days to correct the Deliverables at no cost to Anthem; and (iii) the Deliverables Final Acceptance Period shall begin again. In the event Supplier fails to modify a rejected Deliverable to conform to the Specifications contained in the applicable SOW, as determined in Anthem's reasonable discretion, Anthem may terminate the applicable SOW immediately and receive from Supplier a refund of: (i) the fees previously paid to

Supplier for the rejected Deliverable; and (ii) the fees previously paid for all other Deliverables which are materially affected by such non-conformity. If Deliverables are deemed unacceptable and the Parties fail to resolve the matter to their reasonable satisfaction, then either Party may submit the matter for dispute resolution pursuant to the procedures provided for in Article 16 (Dispute Resolution). If the Parties intend that all Services and/or Deliverables performed and provided in multiple phases under a SOW are to be subject to final Acceptance testing under this paragraph, because such interim phases culminate in an integrated deployment or other solution, notwithstanding any preliminary acceptance that may have been determined during an intermediate phase of the project, then the Parties shall so explicitly provide in the SOW. To the extent a project involves Deliverables integrated with Services, then the foregoing testing, rejection and refund procedures and remedies shall include all related Services.

4.10.3 Deemed Acceptance; Further Notice. If Anthem does not furnish a written notice of acceptance or non-acceptance to Supplier as contemplated in this Section 4.10, prior to the end of the applicable acceptance period, then Supplier will give Anthem's Account Manager written notice (which may be by e-mail) of Anthem's failure to provide notice of acceptance or non-acceptance. In the event that Supplier has not received written notice of acceptance or non-acceptance of the applicable Services and/or Deliverables within ten (10) business days after Anthem's receipt of such notice, then and only then will Anthem be deemed to have accepted such Services and/or Deliverable or other items as applicable.

4.10.4 Training. Upon Anthem's request, and promptly following the delivery or installation of any Deliverable(s), Supplier shall provide Anthem with training on the use and operation of the Deliverable(s) as is necessary for Anthem to operate and maintain such Deliverable(s). Anthem shall pay Supplier the fee as set forth in the applicable SOW for such training. Unless otherwise specified in the SOW, the training shall be conducted by Supplier at Anthem's facilities for at least four (4) Anthem employees.

4.11 Transition Assistance. At Anthem's request, commencing upon the termination of this Agreement or any SOW hereunder, or other discontinuation of a component of the Services, for any reason, Supplier shall provide up to one-hundred eighty (180) days of assistance to Anthem for transition of the Services to Anthem or a third-party designee of Anthem. Such transition assistance shall be rendered at the lower of (a) the time-and-materials rate set forth in the SOW for the relevant Services, or (b) Supplier's lowest published time-and-materials rate. Within ten (10) calendar days of Anthem's request for transition assistance, the Parties shall meet to develop a transition plan. Such transition plan and transition assistance may include, by way of example: detail of Supplier's then-current responsibilities and resource commitments; knowledge transfer sufficient to assure a smooth transition and to enable Anthem or its designee to assume responsibility for continued performance of the Services with minimal disruption to Anthem's business and operations; Supplier information concerning personnel, software, skill sets and other resources used by Supplier to provide the Services (including third party services required to provide the Services); explanation of security and problem management processes and standards; provision of all documentation, logs, and applicable records to Anthem; return of any Anthem assets, information, data, and Confidential Information; anything else reasonably related to the transition of affected Services. The Parties may provide for different transition assistance responsibilities, timing and payment schedules in a SOW.

4.12 Supplier Resources and Materials. Except as expressly provided otherwise in this Agreement or in a Statement of Work, Supplier shall (at its own risk and expense) provide all of the materials and resources necessary for delivering the Services, providing the Deliverables and otherwise meeting Supplier's obligations under this Agreement. Any project-specific resources (and the financial and operational responsibility therefore) shall be detailed in each applicable Statement of Work. If an applicable SOW provides that Anthem will be paying for any such materials, all such costs shall be set

forth in detail in the applicable SOW; any such third party charges shall be passed through to Anthem at Supplier's actual cost, with no mark-up.

4.13 Anthem Property. Any tangible property furnished to Supplier by Anthem or its Affiliates in connection with this Agreement shall be deemed bailed to Supplier for the mutual benefit of the Parties and title thereto shall at all times remain in Anthem or its Affiliate, as the case may be; in no event may Supplier transfer any such Anthem tangible property outside the continental United States without Anthem's prior written consent, which may be given or withheld in Anthem's reasonable discretion. Supplier assumes all risk of loss of any such property while in Supplier's constructive possession or control, and Supplier shall promptly pay Anthem for all such tangible property that is damaged or destroyed during any such time or that Supplier otherwise fails to return to Anthem. Supplier shall maintain at all times, and shall submit to Anthem upon written request from time to time, an accurate, detailed and current written list of any property of Anthem or its Affiliates (including designs, reports, manuals, documents, specifications, hardware, software and equipment) received or obtained by Supplier pursuant to this Agreement. No property of Anthem or its Affiliates shall be removed from Anthem's or its Affiliates' premises without the prior written consent of Anthem. Any property of Anthem or its Affiliates' shall be promptly returned upon the earlier of: (i) Anthem's request for the return thereof; or (ii) completion or termination of the applicable Statement of Work to which such property pertains. Supplier shall, at its risk and expense, while any property of Anthem or its Affiliates is in Supplier's custody or control: (a) maintain such materials in good condition; and (b) insure such materials in an amount equal to the replacement cost thereof with loss payable to Anthem.

4.14 Use of Anthem Facilities. If Anthem requires Supplier to provide Services at an Anthem facility, Anthem shall provide Supplier with adequate space in such Anthem facility necessary for Supplier to perform the Services (as such space is identified in the relevant Statement of Work). Supplier shall use the Anthem facilities for the sole and exclusive purpose of providing the Services and delivering the Deliverables. Access to Anthem facilities shall be restricted to normal Anthem business hours, or the normal business hours of the particular Anthem facility or Service Location, as applicable. Access to Anthem facilities outside of normal business hours will be based on demonstrable project or other support effort needed and must be approved in advance by Anthem's Project Manager or his/her designee. Supplier shall repair, or cause to be repaired, at Supplier's sole cost and expense, any and all damage caused by negligent or willful misconduct of Supplier personnel to Anthem facilities or other Anthem facilities, including Anthem's buildings, grounds, equipment and furniture, caused by the negligence or willful misconduct of Supplier or any of its personnel or subcontractors, or any other person performing Services on Supplier's behalf under this Agreement or any Statement of Work. Supplier shall immediately notify Anthem of any and all such damages. All costs incurred by Anthem, as reasonably determined by Anthem, for such repairs shall be repaid by Supplier by cash payment upon demand and without limitation of Anthem's other rights and remedies provided by law, in equity, or otherwise under this Agreement. Anthem may deduct any such costs from any amounts due to Supplier from Anthem under this Agreement.

5. RELATIONSHIP MANAGEMENT

5.1 Progress Reports. At the frequency specified in each applicable SOW and at other times as requested by Anthem, Anthem and Supplier shall meet to review Supplier's performance and discuss issues related to the provision of Services and Supplier-Provided Materials, including Supplier's compliance with the performance standards in the applicable SOW.

5.2 Account Relationship Manager. At Anthem's request, Supplier shall designate an Account Manager who shall act as liaison with Anthem on behalf of Supplier with respect to the relationship and responsibilities of the Parties. Such Account Manager shall be responsible for coordinating and managing delivery of all Services and/or Supplier-Provided Materials, and also for

coordinating, cooperating and resolving any concerns, service problems or other matters relating to the overall relationship between the Parties. Anthem shall designate a corresponding Account Manager to act as liaison on behalf of Anthem.

5.3 Supplier Financial Information. Upon Anthem's request, Supplier will provide Anthem with complete and accurate annual financial statements so long as this Agreement is in effect. Publicly traded companies will supply their Forms 10Qs and 10K filed with the Securities and Exchange Commission. Privately held companies will provide balance sheet and income statement with footnotes. Supplier shall provide Anthem with such statements within ninety (90) days after the end its annual accounting period. Supplier may use the automated Securities Exchange Commission Filing email distribution process to provide financial statements to Anthem. Any information disclosed hereunder shall be Confidential Information (as defined in Section 10 (Confidentiality)).

5.4 Continuous Improvement. Supplier shall work with Anthem to drive continuous improvements in effectiveness, cost efficiency and best practices. Supplier shall monitor improvements and the Supplier Account Manager shall report progress to Anthem as requested by Anthem on an annual basis.

6. CHANGE CONTROL.

6.1 Requests by Anthem. Anthem may request changes or modifications to any Statement of Work issued hereunder by delivering to Supplier a written change order, describing the requested changes in such reasonable detail as to enable Supplier to evaluate them ("Request"). Changes, modifications or enhancements to the Services or Deliverables being provided pursuant to a Statement of Work that are not material shall be deemed to be part of the Services or Deliverables, as the case may be, and shall not be subject to this Section or any other change control provision. Changes, modifications or enhancements to the Services being provided pursuant to a Statement of Work that are material (a "Change") shall be subject to this Section. If the Parties are unable to agree whether a Change, modification or enhancement to the Services are material, the disagreement shall be subject to the dispute resolution procedures set forth in the Agreement.

6.2 Process. Within ten (10) business days after delivery of such a Request or as otherwise agreed by the parties, Supplier shall deliver to Anthem a proposed plan that: (i) assesses any impact of the Request on any Services or Deliverables already to be provided under such Statement of Work; (ii) describes the Request and any new or additional Services or Deliverables to be provided pursuant to it; (iii) sets forth cost estimates, specifications, implementation plans and time schedules with milestone and completion dates; (iv) contains completion and acceptance criteria; and (v) sets forth any other necessary and appropriate information ("**Change Order**"). Supplier may also request changes or modifications to any Statement of Work from time to time by preparing and delivering to Anthem a proposed SOW Amendment that describes the proposed changes. Notwithstanding the foregoing, Anthem may, in its sole discretion, with a Change Order, extend any scheduled completion date under any Statement of Work upon providing written notice thereof to Supplier, provided however that Anthem shall be liable for any efforts, Services or other pre-approved expenses due to Supplier caused by such extension, but only to the extent Supplier is unable, after diligent efforts, to redistribute personnel or other assets during the remaining duration of the extension period either to other Anthem or Anthem Affiliate Services or Deliverables or services provided by Supplier to third party customers of Supplier.

6.3 Acceptance or Rejection. If within seven (7) calendar days after receipt of a proposed Change Order Anthem notifies Supplier in writing that it does not accept the Change Order, or fails to notify Supplier with respect to such Change Order, then such Change Order shall be deemed rejected, and

Supplier shall take no further action with respect to it. If Anthem accepts Supplier's Change Order within such timeframe by the express written approval and authorized signature of Anthem on such Change Order and the delivery of such Change Order back to Supplier before its revocation or by issuance of a purchase order by Anthem through Anthem's Procurement Process Technology, then this Agreement and the applicable Statement of Work shall thereby be amended in accordance with such Change Order, and such Change Order shall be deemed adopted and incorporated therein.

6.4 No Changes by Supplier. Except as may be necessary on an emergency basis, as determined by Anthem, no changes, modifications or enhancements in Services shall be made without Anthem's prior written consent, which shall be provided at its sole discretion, unless such change, modification or enhancement: (a) has no impact on the Services being provided by Supplier; (b) has no impact on the security of Anthem Data and Anthem's systems; and (c) causes no increase in fees or other costs chargeable to Anthem hereunder. If an emergency arises which requires Supplier to make a change, modification or enhancement to the Services, Supplier shall notify Anthem thereof as soon as practicable.

7. TERM; TERMINATION.

7.1 Agreement. The term of this Agreement shall begin on the Effective Date and shall end ____ (____) years thereafter unless earlier terminated in accordance with this Agreement; provided however, that upon expiration, any SOW(s) then in effect (and no additional SOWS) that have specified a term longer than the Term stated above shall continue to be subject to the terms and conditions contained in this Agreement. Notwithstanding the foregoing, Anthem shall have the right, but not the obligation, to extend the Term on the then existing terms and conditions (including price) for up to twelve (12) months on thirty (30) days notice. Anthem will have four (4) such rights. The initial term and any renewal term shall be referred to herein as the "**Term.**"

7.2 SOWs. Each SOW is an independent obligation of the Parties, and each SOW, if not entered into as of the Effective Date, shall commence as of the commencement date set forth in (or if not specified, as of the date last set forth in the signature area of) the relevant SOW.

7.3 Termination for Supplier's Breach. Anthem, in its sole discretion, may terminate the entire Agreement or any and all Statements of Work (i) immediately if Supplier is in breach of Sections 9 (Security), 10 (Confidentiality), 12.1 (General Warranties) or 12.2 (Supplier's Representations, Warranties, and Covenants); or (ii) upon thirty (30) days written notice and opportunity to cure in the event of a material breach by Supplier if Supplier has not remedied such breach within thirty (30) days of its receipt of written Notice from Anthem of such breach. Should Supplier again materially breach the Agreement in substantially the same manner as a prior material breach by Supplier within one (1) year of such prior material breach, Anthem may terminate any or all Statements of Work or this entire Agreement upon no less than ten (10) business days written notice. Notwithstanding the foregoing, Anthem, in its sole discretion, may immediately cease receiving Supplier-Provided Materials or Services from Supplier and cease providing Supplier with access to Anthem's computer systems, facilities, personnel or information.

7.4 Termination for Anthem's Breach. Subject to the following sentence, Supplier may terminate a SOW upon written notice in the event of a material breach of such SOW by Anthem if Anthem has not remedied such breach within thirty (30) days of its receipt of written notice from Supplier of such breach. Prior to issuing any notice of termination, Supplier shall escalate the matter to Anthem executives pursuant to the informal dispute resolution procedures set forth in Section 16, Dispute Resolution herein. If Supplier effectuates termination of an Exhibit or SOW hereunder, Supplier shall, at

Anthem's option, provide necessary transition assistance to Anthem after such termination notice is given. Transition Services are further covered in Section 4.11.

7.5 Termination for Convenience. Anthem may terminate this Agreement, or any SOW issued hereunder, in whole or in part, for any or no reason upon not less than thirty (30) days prior written notice of termination to Supplier.

7.6 Termination Due to Insolvency. Either Party may terminate this Agreement or any SOW immediately upon the occurrence of any of the following events with respect to the other Party: (a) the other Party becomes insolvent, generally unable to pay its debts as they become due, or makes an assignment for the benefit of its creditors or seeks relief under any bankruptcy, insolvency or debtor's relief law; (b) if proceedings are commenced against the other Party under any bankruptcy, insolvency or debtor's relief law, and such proceedings have not been vacated or set aside within sixty (60) days from the date of commencement thereof; (c) a receiver is appointed for the other Party or its material assets; or (d) if the other Party is liquidated, dissolved or ceases operations.

7.7 Termination Upon Change of Control of Supplier. If a change in Control of Supplier occurs, Anthem may at its option, terminate this Agreement or any SOW, in whole or in part, by giving Supplier at least thirty (30) days' prior written notice and designating a date upon which such termination will be effective. Any such notice must be given with six (6) months following the later of Supplier's provision of written notice to Anthem of, or, if Supplier fails to give such notice, the date on which Anthem learns of such change in Control. For this purpose, "Control" and its derivatives means the legal, beneficial or equitable ownership, directly or indirectly, of at least fifty percent (50%) of the aggregate of all voting equity interests in an entity or equity interests having the right to at least fifty percent (50%) of the profits of Supplier or, in the event of dissolution, to at least fifty percent (50%) of the assets of an entity and, if Supplier is a partnership, also includes the holding by an entity of the position of sole general partner in Supplier.

7.8 Effect of Termination or Expiration. In the event that a SOW expires or in the event that Anthem terminates a SOW pursuant to the terms contained in such SOW, Anthem may, in its sole discretion, simultaneously terminate other Statements of Work materially and adversely affected by such termination or expiration. Notwithstanding the foregoing, the termination of a particular SOW, or portion of a SOW, shall not result in the termination of the Agreement unless such termination explicitly provides for termination of the entire Agreement between the Parties. However, termination of the Agreement shall serve to terminate all Statements of Work unless such notice of termination specifies otherwise. All sections identified as surviving the termination of a SOW, as well as Sections 3.5 (Record Retention), 4 (Services), 8 (Intellectual Property Ownership), 9 (Security), 10 (Confidentiality), 13 (Indemnification), 14 (Limitation of Liability) and 16 (Dispute Resolution) inclusive, shall survive the expiration or termination of the Agreement. In the event of termination for any or no reason of any SOW, Anthem shall pay Supplier any undisputed Fees and/or expenses owed in accordance with such SOW up to the effective date of termination. If the Agreement includes Deliverables, Supplier shall promptly deliver such Deliverables, in whatever stage of completion, to Anthem. The return or destruction of Confidential Information upon termination is addressed in Section 10.5 below.

8. INTELLECTUAL PROPERTY OWNERSHIP.

8.1 Custom IP. Supplier acknowledges and agrees that Anthem shall be the sole and exclusive owner of all rights in the Custom IP. Supplier hereby unconditionally and irrevocably conveys, transfers, delivers and assigns and agrees to unconditionally and irrevocably convey, transfer, deliver and

assign to Anthem, and Anthem accepts and agrees to accept, Supplier's entire right, title and interest worldwide in and to such works, free from any liens and encumbrances, including all patents, copyrights, trade secrets and other proprietary rights therein, effective immediately upon the authorship, conception, creation, discovery, or development thereof, together with all federal, state and provincial registrations, applications for registration and all renewals and extensions thereof (including any continuations, continuations-in-part, divisionals, reissues, substitutions and reexaminations), all goodwill associated therewith, and all benefits, privileges, causes of action and remedies relating to any of the foregoing, whether before or hereafter accrued (including the exclusive rights to apply for and maintain all such registrations, renewals and extensions, to sue for all past, present and future infringements or other violations of any rights relating thereto, and to settle and retain proceeds from any such actions).

8.2 Confirmation of Anthem's Ownership of Custom IP. Supplier further agrees, at no additional cost, to execute, or cause to be executed by its employees, agents, or subcontractors, standard assignments of IP rights and ancillary and confirmatory documents that may be required or appropriate so that title to any Custom IP shall be clearly and exclusively held by Anthem or any nominee thereof. Supplier shall deliver to Anthem any Source Code incorporated in each Deliverable at the time of completion of such Deliverable. In the event Anthem is unable for any reason to secure Supplier's signature to any document Anthem requests Supplier to execute under this Section, Supplier hereby irrevocably designates and appoints Anthem and Anthem's duly designated authorized officers and agents as Supplier's agents and attorneys-in-fact to act for and in Supplier's behalf and instead of Supplier to execute such document and to file such application and to do all other lawfully permitted acts with the same legal force and effect as if executed by Supplier.

8.3 License; Waiver of Rights. To the extent, if any, that any Custom IP or IP rights therein are not assignable or that, notwithstanding Section 8.2 (Confirmation of Anthem's Ownership of Custom IP), Supplier for any reason retains any right, title, or interest in and to any Custom IP or any IP rights therein, Supplier (i) unconditionally and irrevocably waives the enforcement of such rights, and all claims and causes of action of any kind against Anthem or its Affiliates with respect to such rights, (ii) agrees, at Anthem's request and expense, to consent to and join in any action to enforce such rights, and (iii) hereby grants to Anthem and its Affiliates a perpetual, irrevocable, fully paid-up, royalty-free, transferable, sublicensable (through multiple levels of sublicensees), exclusive, worldwide right and license under its IP rights to use, reproduce, distribute, display and perform (whether publicly or otherwise), prepare derivative works of and otherwise modify, make, sell, offer to sell, import and otherwise use and exploit (and have others exercise such rights on behalf of Anthem or its Affiliates) all or any portion of such Custom IP. The license granted herein shall commence on the Effective Date, and notwithstanding anything to the contrary contained in this Agreement, shall continue in perpetuity and without regard to the Term of this Agreement. Supplier hereby waives and quitclaims to Anthem and its Affiliates any and all claims, of any nature whatsoever, which Supplier now or may hereafter have for infringement of any Custom IP or IP rights therein assigned hereunder to Anthem.

8.4 Supplier IP. Supplier shall identify all Supplier IP to be incorporated into the Services or Deliverables, if any, in each applicable Statement of Work. Supplier hereby grants to Anthem and its Affiliates a perpetual, irrevocable, fully paid-up, royalty free, transferable, sublicensable (through multiple levels of sublicensees), worldwide, non-exclusive right and license under its IP rights, to use, reproduce, distribute, display and perform (whether publicly or otherwise), prepare derivative works of and otherwise modify, make, import and otherwise use and exploit (and have others exercise such rights on behalf of Anthem or its Affiliates) all or any portion of the Supplier IP incorporated into the Deliverables or Services, for use in connection with Anthem's business or the business of any Anthem Affiliate (including its distribution of products or provision of services to third-parties). The license

granted herein shall commence on the Effective Date and, notwithstanding anything to the contrary contained in this Agreement, shall continue in perpetuity and without regard to the Term of this Agreement.

8.5 Anthem IP. Except as may otherwise be provided in a Statement of Work, Supplier shall only use the Anthem IP in the form provided by Anthem and solely in connection with this Agreement. Subject to Section 17.2 below, Anthem hereby grants to Supplier, solely for the performance of the Services and creation of the Deliverables a non-exclusive, non-transferable, non-sublicensable right to access, operate and use the Anthem IP. Upon expiration or termination of this Agreement for any reason, (i) the rights granted to Supplier, its agents and subcontractors, in this Section shall immediately revert to Anthem, and (ii) Supplier shall (a) deliver to Anthem, at no cost to Anthem, a current copy of all of the Anthem IP in the form in use as of the date of such expiration or termination, and (b) immediately cease use of, and completely destroy or erase all other copies of the Anthem IP in Supplier's or its agents' or subcontractors' possession in any form, including electronic, hard copy, or other memory device, and at Anthem's request, have its officers certify in writing that it has so ceased use of, destroyed or erased all copies of the Anthem IP and that it shall not make any further use of the Anthem IP.

8.6 Third-Party IP. Supplier shall not incorporate Third-Party IP in any Service or Deliverable without obtaining Anthem's prior written consent. To the extent any Third-Party IP is required to be so incorporated, Supplier shall identify all Third-Party IP embedded in Services or Deliverables, if any, in each applicable Statement of Work. Such identification shall include, at a minimum, the following information: (i) the nature of the Third-Party IP; (ii) the owner of the Third-Party IP; (iii) Supplier's authority to include the Third-Party IP in the Deliverables or Services; and (iv) any restrictions or royalty terms applicable to the incorporation of the Third-Party IP in the Deliverables or Services. Supplier represents and warrants that the Deliverables, including the Third-Party IP, do not include any embedded software or open source software of any kind or any IP that is subject to licensing terms requiring disclosure of source code under any circumstances. All software a Party licenses from a third-party vendor will be and remain the property of such third-party or such third-party's licensors. If Anthem provides Supplier with access to or use of Third-Party IP licensed by Anthem from third-parties, Supplier shall be responsible for (a) complying with all applicable obligations under any third-party license agreements, (b) indemnifying, defending and holding Anthem harmless from and against any breach by Supplier of such license agreements as set forth in Section 13 below, and (c) treating all such Third-Party IP as Confidential Information of Anthem. Unless provided otherwise in a Statement of Work, Supplier shall obtain, at Supplier's sole cost and expense, an irrevocable, fully paid-up, royalty-free, perpetual, worldwide, non-exclusive license for Anthem and Anthem's agents and assigns, to use the Third-Party IP incorporated into the Deliverables and Services. Supplier will not incorporate, integrate or bundle Open Source software in or with any Deliverable, without Anthem's prior written consent, and to the extent that Supplier uses Open Source software in the performance of Services, it shall ensure that such use does not grant, or purport to grant, to any third-party any IP rights in the Deliverables, and does not cause a Deliverable, or any part thereof to become subject to the terms of such Open Source software license.

8.7 Reservation of Rights. Except as provided herein, each Party (and each Anthem Affiliate) reserves all rights in its IP and nothing contained herein shall be construed as granting the other Party any ownership interest in its IP. Each Party shall include, maintain, reproduce and perpetuate all notices or markings on all copies of all tangible media comprising each Party's IP or Confidential Information in the manner in which such notices or markings appear on such tangible media or in the manner in which either Party may reasonably request. Nothing in this Agreement waives or limits extra-contractual rights or remedies available to Anthem or its Affiliates to protect IP rights afforded Anthem under the law of any

jurisdiction, including trademarks and service marks.

8.8 Waiver of Moral Rights. Supplier hereby forever waives and agrees never to assert against Anthem, its Affiliates, their successors, or licensees any and all moral rights Supplier may have in the Custom IP, and any elements thereof, and any results or proceeds therefrom, even after expiration or termination of this Agreement, to the extent permitted by applicable law. However, this Section 8.8 shall not be interpreted as a waiver of moral rights as to Supplier IP, except as may be embedded in the Custom IP.

9. SECURITY.

9.1 Limited Access. To the extent made accessible to Supplier, Supplier shall, at all times, limit access to Anthem Confidential Information to those employees or subcontractors that have an actual need to access such data for purposes of providing the Services. Prior to gaining access to Anthem Confidential Information, Supplier shall require all employees or subcontractors to comply with confidentiality, security and IP provisions no less stringent than the provisions set forth in this Agreement and, at Anthem's request, have an Officer certify in writing it has done so.

9.2 Notification of Security Breaches. Supplier shall immediately notify Anthem should it discover any breach of the security provisions set forth in this Agreement and will immediately coordinate with Anthem to investigate and remedy such breach(es) in a diligent and timely manner. Except as may be strictly required by Applicable Law, Supplier agrees that it will not inform any third-party of any such security breach, without Anthem's prior written consent; however, if such disclosure is required by Applicable Law, Supplier agrees to work with Anthem, at no additional cost to Anthem, regarding the content of such disclosure so as to minimize any potential adverse impact upon Anthem and its members.

9.3 Access to Anthem Systems. If Supplier is given access, whether on-site or through remote facilities, to any Anthem computer or electronic data storage system, in order for Supplier to perform any of its obligations hereunder, Supplier shall limit such access and use solely to perform such Services or other obligations and will not attempt to access any computer system, electronic file, software or other electronic services other than those specifically required to perform the Services or other obligations. Supplier shall limit such access to those of its personnel with an express requirement to have such access in connection with this Agreement or the applicable SOW, shall advise Anthem in writing of the name of each such personnel who will be granted such access (and identifying whether each is an employee or subcontractor of Supplier), and shall comply with any security policies Anthem may promulgate from time to time relating to use of Anthem electronic resources and systems. All user identification numbers and passwords disclosed to Supplier and any information obtained by Supplier as a result of Supplier's access to, and use of, Anthem computer and electronic storage systems shall be deemed to be, and shall be treated as, Anthem Confidential Information (as defined in Section 10.2 Confidential Information) under applicable provisions of this Agreement. Supplier shall cooperate with Anthem in the investigation of any apparent unauthorized access by Supplier to Anthem computer or electronic data storage systems or unauthorized release of Anthem Confidential Information by Supplier. Supplier's access shall be subject to such other business control and information protection policies, standards, and guidelines as may be provided to Supplier by Anthem from time to time and in Exhibit F (Required Information Security Controls) if made part of this Agreement. Any other use by Supplier of any other Anthem assets or property or systems is strictly prohibited. Supplier warrants and agrees that its personnel will not remotely access Anthem's system from a networked computer unless the network is protected from all third party networks by a firewall that is maintained with all patches up to date by a 7x24 administrative staff. Said firewall must be certified by the International Computer Security

Association (ICSA) (or an equivalent certification as determined by Anthem) if the connection to Anthem's network is an ongoing connection such as frame relay or T1 line.

10. **CONFIDENTIALITY.**

10.1 **HIPAA, Medicare, FEP, Medicaid.** The provisions set forth in this Section 10 are in addition to and not in lieu of any confidentiality, privacy, security and other requirements imposed on Supplier in the Exhibits that form part of this Agreement. Notwithstanding anything to the contrary, in the event a BAA is not included with this Agreement or otherwise in place between the Parties, and Supplier is engaged for services that include the potential for access to PHI, Supplier must enter into a BAA acceptable to Anthem prior to performing such services. In the event the BAA is not signed by Supplier, Anthem may withhold payment for such services and/or suspend or terminate such services without penalty or termination fees.

10.2 **Confidential Information.**

10.2.1 During the Term, a Party (the "Receiving Party") may be exposed to or acquire information regarding the business, projects, operations, finances, activities, affairs, research, development, products, technology, technology architecture, business models, business plans, business processes, marketing and sales plans, customers, finances, personnel data, health plan rating and reimbursement formulas, computer hardware and software, computer systems and programs, processing techniques and generated outputs, intellectual property, procurement processes or strategies or suppliers of the other Party or their respective directors, officers, employees, agents or clients (collectively, the "Disclosing Party"), including, without limitation, any idea, proposal, plan, procedure, technique, formula, technology, or method of operation (collectively, "***Confidential Information***"). With respect to Anthem only, Confidential Information shall include all Anthem Data and all Confidential Information of Anthem Affiliates.

10.2.2 Confidential Information shall not include any information that a Party can demonstrate: (i) was in the public domain at the time of disclosure to such Party; (ii) was published or otherwise became part of the public domain after disclosure to such Party through no fault of such Party; (iii) was previously disclosed to such Party without a breach of duty owed to the other Party by a third-party who had a lawful right to such information; or (iv) was independently developed by such Party without reference to Confidential Information of the other Party.

10.2.3 In addition, either Party may disclose Confidential Information to the extent disclosure is based on the good faith opinion of such Party's legal counsel that disclosure is required by law or by order of a court or governmental agency; provided that, the Party that is the recipient of such Confidential Information shall give prompt notice to the Disclosing Party, use all commercially reasonable efforts to maintain the confidentiality of the Confidential Information, and cooperate with the owner of such Confidential Information, in efforts to protect the confidentiality of such Confidential Information by an appropriate protective order. The owner of such Confidential Information reserves the right to obtain a protective order or otherwise protect the confidentiality of such Confidential Information. Each Party shall be responsible for its own costs with respect to the performance of its obligations under this Section. Either Party may disclose the existence of this Agreement and the terms of this Agreement to the extent required to enforce its terms or the rights of such Party hereunder or to comply with its legal obligations (but in the event either Party files this Agreement or portions thereof with any public agency it shall redact sensitive portions hereof, to the mutual written agreement of the other Party, which agreement shall not be unreasonably withheld or delayed).

10.2.4 **Anthem Non-Disclosable Information.** With respect to Anthem only, Confidential Information shall also include the following: (i) PHI and NPFI; (ii) other medical information and

personal information regarding Anthem's or its Affiliates' health plan members, employees, or medical or hospital service providers; (iii) other information that Anthem or its Affiliates are required by law, regulation or company policy to maintain as confidential; (iv) other financial information concerning Anthem's or its Affiliates' health plan members, employer groups and other health plan groups or medical or hospital service providers that is disseminated by Anthem or its Affiliates internally for staff use; (v) personnel and payroll records, patient accounting and billing records, and information contained in those records; (vi) Anthem's or its Affiliates' trade secrets; and (vii) information that could aid others to commit fraud, sabotage or otherwise misuse Anthem's or its Affiliates' products or services or damage their business, including without limitation Exhibit F attached hereto and other Anthem security policies (collectively, the "Anthem Non-Disclosable Information"). Due to the sensitive nature of the Anthem Non-Disclosable Information and due to Anthem's obligations to maintain the privacy of its customers and providers, Supplier acknowledges and agrees that Anthem Non-Disclosable Information shall at all times remain confidential and shall not be subject to exceptions, except as set forth in Exhibit A, BAA.

10.3 General Obligations. Each Party agrees to hold the Confidential Information of the other Party in strict confidence, to use such information solely in the course of performing its obligations hereunder, and to make no disclosure of such information except as authorized in accordance with the terms of this Agreement. To the extent a Party may be exposed to the Confidential Information of a third party (for example, because Supplier may be maintaining Anthem systems on which third party software is loaded, the Parties agree to accord such third party Confidential Information the same protections accorded a Party's Confidential Information hereunder. A Party may disclose Confidential Information to its personnel and the personnel of its subcontractors who have an absolute need to know such Confidential Information in order to fulfill its obligations hereunder and who have previously executed a written confidentiality agreement imposing confidentiality obligations no less restrictive than those applicable hereunder. In addition, either Party may disclose Confidential Information of the other Party to third party professional advisors (including accountants, auditors, attorneys, financial or other advisors) which are acting solely for the Party's benefit and on such Party's behalf, provided: (i) such professional advisors have previously executed a written confidentiality agreement imposing confidentiality obligations no less restrictive than those applicable hereunder; (ii) such professional advisors have a need to know such information in order to provide advice or services to the disclosing Party and agree to use the disclosing Party's Confidential Information solely for the purpose of providing such advice or services; (iii) such professional advisors agree not to disclose the Confidential Information to any other Party without the disclosing Party's prior written consent; and (iv) notwithstanding anything to the contrary, no Anthem Non-Disclosable Information is disclosed by the other Party to its professional advisors. Each Party shall be primarily responsible and liable for any confidentiality breaches by its personnel and the personnel of its subcontractors. Each Party shall immediately advise the other Party of any actual or potential violation of the terms of this Section 10, and shall reasonably cooperate with the Disclosing Party in relation thereto.

10.4 Continuing Obligations. A Party's obligation to maintain the confidentiality of Confidential Information shall remain in force until information falls within one of the exceptions noted in Section 10.2.2. Supplier's obligation to maintain the confidentiality of Anthem Non-Disclosable Information shall neither terminate nor expire.

10.5 Return of Confidential Information. Promptly upon expiration or termination of the entire Agreement or of a SOW (with regard to the Confidential Information disclosed under the Agreement or through such Agreement or SOW, as the case may be) or, in the case of Non-Disclosable Information at any time upon Anthem's request, the Receiving Party shall promptly, at the Disclosing Party's option, either return or destroy all (or, if the Disclosing Party so requests, any part) of the Confidential Information, and all copies, summaries and redactions thereof and other materials containing such Confidential Information, including deletion from such Party's files and systems and the Receiving Party shall certify in writing its compliance with the foregoing. Notwithstanding the foregoing, except for

PHI or NPFI (which shall be promptly returned or destroyed), each Party may, subject to the obligations of confidentiality as described in this Section 10, retain (i) one (1) copy of the other Party's Confidential Information for archival purposes only, but such retained Confidential Information shall only be accessed by the retaining Party on a limited need basis to, for example, defend a claim by the other Party or for auditing purposes and (ii) reasonable archival records of payments, invoices and similar information for tax compliance, regulatory compliance, accounting, audit or similar purposes but only for the period of time required by this Agreement or Applicable Law; in each instance, all such retained Confidential Information shall remain the Confidential Information of the Disclosing Party and shall be subject to all of the restrictions contained in this Agreement.

10.6 Injunctive Relief. Each Party acknowledges that in the event of a breach of this Section 10 damages may not be an adequate remedy and the Disclosing Party may be entitled to seek, in addition to any other rights and remedies available under the Agreement or at law or in equity, injunctive relief to restrain any such breach, threatened or actual, without proof of irreparable injury and without the necessity of posting bond even if otherwise normally required.

11. INSURANCE.

11.1 Minimum Requirements. The Supplier shall, at all times during the term of this Agreement keep in force with insurers with an A.M. Best rating of A- or better:

- i. Commercial General Liability insurance with a limit of not less than \$1,000,000 per occurrence and \$2,000,000 in the aggregate naming Anthem as an additional insured and containing a waiver of subrogation;
- ii. Automobile Liability insurance with a minimum \$1,000,000 per occurrence combined single limit for owned, non-owned and hired automobiles;
- iii. Workers' Compensation coverage with statutory limits and employers liability insurance, containing a waiver of subrogation with respect to Anthem for workers' compensation when applicable and permitted by law; unless, if Supplier is a sole proprietor, and is not, pursuant to applicable laws, statutes, rules or regulations required to required workers' compensation;
- iv. Professional Liability insurance, applicable to the industry or specialty with a minimum \$1,000,000 limit for each wrongful act and aggregate of not less than \$3,000,000 if professional services are being rendered. In the event of cancellation of the professional liability insurance policy, an extended reporting period endorsement ("tail policy") is required for the term of at least one year in the amount of not less than the same limits above;
- v. Commercial Crime/Employee Dishonesty with a limit of not less than \$500,000. When applicable, Supplier will name Anthem as Loss Payee to the extent their interests may appear;
- vi. Cyber, Network Security and Privacy liability) coverage with a minimum of not less than \$1,000,000 per claim;
- vii. Technology Professional Liability insurance, including Network Security and Privacy liability with a minimum \$5,000,000 limit for each wrongful act and aggregate of not less than \$5,000,000 if professional services are being rendered. In the event of cancellation of the professional liability insurance policy, an extended reporting period endorsement ("tail policy")

is required for the term of at least one year in the amount of not less than the same limits above, and

- viii. Umbrella Liability Coverage with a minimum of not less than \$2,000,000.

The forgoing coverage amounts, with the exception of the Umbrella Liability coverage, may be met in part by an appropriate umbrella or excess liability policy.

11.2 Any materials or equipment brought on jobsite shall be insured under an all risk property insurance policy and shall be the sole responsibility of Supplier.

11.3 Supplier agrees that any subcontractors coming on the jobsite shall maintain workers' compensation insurance coverage. Supplier is solely responsible and liable for its subcontractors and any actions or inactions, damages or injuries by or to its subcontractors.

11.4 Proof of Insurance; Notice of Cancellation. Promptly upon Anthem's written request for same, Supplier shall cause its insurers or insurance brokers to issue certificates of insurance evidencing that the coverages required under this Agreement are maintained and in force. In addition, Supplier will use reasonable efforts to give thirty (30) days prior written notice to Anthem prior to cancellation or non-renewal of any of the policies providing such coverage; provided, however that Supplier shall not be obligated to provide such notice if, concurrently with such cancellation or non-renewal, Supplier provides self-insurance coverage as described below or obtains coverage from another insurer meeting the requirements described above. The furnishing of acceptable evidence of insurance does not relieve Supplier from any liability or obligation for which it is otherwise responsible to Anthem. The limits of insurance or applicable deductibles will not limit the liability of Supplier nor relieve Supplier of any liability or financial responsibility. Failure to maintain the required insurance coverage shall be deemed a material breach of the Agreement by Supplier. The failure of Supplier to purchase or maintain such insurance coverages, or the failure of Supplier to provide, or of Anthem to request, a copy of the certificates evidencing such coverages will not be considered or construed as a waiver by Anthem of the requirement that Supplier maintains such coverages, which such requirement will be continuing, and Supplier remains liable for all injuries and/or damages in accordance with the terms of this Agreement.

11.5 Supplier Right to Self-insure Coverage. Notwithstanding the foregoing, Supplier reserves the right to self-insure coverage, in whole or in part, in the amounts and categories designated above, in lieu of Supplier's obligations to maintain insurance as set forth above, at any time. Promptly upon Anthem's written request for same, Supplier shall provide evidence of all self-insured coverages required under this Agreement.

12. REPRESENTATIONS, WARRANTIES, AND COVENANTS.

12.1 General Warranties of Both Parties

12.1.1 Compliance with Laws. Each Party shall at all times comply with all Applicable Laws and regulations in the performance of this Agreement

12.1.2 Existence. Each Party is duly organized and existing and is in good standing and is qualified to do business under the laws of any jurisdiction where the ownership of assets or conduct of its business require it to be so qualified, and each Party possesses any and all licenses and/or governmental approvals required to perform the Services and/or to provide the Supplier-Provided

Materials contemplated by this Agreement, and is qualified to perform such Services and/or provide such Supplier-Provided Materials.

12.1.3 Duly Authorized. Each Party's execution, delivery and performance of this Agreement has been duly authorized by all appropriate corporate action and this Agreement constitutes a valid, binding and enforceable obligation.

12.2 Supplier's Representations, Warranties, and Covenants. Supplier hereby represents, warrants and covenants:

12.2.1 No Conflict. Neither the execution, delivery, nor performance of this Agreement will conflict with or violate any other agreement, license, contract, instrument or other commitment or arrangement to which either Party is bound.

12.2.2 No litigation. There is no litigation and Supplier knows of no material threat of litigation that will affect the performance of its obligations hereunder.

12.2.3 Performance. At all times during the Term, each of Supplier's personnel assigned to perform Services or any other obligations under the Agreement shall have the proper skill, training and background so as to be able to perform the Services required to be performed by it hereunder and will perform such Services in a timely, good, workmanlike manner in accordance with high industry standards for such Services. At a minimum, Supplier will maintain staffing levels and continuity of personnel consistent with its obligations to perform Services hereunder and in the event of a delay or other problem, Supplier will train and staff additional personnel as needed.

12.2.4 Supplier's Employees. Supplier shall perform all obligations of an employer with respect to all personnel hired by Supplier in connection with any Services to be performed, including, but not limited to the withholding and reporting of contributions, insurance deductions and applicable taxes (including payroll and unemployment insurance taxes) required by Applicable Law.

12.2.5 Continuity of Key Personnel. Key personnel, if so specified in a SOW, shall be assigned pursuant to such SOW and should any such key personnel be unable to perform his or her obligations for any reason, Supplier shall replace such personnel as quickly as possible with personnel approved by Anthem in its sole discretion.

12.2.6 No Material Defects; Conformity with and Completeness of Documentation. Any Services and/or Supplier-Provided Materials to be provided, as applicable, shall be free from material errors or other defects; shall function properly; and shall substantially conform to all written specifications applicable thereto for a period of one (1) year after conclusion of any Final Acceptance Period. The Documentation and other materials describing the Services and/or Supplier-Provided Materials hereunder completely and accurately reflect their operation and functionality. If the Services and/or Supplier-Provided Materials include a service or product from a third party and that third party provides a warranty, Supplier shall assign all rights under the third party warranty to Anthem.

12.2.7 All Rights; No infringement. Supplier has all rights and authorizations necessary to perform any Services and/or use or provide any Supplier-Provided Materials for Anthem's use and enjoyment as contemplated herein; and that unless otherwise specified in a SOW or attachment thereto, Supplier shall deliver all Deliverables and/or other Supplier-Provided Materials to Anthem free and clear of any liens, claims, charges or encumbrances; and that Supplier has proper title in all Deliverables and/or other Supplier-Provided Materials for which ownership is to be transferred to Anthem. Further, if applicable, Supplier shall pass through to Anthem any product and third party end-user warranties and indemnities relating to the Deliverables. To the extent Supplier is not permitted to so pass-through,

Supplier agrees to enforce such warranties and indemnities on behalf of Anthem. All Supplier-Provided Materials, and all elements thereof to be provided by Supplier, if any, unless provided by Anthem, and any Services performed by Supplier, will not violate, misappropriate or infringe upon any patent, copyright, trademark, trade secret, or other intellectual, contractual, proprietary, employment, or confidentiality right of a third party; there are no claims of any third party against Supplier relating to any IP that is the subject of, to be provided under, or to be used directly or indirectly pursuant to this Agreement.

12.2.8 No Disabling Devices. All Supplier-Provided Materials and/or Services provided by Supplier do not, and will not when delivered or provided, contain any computer code (i) designed to disrupt, disable, harm, or otherwise impede in any manner the operation thereof, or any other associated software, firmware, hardware, computer system or network (sometimes referred to as “viruses” or “worms”) and Supplier has taken reasonable steps to test for, and has found no such, viruses or worms. Supplier shall not allow unauthorized traffic to pass into Anthem’s networks. Supplier agrees that in the event of any dispute with Anthem regarding an alleged breach of this Agreement or for any other reason, Supplier will not use any type of electronic means to prevent or interfere with Anthem’s use of any system or Deliverable created for Anthem under this Agreement or any SOW without first obtaining a valid court order authorizing same. Anthem shall be given proper notice and an opportunity to be heard in connection with any request for such a court order. Supplier understands that a breach of this provision could foreseeably cause substantial harm to Anthem and to numerous third parties having business relationships with Anthem. No limitation of liability shall apply to a breach of this paragraph.

12.2.9 Deliverable Functionality. Each Deliverable will accept input, perform processes, and provide output in a manner that (i) is consistent with its intended use and all applicable specifications; (ii) prevents ambiguous or erroneous results; and (iii) will not result in any adverse effect on functionality or performance of any Deliverable.

12.2.10 Alpha/Beta Site. Supplier shall not use Anthem as an alpha or beta site for any Supplier-Provided Materials or Services to be provided, if any, without the prior written consent of Anthem.

12.2.11 Government Programs; Ineligible Persons. Supplier represents and warrants that neither Supplier nor its employees, subcontractors or agents providing Services or Supplier-Provided Materials under this Agreement has been, nor shall be during the term of this Agreement (i) excluded from participation in the Medicare, Medicaid and/or any state health care program; (ii) listed on any General Services Administration List of parties Excluded from Federal Procurement and Non-procurement Programs; (iii) sanctioned by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of Inspector General, or any other federal agency; and (iv) under a corporate integrity agreement with the United States Department of Health and Human Services, Office of Inspector General, or any other federal agency; in the event Supplier or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Supplier has an obligation to (i) immediately notify Anthem of Supplier’s status as an ineligible person and (ii) within ten (10) days of Supplier receiving such notice, Supplier will remove such individual from responsibility for, or involvement with, Supplier’s business operations related to the federal government healthcare contracts. Anthem shall have the right to immediately terminate this Agreement or applicable SOW in the event it receives notification of the Supplier’s ineligible person status. Supplier also covenants and represents that it complies with the rules set forth by the Office of Foreign Assets Control of the United States Department of Treasury.

12.2.12 Criminal Convictions. Neither Supplier nor its employees, subcontractors or agents has been, nor shall be during the Term, convicted of a criminal offense related to the delivery of an item or service under Medicare, Medicaid and/or under any state health care program.

12.2.13 Embedded Software. All Open Source Software (as defined herein) and non-Open Source third-party software components provided by Supplier to Anthem shall be considered "Embedded Software" and subject to all warranties, indemnities and other requirements of this Agreement, including scope of license, maintenance and support. "Open Source Software" means any software, programming or other IP that (a) contains or is derived in any manner (in whole or in part) from any software that is distributed as free software, open source software, shareware or similar licensing or distribution models; and (b) is subject to any agreement with terms requiring that such IP be (i) disclosed or distributed in source code or object code form; (ii) licensed for the purpose of making derivative works; and/or (iii) freely redistributable by end users to third parties without payment of compensation. Open Source includes but is not limited to software licensed or distributed under any of the following licenses or distribution models: the GNU General Public License, GHN Library General Public License, Artistic License, BSD license, Mozilla Public License, or any similar license, including those licenses listed at www.opensource.org/licenses. Supplier has identified each item of Embedded Software in an attachment to this Agreement or in the Order Schedule, and has provided Anthem with copies of all relevant license agreements relating to such Open Source Software, and has sufficient rights to provide all Embedded Software to Anthem for use as permitted hereunder.

12.2.14 Compliance with Applicable Laws. Supplier shall perform its obligations hereunder in accordance with all Applicable Law, and shall be responsible for obtaining all licenses, authorizations, permits and the like required by Applicable Laws and regulations, and any fees, costs or expenses incurred by Supplier shall be borne solely by Supplier. Supplier shall be solely responsible for any fines and penalties imposed on Supplier or Anthem resulting from Supplier's failure to comply with any such Applicable Laws and regulations and Supplier shall indemnify, protect and defend Anthem therefrom.

12.2.15 Location of Work. Supplier warrants that all Services shall be performed in locations approved in writing by Anthem in advance. All such locations shall be in the United States and at no other location, and any Services governed by Exhibit E shall be provided in the applicable State unless otherwise agreed in writing by Anthem.

12.2.16 Compliance with Foreign Corrupt Practices Act.

12.2.16.1 Acknowledgement. The FCPA makes it unlawful for a U.S. Company, U.S. citizens, or anyone acting on a U.S. company's behalf (including certain foreign subsidiaries of U.S. companies) to offer, pay, promise or authorize to pay any money, gift or any other items of value directly or indirectly to any Foreign Official with the intent of causing the Foreign Official to misuse such official's position to obtain or retain business for the U.S. company or one of its subsidiaries or affiliates. Under the FCPA, the term Foreign Official is broadly defined to include not only traditional government officials and those employed by government agencies, departments, or ministries, but also employees of companies which are owned or controlled by the state. To obtain or retain business has also been construed broadly to mean other discretionary decisions of government officials, even if they do not relate directly to purchasing decisions. Supplier acknowledges and confirms its understanding of the FCPA, and its receipt of a copy of the FCPA, and agrees to comply with those provisions and not to take or fail to take any action that might in any way cause Supplier or the Company to be in violation of the FCPA, or any other applicable anti-bribery laws (including the U.S. Travel Act).

12.2.16.2 Representations, Warranties and Covenants of Supplier. Supplier makes the following representations and warranties to Anthem, and covenants and agrees as follows:

12.2.16.2.1 Public and Commercial Bribery Representations, Warranties and Covenants of Supplier. Supplier hereby represents, warrants and covenants to Anthem that it has not, and covenants and agrees that it will not, in connection with the transactions contemplated by the Agreement or in connection with any other business transactions involving Anthem, make or promise to make any payment or transfer of any item of value, directly or indirectly to any Foreign Official with the intent of causing the Foreign Official to misuse such official's position to obtain or retain business for Anthem or one of its subsidiaries or affiliates. In addition, Supplier will not provide any gifts or business entertainment to a Foreign Official on behalf of the Company, or in connection to any business transactions involving the Company, without the written pre-approval by the Company's Chief Compliance Officer and Chief Accounting Officer (or their designees). It is the intent of the parties that no payments or transfers of value shall be made which have the purpose or effect of public or commercial bribery, acceptance of or acquiescence in extortion, kickbacks or other unlawful or improper means of obtaining business.

12.2.16.2.2 No Governmental Ownership of Supplier. Supplier hereby represents and warrants to Anthem that no ownership interest, direct or indirect, in Supplier or in the contractual relationship established by the Agreement, is held or controlled by any Foreign Official, governmental body, political party, or a family member (or friend) of a Foreign Official through whom the Foreign Official will indirectly benefit from the Agreement.

12.2.16.2.3 Supplier Compliance Procedures Acknowledgement. Supplier agrees (i) any payments to Supplier by Anthem under the Agreement shall be made by check or wire transfer only, directly to Supplier or to a bank account in Supplier's name, and no requests for cash payments or other payments in non-bearer form shall be accepted; (ii) any payments to Supplier by Anthem shall be made in the country where Supplier is to perform its duties under the Agreement or in the United States; (iii) Supplier agrees that its books and records showing expenses incurred pursuant to this Agreement shall reflect the purpose for which each expenditure was made and for whose benefit the expenditure was made and that there will be written records of each and every service that Supplier performs for Anthem or on Anthem's behalf; (iv) Supplier shall retain accurate, detailed records of, and permit Anthem to review upon written request, any expenses or costs of Supplier which Anthem is required to reimburse under the Agreement, including any training-related expenses; and (v) the terms of the Agreement may be disclosed to government agencies and other persons with a legitimate need for such information, including, but not limited to, the U.S. Department of Justice.

12.2.16.3 Anthem's Rights upon an FCPA Default. In the event that Anthem believes in good faith, and whether or not it has conducted an investigation, that Supplier has acted in any way that may subject Anthem or any of its affiliates to liability under the FCPA, Anthem shall have the unilateral right, exercisable immediately upon written notice to Supplier, to terminate the Agreement, subject to the provisions of **Section 7** of the Agreement

12.2.17 Affordable Care Act Compliance

12.2.17.1 For purposes of Section 4980H of the Internal Revenue Code of 1986, as amended ("Code"), Supplier agrees and confirms that Supplier, and not Anthem, is the common-law employer of each Supplier personnel. Accordingly, the Supplier is responsible for complying with the requirements of Section 4980H of the Code, and the regulations promulgated thereunder with respect to each Supplier personnel, including, without limitation, the obligation to offer "Compliant Coverage" (as hereafter defined) on behalf of Anthem in accordance with Treas. Reg. § 54.4980H-4(b)(2). As such,

the Parties acknowledge and agree that the fee paid by Anthem to Supplier is higher than the fee that Anthem would otherwise pay the Supplier if the Supplier personnel did not enroll in such Compliant Coverage. For purposes of this Agreement, "Compliant Coverage" means coverage under an "eligible employer-sponsored plan" under Code Section 5000A(f)(2) and applicable regulations and guidance thereunder sponsored by Supplier which, with respect to the individual covered by such coverage, as applicable, (i) provides "minimum essential coverage" as defined in Code Section 5000A(f)(1); and (ii) satisfies the terms of Code Section 36B(c)(2)(C)(i) (coverage must be affordable) and Code Section 36B(c)(2)(C)(ii) (coverage must provide minimum value).

12.2.17.2 For each calendar month covered by this Agreement, Supplier shall provide each Supplier personnel who is a "full-time employee," as defined in Code Section 4980H(c)(4), the opportunity to enroll himself/herself, and his/her "Dependent(s)" (as defined under applicable regulations and guidance under Code Section 4980H) in Compliant Coverage. Supplier, and not Anthem, shall be responsible for determining whether any Supplier personnel is a full-time employee under Code Section 4980H(c)(4), which determination shall be made in accordance with a method for determining whether an employee is a full-time employee described in applicable regulations or guidance issued under Code Section 4980H. The obligation to provide Compliant Coverage under this subsection applies even to those employees who Supplier determines are not full-time employees, but who are later determined by the Internal Revenue Service, a court or other governmental authority to be full-time employees under Code Section 4980H(c)(4).

12.2.17.3 Supplier's obligations under Section 12.2.17.2 above are absolute and are not dependent on whether Supplier would be subject to a "Penalty" (as hereafter defined) if Supplier personnel enrolled in a qualified health plan with respect to which an applicable premium tax credit or cost-sharing reduction is allowed or paid with respect to the Supplier personnel. By way of illustration and not limitation, Supplier shall, for example, be obligated under Section 12.2.17.2 to offer any Supplier personnel the opportunity to enroll in Compliant Coverage regardless of whether Supplier is, in fact, an "applicable large employer" with respect to such Supplier personnel or whether Supplier has determined that, if Supplier failed to offer Compliant Coverage to an Supplier personnel for any reason, such as offering Compliant Coverage to at least 95% of its other full-time employees, Supplier would not be subject to a Penalty. For purposes of this Agreement, "Penalty" means an assessable payment described in Code Section 4980H(a) or Code Section 4980H(b).

12.2.17.4 At least annually, or with such other frequency as reasonably requested by Anthem, Supplier shall certify to Anthem its compliance with the terms of this Section 12.2.17.

12.2.18 Outbound Telecommunications Requirements

12.2.18.1 Supplier shall comply with all applicable telecommunication laws and regulations including, without limitation, the Telephone Consumer Protection Act (47 USC 227), and the rules, and regulations and guidance promulgated thereunder issued by the Federal Communications Commission (47 CFR Parts 64 and 68); the Telemarketing and Consumer Fraud and Abuse Prevention Act (15 USC 6101-8) as implemented by the Telemarketing Sales Rule issued by the Federal Trade Commission (16 CFR Part 310); and all state laws, rules, regulations and (for Medicaid) state contract provisions that apply to outbound health related telephone contact, including text or SMS messages sent to wireless numbers, and outbound telemarketing telephone contact, including text or SMS messages sent to landline or wireless numbers with Covered Individuals, potential members, and providers.

12.2.18.2 Further, Supplier is subject to Anthem's VENDOR GUIDELINES FOR TCPA (the "Guidelines"), which Anthem shall communicate to Supplier in writing (email is acceptable). The Guidelines are designed to ensure that Anthem's outbound telephone contacts with Covered Individuals or potential members, including text or SMS messages, comply with the law and also meet Anthem's quality standards. To the extent the Guidelines conflicts with terms of this agreement, the Guidelines shall govern.

12.2.18.3 In accordance with Anthem's record retention obligations, Supplier is responsible for retaining records, including but not limited to call logs and recordings, in accordance with Anthem's requirements and must retain records for at least four years from the last phone call or text message. Supplier shall inform Anthem, in writing, at least five business days prior to the disposal of any such records. This writing shall be sent to TCPAComplianceHelpDesk@Anthem.com and copied to your Anthem contact.

12.2.18.4 Supplier shall comply with the Guidelines existing as of the Effective Date and shall take all necessary steps to remain compliant with the Guidelines as they are amended and revised from time to time

12.2.18.5 Supplier is responsible for compliance with the obligations stated above and will indemnify Anthem, including reimbursement of attorney's fees and costs associated with litigation, and accept Anthem's tender of defense should there be a lawsuit or third-party claim against Anthem relating to Supplier's alleged violation of the above-mentioned laws, including the TCPA.

12.2.19 Website Accessibility Standards. To that extent that Supplier is providing development, design and/or maintenance of any electronic and information technology, including, without limitation, any consumer facing web and mobile experiences, Supplier shall ensure that all such electronic and information technology meets, to the extent possible, the accessibility requirements set forth in Section 508 of the Rehabilitation Act (29 USC 794(d)), the related Technical Standards issued by the Architectural and Transportation Barriers Compliance Board (aka the "Access Board"), success level AA or higher of the most current Web Content Accessibility Guidelines issued by the Worldwide Web Consortium, and any other federal or state law which requires specific design elements to accommodate disabled individuals.

12.2.20 Certain Employment Obligations. When Supplier provides services or goods to Anthem relating to one of its federal contracts, Supplier agrees to comply with the following federal regulations, as applicable: **Supplier shall abide by the requirements of 41 CFR §§ 60-1.4(a), 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities, and prohibit discrimination against all individuals based on their race, color, religion, sex, or national origin. Moreover, these regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, national origin, protected veteran status or disability.**

12.2.21 Certification of Compliance. Upon request by Anthem, Supplier shall provide Anthem with reasonable assurances of Supplier's compliance with the terms of this Agreement and any Exhibit(s). Reasonable assurances may include, but are not limited to, Supplier's signed certification of such compliance, as it applies to certain requirements, and/or the Agreement or Exhibit(s) generally.

12.3 Certain Warranty Remedies. Should Anthem be prevented from using any Supplier-Provided Materials or receiving any Service due to a breach of the aforementioned warranties, and in addition to all other obligations and remedies herein, Supplier shall at its expense but at Anthem's discretion, and in addition to any other rights or remedies available to Anthem under the Agreement, at law or in equity, (i) modify the Supplier-Provided Materials without impairing in any material respect its functionality or performance, so that it complies with all warranties, (ii) in the case of an infringement of third-party rights, procure for Anthem the right to continue to use the Supplier-Provided Materials or affected Service, or (iii) replace the affected Supplier-Provided Materials with equally suitable and functionally equivalent, non-infringing software, materials, equipment, processes, items, and/or documentation, as applicable, or, as to Services, secure equally suitable alternatives.

12.4 Refund for Certain Service Failures. To the extent Services are to be performed by Supplier and Supplier fails to provide Services in accordance with this Agreement, Supplier shall at its expense but at Anthem's discretion, and in addition to any other rights or remedies available to Anthem under the Agreement, at law or in equity, refund to Anthem all amounts paid for the failed Services and all other Services materially or adversely affected.

12.5 Anthem's Representations and Warranties. Anthem hereby represents and warrants that the materials provided to Supplier by Anthem, and elements thereof, shall not, to the best of Anthem's knowledge, violate or infringe upon any IP or confidentiality right of a third party.

13. INDEMNIFICATION.

13.1 Supplier's Indemnities. Supplier shall indemnify, defend and hold harmless Anthem and its Affiliates, and their respective successors and assigns (and its and their respective officers, directors, employees, sublicensees, customers and agents) from and against any third party claims and damages based upon (i) any allegation that any portion of the Supplier-Provided Materials and/or Services, as applicable, provided by Supplier to Anthem pursuant to this Agreement, infringes, misappropriates or violates any IP right of any person or entity; (ii) a breach of Supplier's representations and warranties; (iii) the failure by Supplier to comply with applicable governmental laws or regulations; (iv) a breach of Supplier's obligations with regard to PHI and NPFI as set forth in Section 10 and Exhibit A (BAA); (v) a breach of Supplier's obligations under Exhibits B, C, E and/or G, (vi) a breach of Supplier's security or confidentiality obligations as set forth in Sections 9 (Security) (including Exhibit G referenced therein) and 10 (Confidentiality), respectively; (vii) any claim relating to any act, omission, negligence or willful misconduct on the part of Supplier, its personnel, subcontractors, and/or agents, resulting in personal injury, death, or damage to property; (viii) any claim of a Supplier subcontractor against Anthem; and (ix) any act or conduct by a subcontractor based on a claim falling within the foregoing categories (i) through (viii), inclusive. In addition to the indemnification obligations set forth in this Agreement, in the event of a disclosure of Protected Health Information or Nonpublic Personal Financial Information by Supplier, Supplier shall indemnify Anthem for all costs related to the investigation as well as, at Anthem's election, furnishing notice to affected Anthem participants and/or the offer of ongoing credit monitoring services to such affected individuals. This indemnification by Supplier shall survive the termination of this Agreement.

13.2 Anthem's Indemnities. Anthem shall indemnify, defend and hold harmless Supplier from and against any third party claims and damages based upon (i) any allegation that the Confidential Information provided by Anthem to Supplier pursuant to this Agreement infringes, misappropriates or violates any IP right of any person or entity; (ii) any claim relating to any act, omission, negligence or willful misconduct on the part of Anthem or its personnel resulting in personal injury, death, or damage to

property; (iii) breach of Anthem's representations and warranties; and (iv) breach of Anthem's confidentiality obligations as set forth in Section 10.

13.3 Notice and Participation. The indemnified Party may, at its own expense, assist in the defense of any indemnifiable claim described in this Section 13 if it so chooses, provided that, as long as indemnifying Party can demonstrate sufficient financial and legal resources, indemnifying Party shall control such defense and all negotiations relative to the settlement of any such claim, and further provided that any settlement intended to bind the indemnified Party or which may adversely affect the indemnified Party shall not be final without such indemnified Party's prior written consent, not to be unreasonably withheld or delayed. Notwithstanding the foregoing, if the claim relates to a violation of governmental law or regulation as set forth in Section 13.1 (iii) or to a breach of Supplier's obligations relating to PHI and NPFI as set forth in Section 13.1 (iv), and Anthem determines in its own discretion it has a compelling interest in conducting its own defense, then Supplier shall indemnify Anthem for Anthem's reasonable costs of defense (including attorneys' fees) and for all related damages, assessment of fines, penalties or other regulatory assessment, and/or settlement or compromise (and provided Anthem gives Supplier an opportunity to comment on any proposed settlement or compromise). The indemnified Party shall provide the indemnifying Party with reasonable written notice of any claim that such indemnified Party believes falls within the scope of this Section 13.3. Each Party shall use reasonable efforts to mitigate any potential damages or other adverse consequences arising from or related to the Services and/or Supplier-Provided Materials.

14. LIMITATION OF LIABILITY.

14.1 No Consequential Damages. Except as set forth in Section 14.3 below, neither Party or its Affiliates shall be liable for any indirect, incidental, special, consequential, exemplary or punitive damages (including, without limitation, loss of profits) arising out of or relating to this Agreement, even if such Party or its Affiliate has been advised of the possibility of such damages.

14.2 Limit on Direct Damages. Except as set forth in section 14.3 below, neither Party's nor its Affiliates' aggregate liability arising out of or relating to this Agreement shall exceed the greater of (a) the amount paid or payable by Anthem to Supplier, pursuant to this Agreement, in the thirty-six (36) months preceding the month in which the event occurred or dispute arose giving rise to the claim for damages or (b) two (2) times the total fees payable by Anthem to Supplier, or in the event the Services are provided pursuant to a credit from Supplier, then two (2) times the value of the credit pursuant to this Agreement. Any amount owed by Supplier to Anthem or its Affiliates in the way of Service credits and a failed service level agreement as set forth in a SOW, if applicable, shall not count toward any calculation of damages under this section.

14.3 Exceptions to Limitation of Liability. The limitations of liability in Sections 14.1 and 14.2 shall not apply to (i) a Party's indemnification obligations under the Agreement, (ii) a breach by a Party of its confidentiality or security obligations under the Agreement, (iii) claims relating to willful misconduct, gross negligence, personal injury or damage to property, (iv) abandonment by Supplier of the Agreement, a breach by Supplier of the paragraph entitled "Electronic Self-Help", or (v) any fines or penalties arising from Supplier's acts or omissions in performing Services (unless such acts or omissions were undertaken at Anthem's instruction).

15. SUBCONTRACTORS.

15.1 Supplier shall not subcontract any of its obligations without (i) notifying in writing Anthem of the scope of the proposed subcontract, the identity and qualifications of the proposed

subcontractor and the reasons for subcontracting the work in question (and allowing Anthem a reasonable period of time for evaluation of Supplier's request), (ii) causing the proposed subcontractor to agree in writing to perform and be subject to all of Supplier's obligations under this Agreement, and (iii) obtaining Anthem's prior written approval of that subcontractor. Neither Supplier nor any authorized subcontractor may subcontract its performance of any obligation under any Agreement without the prior written consent of Anthem in each instance. Supplier shall also include language in its subcontract prohibiting further subcontracting without Anthem's prior written approval.

15.2 Notwithstanding Anthem's approval of a subcontract arrangement, Supplier shall remain primarily liable for the performance of all subcontracted obligations and Supplier shall promptly pay for all Services, materials, equipment and labor used by Supplier. Regardless of any subcontract, Supplier shall remain Anthem's sole point of contact under this Agreement. At Anthem's reasonable request, Supplier shall promptly remove and/or replace any subcontractor.

16. DISPUTE RESOLUTION.

16.1 Informal Dispute Resolution.

16.1.1 Good Faith Efforts. The Parties agree that they will make a good faith attempt to resolve any dispute arising under this Agreement before instituting legal action. Such good faith attempt shall include, but not be limited to, elevating the issue to management personnel of each Party who have the power to settle the dispute on behalf of that Party and, failing that, to a vice president level executive for each Party, as noted in 16.1.2 below.

16.1.2 Escalation to Executives. To the extent any disagreements arising under this Agreement are not resolved by the management personnel of each Party within a reasonable time after the occurrence of the disagreement, either Party may give to the other notice in writing (the "Notice") that a dispute has arisen. The Notice shall contain (i) a detailed description of the dispute and all relevant underlying facts, and (ii) a detailed description of the amount(s) in dispute and how they have been calculated. Within fourteen (14) days after the date of the Notice, such dispute shall be referred to a vice president level executive for each Party.

16.1.3 Failure of Informal Efforts. If such executive officers of both Parties are unable to resolve the dispute within fourteen (14) days of the referral to them, either Party shall be free to pursue any claim in accordance with this Section 16.

16.2 Binding Arbitration.

16.2.1 Except as otherwise provided below in this paragraph, all disputes that arise from or relate to this Agreement shall be decided exclusively by binding, non-appealable arbitration in Marion County, Indiana under the JAMS Comprehensive Arbitration Rules (the "Rules"), provided, however, the Parties may agree in writing to further modify the Rules. The dispute shall be decided by a sole arbitrator, who shall be a retired or former judge, or an attorney with at least ten (10) years of experience, and be mutually acceptable to the Parties. If the amount in controversy exceeds two million dollars (\$2,000,000.00), then a three person panel of arbitrators with similar qualifications shall preside rather than a sole arbitrator, unless the Parties agree in writing that the dispute shall be decided by a sole arbitrator. The sole arbitrator (or panel) shall be selected by mutual agreement of the Parties, or, if the Parties cannot agree upon an arbitrator within ten (10) days, then each Party shall select an arbitrator who shall confer and select a third arbitrator to serve. If a three person panel is required, each Party shall select an arbitrator and the two arbitrators shall together designate a third to serve with them on such

panel. The arbitrator shall issue a short written statement (not to exceed 15 pages, excluding exhibits) setting forth its decision and reasons therefore. The Parties agree that the arbitrator's award shall be final, and may be filed with and enforced as a final judgment by any court of competent jurisdiction.

16.2.2 Costs and Fees. Each Party will bear its own attorneys' fees and its own costs and expenses (including filing fees), and will also bear one half of the total arbitrator's and other administrative fees of arbitration

16.2.3 No Power to Alter Agreement. The arbitrator shall have no power to (i) award damages in excess of the amount or other than the types allowed by Section 14 (Limitation of Liability); or (ii) alter any of the provisions of this Agreement. Either Party may seek interim measures of protection concerning any subject matter of the dispute subject to arbitration, including but not limited to interim injunctive relief, in a court of competent jurisdiction located in Marion County, Indiana.

16.2.4 Appeal. If the total amount of the arbitration award is five million dollars (\$5,000,000) or more, inclusive of interest, costs, and attorneys' fees, the Parties shall have the right to appeal the decision of the arbitrator(s) pursuant to the JAMS Optional Arbitration Appeal Procedure. In reviewing a decision of the arbitrator(s), the appeal panel shall apply the same standard of review that a United States Court of Appeals would apply in reviewing a similar decision issued by a United States District Court in the jurisdiction in which the arbitration hearing was held.

16.3 Disputes Involving Confidential Information or Intellectual Property. Notwithstanding the foregoing, in any dispute concerning Anthem Confidential Information and intellectual property, Anthem may elect to have the dispute resolved by a court of competent jurisdiction located in the Marion County, Indiana and upon Anthem's commencement of any such action, any arbitration then pending shall be stayed, insofar as it concerns Anthem Confidential Information or intellectual property. Without limiting the generality of the foregoing, Supplier acknowledges that irreparable injury may result to Anthem in the event that Supplier fails to perform its obligations under this Agreement with respect to Anthem Confidential Information or IP and agrees that, in such event, Anthem shall be entitled, in addition to any other remedies and damages available to it, to seek interim injunctive relief to restrain the breach or compel the performance of this Agreement.

16.4 Consent to Jurisdictions. The Parties consent and agree to the exclusive jurisdiction of the tribunals mentioned in this Section 16, and waive any and all objections to such forums, including but not limited to objections based on improper venue or inconvenient forum.

16.5 Waiver of Jury Trial. Each of the parties hereby unconditionally waives any right to a jury trial with respect to and in any action, proceeding, claim, counterclaim, demand, dispute or other matter whatsoever arising out of this agreement.

16.6 Continued Services; Enforcement. In all circumstances other than Anthem's failure to pay undisputed amounts as set forth herein, Supplier shall continue timely performance of any Services it provides or its other obligations under this Agreement and, if it discontinues or does not timely perform such Services or other obligations, Anthem may seek a temporary and/or permanent injunction or similar order in any state or federal court within the State of Indiana for the sole purpose of compelling continued and timely performance of Supplier's obligations hereunder. The provisions of this Section may be enforced by any court of competent jurisdiction, and the prevailing Party in any such action shall be entitled to an award of all costs, fees and expenses, including attorneys' fees.

16.7 Statute of Limitations. The statute of limitations with respect to any claim or matter submitted to arbitration shall be suspended as of the date of a demand for arbitration hereunder (or, if not determinable, as of the date of receipt of such request), and shall be tolled until the date of any formal settlement agreement entered into by the Parties or the date of any final determination issued by an arbitrator, as the case may be, but in any event not longer than six (6) months from the date such statute of limitations was suspended, unless the Parties specifically agree in writing to a different tolling period.

16.8 Electronic Self-Help. Supplier agrees that in the event of any dispute with Anthem regarding an alleged breach of this Agreement or for any other reason, Supplier will not use any type of electronic means to prevent or interfere with Anthem's use of any system or Deliverable created for Anthem under this Agreement or any SOW without first obtaining a valid court order authorizing same. Anthem shall be given proper notice and an opportunity to be heard in connection with any request for such a court order. Supplier understands that a breach of this provision could foreseeably cause substantial harm to Anthem and to numerous third parties having business relationships with Anthem. No limitation of liability shall apply to a breach of this paragraph.

17. MISCELLANEOUS.

17.1 Assignment. Supplier may not assign its rights or obligations under the Agreement to any third party without the prior written consent of Anthem. Anthem may assign this Agreement to any Affiliate or in the case of a merger or acquisition of all or substantially all of Anthem's assets. The Agreement shall be binding upon and inure to the benefit of the Parties and their respective successors and permitted assigns.

17.2 Trademarks and Branding/No Publicity.

17.2.1 Except as may be explicitly set forth in this Agreement, neither Party shall use the name, logo, service marks, domain names, symbols or any other name or mark of the other Party or the other Party's Affiliates, without the prior written consent of the other Party. Without limiting the foregoing, except as may be required by applicable law or legal process, neither Party shall at any time either during the Term or at any time after any expiration or termination of this Agreement: (i) disclose in advertising campaigns, public relation campaigns or otherwise publicize or disclose the existence of this Agreement, or any terms or conditions of this Agreement, or Anthem's or its Affiliates' status as a customer of Supplier (provided that each Party may disclose the existence of this Agreement when responding to a request for proposal or request for information) or (ii) provide a hyperlink from any Internet site that it maintains to any Internet site maintained by the other Party or any of the other Party's Affiliate. Supplier shall not extract any information or other data from any Internet site maintained by Anthem or any Anthem Affiliate, including framing and deep linking, without the express written consent of Anthem

17.2.2 In addition, Supplier has no license to use the Blue Cross and/or Blue Shield names, symbols, or derivative marks (the "Brands") and nothing in the Agreement shall be deemed to grant a license to Supplier to use the Brands. Any references to the Brands made by Supplier in its own materials are subject to review and approval by Anthem.

17.2.3 Supplier shall have the sole right to label and brand its services and products, and shall have the sole right to use its service and product names and brands. Anthem shall have the sole right to label and brand its services and products that are provided by Supplier or that use Supplier IP as permitted under this Agreement.

17.3 Governing Law. The Agreement shall be governed by and construed in accordance with the laws of the State of Indiana, without giving effect to its conflict of laws principles.

17.4 Notices. All notices, requests, claims, demands, and other communications (each a “*Notice*”) under the Agreement shall be in writing and shall be given or made by delivery in person, by email, by facsimile, by courier service, or by certified mail (postage prepaid, return receipt requested) to the respective Party at the following address set forth below or at such other address as such Party may hereafter notify the other Party in accordance with this Section. Each such Notice will be effective as follows: (a) as of the day transmitted by facsimile if receipt has been electronically confirmed; (b) as of the date emailed if receipt has been electronically confirmed or so long as a duplicate copy is contemporaneously provided by another Notice methodology set forth in this Section; (c) as of the date actually delivered if sent by a recognized commercial express delivery service that uses delivery tracking technology; (d) four (4) business days after the date actually deposited with the U.S. mail if sent postage-paid First Class; and (e) as of the date actually delivered if delivered by personal courier to the office location of the recipient during normal business hours.

For Anthem:

Anthem, Inc.
220 Virginia Avenue
Indianapolis, IN 46204
Attention: General Counsel

With a mandatory copy to:

Anthem, Inc.
220 Virginia Avenue
Indianapolis, IN 46204
Attention: Procurement - Contract Administration

For Supplier:

Please provide the following and then delete this list

Vendor name
Vendor Contact Name
Vendor Contact Address
Vendor Contact Phone Number
Vendor Contact E-Mail

17.5 Modification; Waiver.

17.5.1. No modification to the Agreement shall be valid unless in writing and signed by each Party. No delay or omission by either Party to exercise any right or power it has under this Agreement shall impair or be construed as a waiver of such right or power. A waiver by any Party of any breach or covenant shall not be construed to be a waiver of any succeeding breach or any other covenant. All waivers must be in writing and signed by the Party waiving its rights.

17.5.2. Nothing on any invoice, purchase order acknowledgment, click wrap, shrink wrap license or any other “boilerplate” or standard terms issued by Supplier at any time during the Term

shall contradict, vary or amend the terms of this Agreement and any contrary or differing term shall have no force and effect.

17.6 No Gratuities or Kickbacks. Anthem may, by written notice to Supplier, terminate the Agreement, any SOW, and some or all rights of Supplier hereunder, if Anthem has a reasonable cause to believe that gratuities (in the form of entertainment, gifts or otherwise that are of inappropriate value and/or not in accordance with Anthem's policies in excess of that which is reasonable and customary in Anthem's industry, or which would not be considered in good taste if publicly scrutinized) were offered or given by Supplier, or any employee, subcontractor, agent or representative of Supplier, to an officer or employee of Anthem or any Anthem Affiliate in a position to secure or influence the awarding or amendment of the entire Agreement or, of any SOW or any determination with respect to Supplier's performance hereunder, or any decision or action favorable to Supplier.

17.7 Force Majeure.

17.7.1 General. A delay by a Party in the performance of its obligations under this Agreement shall not be deemed a default of this Agreement to the extent that such delay is attributable to a Force Majeure Event and could not have been prevented or minimized by the non-performing Party by means of the exercise of reasonable precautions, or cannot reasonably be circumvented by the non-performing Party in a commercially reasonable manner, including through the use of alternate sources or work-around plans. Notwithstanding the foregoing, Supplier acknowledges and agrees that this Section 17.7 shall not limit Supplier's obligation to initiate the applicable BCP and provide timely and effective disaster recovery for the Services described in this Agreement, the applicable Statement of Work, or any Exhibits and schedules thereto.

17.7.2 Right to Terminate. If a Force Majeure Event prevents, hinders or delays a Party's ability to perform for more than ten (10) days and materially and adversely affects the other Party, then in such event the other Party may, in its reasonable discretion, choose to terminate the applicable Statement of Work upon written notice.

17.7.3 Force Majeure Event. The term "Force Majeure Event" shall mean a fire, flood, earthquake, terrorism, or similar act beyond the reasonable control of a Party. A strike, lockout or similar labor dispute by Supplier personnel shall be deemed to be within Supplier's reasonable control. In addition, if Supplier reasonably believes that an act of war, riot, civil disorder, or rebellion is likely, either Party may request that certain changes to the Services be proposed in light of such Force Majeure Event. Unless otherwise mutually agreed by the Parties, if Anthem agrees to changes initiated by Supplier due to an act of war, riot, civil disorder, or rebellion, Supplier shall bear all costs and expenses to perform and implement the changes. If Anthem does not agree to so change the Services, or if the event of war, riot, civil disorder, or rebellion occurs, such event shall be deemed to be a Force Majeure Event.

17.7.4 Allocation of Resources. If a Force Majeure Event causes Supplier to allocate limited resources between or among Supplier's customers, and if the Services are disrupted by such Force Majeure Event, Supplier shall not treat any other customer better than Anthem nor reduce process capacity or performance below the business continuity requirements stipulated in BCP. If a Force Majeure Event causes Supplier to allocate limited resources between or among Supplier's customers, and if the Services are not disrupted by such Force Majeure Event, Supplier shall not reduce process capacity or performance below the level of the process capacity and performance immediately prior to the Force Majeure Event. In addition, Supplier shall not redeploy or reassign any key personnel to another Supplier account in the event of a Force Majeure Event without Anthem's prior written consent.

17.8 Severability. If any provision of the Agreement is held to be invalid, illegal or unenforceable in any respect under Applicable Law, such provision shall be excluded from the Agreement and the balance of the Agreement shall be interpreted as if such provision were so excluded and shall be enforceable in accordance with its terms.

17.9 Relationship of Parties. The Parties intend to be, are, and shall at all times be independent contractors with respect to this Agreement and all performance under this Agreement. Under no circumstances shall Supplier, any Supplier personnel, or any other of Supplier's employees, subcontractors, agents, or representatives be considered to be employees or agents of Anthem or any of Anthem's Affiliates, or be entitled to participate in any of Anthem's or its Affiliates' employee benefit programs including workers compensation and disability insurance, group health, dental and vision insurance, unemployment insurance, retirement plans, or stock-based benefits or plans. Neither Party is an agent, partner or employee of the other Party, or its Affiliates, and neither Party has any right or any other authority to enter into any agreements or undertaking in the name of or for the account of the other Party or to create or assume any obligations of any kind, express or implied, on behalf of the other Party nor will the act or omissions of either create any liability for the other Party. No form of joint employer, joint venture, partnership, or similar relationship between the Parties, or between either Party and any Affiliate of the other Party, is intended or hereby created. This Agreement shall in no way constitute or give rise to a partnership or joint venture between the Parties. In no way shall Anthem be construed to be a provider of health services or responsible for the provision of such health services.

17.10 Titles and Subtitles. The titles and subtitles used in the Agreement are used for convenience only and are not to be considered in construing or interpreting the Agreement.

17.11 Counterparts. The Agreement and any Agreement may be executed in two or more counterparts, each of which shall be deemed an original, but all of which, when taken together, shall constitute one and the same instrument.

17.12 Electronic Signatures. The Parties agree electronic signatures may be utilized for execution of this Agreement and any attachments hereto, including but not limited to, Statements of Work. The Parties acknowledge and agree that (i) the issuance of an electronic signature shall be valid and enforceable as to the signing Party to the same extent as an inked original signature; and (ii) these documents shall constitute "original" documents when printed from electronic files and records established and maintained by either Party in the normal course of business. Unless otherwise agreed to by the Parties, the purchase order number (issued by Anthem) shall constitute Anthem's electronic signature and consent to any purchase order and the Supplier's invoice number shall constitute Supplier's electronic signature and consent to provide the Software and/or other related services. Each Party agrees that the Anthem purchase order number or the Supplier invoice number, as issued by the respective Party, shall be sufficient to verify that such Party originated the document. Neither Party shall disclose to any unauthorized person the purchase order Number or the invoice number.

17.13 Deficit Reduction Act Notification to Supplier. Section 6032 of the Deficit Reduction Act of 2005 ("DRA") and state laws enacted pursuant to the DRA require certain entities such as Anthem to establish policies and procedures to help the entity, and its contractors and agents, detect and prevent fraud, waste and abuse relating to services provided for certain government funded programs, including Medicaid. The DRA and state laws also require certain entities to make their suppliers aware: (a) of the provisions of the False Claims Act and similar state statutes prohibiting anyone from knowingly submitting or causing another person or entity to submit false claims for payment of government funds; and (b) that any person in violation is potentially liable for three times the damages or loss to the government plus substantial civil penalties (currently \$5,500 to \$11,000). In addition, the False Statements Act prohibits anyone from making false statements or withholding material information in connection with the delivery of services to, or payments from, the government. Violations of these acts

can also result in criminal convictions and imprisonment of up to five (5) years. As part of Anthem's policies designed to prevent fraud, waste and abuse, Anthem does not retaliate against personnel who report violations (or suspected violations) of state or federal False Claims Acts.

17.14 Covenant Not to Trade on Insider Knowledge. Supplier acknowledges that Anthem, Inc. is a publicly traded corporation. Supplier agrees that it will not purchase or sell any stock of Anthem based on Anthem Confidential Information. Supplier further agrees that, if it discloses Anthem Confidential Information to any other person or entity in accordance with this Agreement, it will advise that other person or entity of the duty not to trade based on Anthem Confidential Information.

17.15 Cumulative Remedies. Except as otherwise expressly provided in this Agreement, all remedies provided for in this Agreement shall be cumulative and in addition to, and not in lieu of, any other remedies available to either Party at law, in equity or otherwise.

17.16 No Third Party Beneficiaries. This Agreement shall not benefit, or create any right or cause of action in or on behalf of, any person or entity other than Anthem its Affiliates and assignees, or Supplier; provided that if either Party's Affiliates' has a cause of action under this Agreement against the other Party, such action must be initiated by a Party to this Agreement against the other Party, and not against such Party's Affiliates directly.

17.17 Entire Agreement. This Agreement sets forth the entire agreement of the Parties with respect to the subject matter thereof, and supersedes any and all prior proposals, agreements, understandings, and contemporaneous discussions, whether oral or written, between the Parties with respect to the subject matter of this Agreement.

IN WITNESS WHEREOF, the undersigned have read, understood and executed this Agreement and agree to be bound by its provisions as of the Effective Date.

_____ Supplier	_____ Anthem, Inc. Anthem
By: _____ Signature	By: _____ Signature
_____ Printed Name	_____ Printed Name
_____ Title	_____ Title
_____ Date	_____ Date

EXHIBIT A**BUSINESS ASSOCIATE AGREEMENT**

If, during the term of any Agreement between Supplier and Anthem, Inc. and/or any of its affiliates (collectively, “Anthem”), Supplier requires the use or disclosure of Protected Health Information, including creating, receiving, maintaining, or transmitting Protected Health Information, then Supplier shall be deemed a Business Associate of Anthem and the following provisions shall apply:

This agreement (“Agreement”) shall be effective on the date of Supplier’s signature and is between the Supplier (“Business Associate”) identified in this Agreement and Anthem, Inc. (“Anthem”) on behalf of itself and its affiliates who are Covered Entities or Business Associates and who have a business relationship with Business Associate, if any (hereinafter collectively “Anthem”). The purpose of this Agreement is to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C.F.R. Parts 160-164, including Subpart E of 45 CFR Part 164), any applicable state privacy laws, any applicable state security laws, any applicable implementing regulations issued by the Insurance Commissioner or other regulatory authority having jurisdiction and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 (the “HITECH Act”) and any regulations adopted or to be adopted pursuant to the HITECH Act that relate to the obligations of business associates.

All capitalized terms in this Agreement that are not defined in this Agreement will have the meaning ascribed to those terms by 45 C.F.R. Parts 160-164, or applicable insurance regulations that are applicable to Anthem’s relationship with Business Associate.

A. Privacy of Protected Health Information and Nonpublic Personal Financial Information.

1. **Permitted and Required Uses and Disclosures.** Business Associate is permitted or required to Use or disclose Protected Health Information (“PHI”) it requests, creates, or receives for or from Anthem (or another business associate of Anthem) only as follows:
 - a) **Functions and Activities on Anthem’s Behalf.** Business Associate is permitted to request, Use, or disclose PHI it creates or receives for or from Anthem (or another business associate of Anthem), consistent with the Privacy Rule, the Security Rule, and the HITECH Act, only as described in this Agreement, or other agreements during their term that may exist between Anthem and Business Associate.
 - b) **Business Associate’s Operations.** Business Associate may Use PHI it creates or receives for or from Anthem as necessary for Business Associate’s proper management and administration or to carry out Business Associate’s legal responsibilities. Business Associate may disclose such PHI as necessary for Business Associate’s proper management and administration or to carry out Business Associate’s legal responsibilities only if:
 - (i) The Disclosure is Required by Law; or

- (ii) Business Associate obtains reasonable assurance evidenced by written contract, from any person or organization to which Business Associate will disclose such PHI that the person or organization will:
 - a. Hold such PHI in confidence and Use or further disclose it only for the purpose for which Business Associate disclosed it to the person or organization or as Required by Law; and
 - b. Notify Business Associate (who will in turn promptly notify Anthem) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI was breached.
- c) Data Aggregation Services. If specifically directed by the Anthem, the Business Associate will provide Data Aggregation services relating to the Health Care Operations of the Anthem.
- d) Minimum Necessary and Limited Data Set. In any instance when Business Associate Uses, requests or discloses PHI under this Agreement or in accordance with other agreements that exist between Anthem and Business Associate, Business Associate shall utilize a Limited Data Set, if practicable. Otherwise, Business Associate may Use or disclose only the minimum amount of PHI necessary to accomplish the intended purpose, except that Business Associate will not be obligated to comply with this minimum necessary limitation with respect to:
 - (i) Disclosure to or request by a Health Care Provider for Treatment;
 - (ii) Use for or Disclosure to an Individual who is the subject of Anthem's PHI, or that Individual's Personal Representative;
 - (iii) Use or Disclosure made pursuant to an authorization compliant with 45 C.F.R. §164.508 that is signed by an Individual who is the subject of Anthem's PHI to be used or disclosed, or by that Individual's Personal Representative;
 - (iv) Disclosure to the United States Department of Health and Human Services ("HHS") in accordance with Section C(5) of this Agreement;
 - (v) Use or Disclosure that is Required by Law; or
 - (vi) Any other Use or Disclosure that is excepted from the Minimum Necessary limitation as specified in 45 C.F.R. §164.502(b)(2).
- e) Use by Workforce. Business Associate shall advise members of its workforce of their obligations to protect and safeguard PHI. Business Associate shall take appropriate disciplinary action against any member of its workforce who uses or discloses PHI in contravention of this Agreement.

2. Prohibitions on Unauthorized Requests, Use or Disclosure.

- a) Business Associate will neither Use nor disclose Anthem's PHI it creates or receives from Anthem or from another Business Associate of Anthem, except as permitted or required by this Agreement or as Required by Law or as otherwise permitted in writing by Anthem. This Agreement does not authorize Business Associate to request, Use, disclose, maintain or transmit PHI in a manner that will violate 45 C.F.R. Parts 160-164.

- b) Business Associate will not develop any list, description or other grouping of Individuals using PHI received from or on behalf of Anthem, except as permitted by this Agreement or in writing by Anthem. Business Associate will not request, Use or disclose any list, description or other grouping of Individuals that is derived using such PHI, except as permitted by this Agreement or in writing by Anthem.
3. **Sub-Contractors and Agents.** Business Associate will require any of its Subcontractors and/or agents that create, receive, maintain, or transmit such PHI to provide reasonable assurance, evidenced by written contract, that Subcontractor or agent will comply with the same privacy and security obligations as Business Associate with respect to such PHI, including the obligations described in Section 4 herein.
4. **Information Safeguards.** Business Associate must use appropriate safeguards to comply with Subpart C of 45 CFR Part 164 and must implement, maintain and use a written information security program that contains the necessary administrative, technical and physical safeguards that are appropriate in light of the Business Associate's size and complexity in order to achieve the safeguarding objectives as detailed in Social Security Act § 1173(d) (42 U.S.C. § 1320d-2(d)), 45 C.F.R. Part 164.530(c), the HITECH Act and any other implementing regulations issued by the U.S. Department of Health and Human Services, as such may be amended from time to time and as required by the Required Information Security Controls document attached to the Agreement between the parties as **Exhibit F** and incorporated herein. Business Associate shall notify Anthem should Business Associate determine it is unable to comply with any such law, regulation, or official guidance. Further, Business Associate shall comply with any applicable state data privacy or security law.

During the term of this Agreement, Business Associate may be asked to complete a security survey and/or attestation document designed to assist Covered Entity in understanding and documenting Business Associate's security procedures and compliance with the requirements contained herein. Business Associate's failure to complete either of these documents within the reasonable timeframe specified by Covered Entity shall constitute a material breach of this Agreement.

Business Associate shall provide Anthem with information concerning the aforementioned safeguards and/or other information security practices as they pertain to the protection of Anthem's PHI, as Anthem may from time to time request. Upon reasonable advance request, Business Associate shall provide Anthem access to Business Associate's facilities used for the maintenance or processing of PHI, and to its books, records, practices, policies and procedures concerning the Use and Disclosure of PHI, in order to determine Business Associate's compliance with this Agreement.

B. PHI Access, Amendment and Disclosure Accounting.

1. **Access.** Business Associate will promptly upon Anthem's request make available to Anthem or, at Anthem's direction, to the Individual (or the Individual's Personal Representative) for inspection and obtaining copies any PHI about the Individual which Business Associate created or received for or from Anthem and that is in Business Associate's custody or control, so that Anthem may meet its access obligations pursuant to and required by applicable law, including but not limited to 45 C.F.R. 164.524, and where applicable, the HITECH Act. Business Associate shall make such information available in electronic format where directed by Anthem.

2. **Amendment.** Business Associate will, upon receipt of notice from Anthem, promptly amend or permit Anthem access to amend any portion of the PHI which Business Associate created or received for or from Anthem, pursuant to and required by applicable law, including but not limited to 45 C.F.R. Part 164.526.

Business Associate will not respond directly to an Individual's request for an amendment of their PHI held in the Business Associate's Designated Record Set. Business Associate will refer the Individual to Anthem so that Anthem can coordinate and prepare a timely response to the Individual.

3. **Disclosure Accounting.** So that Anthem may meet its Disclosure accounting obligations pursuant to and required by applicable law, including but not limited to 45 C.F.R. Part 164.528:

- a) **Disclosure Tracking.** Business Associate will promptly, but no later than within seven (7) days of the Disclosure, report to Anthem for each Disclosure, not excepted from Disclosure accounting under Section B.3(b) below, that Business Associate makes to Anthem or a third party of PHI that Business Associate creates or receives for or from Anthem, (i) the Disclosure date, (ii) the name and (if known) address of the person or entity to whom Business Associate made the Disclosure, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose of the Disclosure (items i-iv, collectively, the "disclosure information"). For repetitive Disclosures Business Associate makes to the same person or entity (including Anthem) for a single purpose, Business Associate may provide (x) the disclosure information for the first of these repetitive Disclosures, (y) the frequency, periodicity or number of these repetitive Disclosures and (z) the date of the last of these repetitive Disclosures. Business Associate further shall provide any additional information, to the extent required by the HITECH Act or any regulation adopted pursuant thereto.
- b) **Exceptions from Disclosure Tracking.** Business Associate need not report Disclosure of information or otherwise account for Disclosures of PHI that this Agreement or Anthem in writing permits or requires (i) for the purpose of Anthem's Treatment activities, Payment activities, or Health Care Operations (except where such recording or accounting is required by the HITECH Act), and as of the effective dates for any such requirements, (ii) to the Individual who is the subject of the PHI disclosed, to that Individual's Personal Representative or to another person or entity authorized by the Individual (iii) to persons involved in that Individual's Health Care or Payment for Health Care; (iv) for notification for disaster relief purposes, (v) for national security or intelligence purposes, (vi) to Law Enforcement Officials or Correctional Institutions regarding Inmates; or (vii) disclosed in a limited data set.

Business Associate need not report any Disclosure of PHI that was made before April 14, 2003.

- c) Except as provided below in subsection d) below, Business Associate will not respond directly to an Individual's request for an accounting of Disclosures. Business Associate will refer the Individual to Anthem so that Anthem can coordinate and prepare a timely accounting to the Individual.
- d) **Disclosure through an Electronic Health Record.** However, when Business Associate is contacted directly by an individual based on information provided to the individual by Anthem, Business Associate shall make the accounting of disclosures available directly to the individual, but only if required by the HITECH Act or any related regulations.

4. **Confidential Communications and Restriction Agreements.** Business Associate will promptly, upon receipt of notice from Anthem, send an Individual's communications to the identified alternate address. Business Associate will comply with any agreement Anthem makes that restricts Use or Disclosure of Anthem's PHI pursuant to 45 C.F.R. §164.522(a), provided that Anthem notifies Business Associate in writing of the restriction obligations that Business Associate must follow. Anthem will promptly notify Business Associate in writing of the termination or modification of any confidential communication requirement or restriction agreement.
5. **Disclosure to U.S. Department of Health and Human Services.** Business Associate shall make its internal practices, books, and records relating to the Use and Disclosure of PHI received from Anthem (or created or received by Business Associate on behalf of Anthem) available to the Secretary of the United States Department of Health and Human Services, for purposes of determining Anthem's compliance with 45 C.F.R. Parts 160-164. Unless the Secretary directs otherwise, Business Associate shall promptly notify Anthem of Business Associate's receipt of such request, so that Anthem can assist in compliance with that request.

C. Breach of Privacy and Security Obligations.

Reporting. Business Associate will report to Anthem: (i) any Use or Disclosure of PHI (including Security Incidents) not permitted by this Agreement or in writing by Anthem; (ii) any Security Incident; (iii) any Breach, as defined in the HITECH Act; or (iv) any other breach of a security system, or the like, as such may be defined under applicable state law (collectively a "Breach"). Except as described in subparagraph "e" below, Business Associate will, without unreasonable delay, but no later than within one business day after Business Associate's discovery of a Breach, make the report by sending a report to Anthem. Such report will be made on a form made available to Business Associate, or by such other reasonable means of reporting as may be communicated to Business Associate by Anthem. Business Associate shall cooperate with Anthem in investigating the Breach and in meeting Anthem's obligations under the HITECH Act, and any other security breach notification laws or regulatory obligations.

- a) **Report Contents.** To the extent such information is available Business Associate's report will at least:
 - (i) Identify the nature of the non-permitted or prohibited access, Use or Disclosure, including the date of the Breach and the date of discovery of the Breach;
 - (ii) Identify the PHI accessed, used or disclosed, and provide an exact copy or replication of the PHI, as appropriate, in a format reasonably requested by Anthem, and to the extent available;
 - (iii) Identify who caused the Breach and who received the PHI;
 - (iv) Identify what corrective action Business Associate took or will take to prevent further Breaches;
 - (v) Identify what Business Associate did or will do to mitigate any deleterious effect of the Breach; and
 - (vi) Provide such other information, including a written report, as Anthem may reasonably request.
- b) **Examples of Security Incidents.** Anthem requires prompt notification from Business Associate if Business Associate experiences any Security Incidents that impact the confidentiality, integrity or availability of Anthem data or information systems. Below are some examples:
 - (i) Business Associate's information systems are exposed to malicious code, such as a virus or worm, and such code could be transmitted to Anthem data or systems.

- (ii) Unauthorized access is granted or obtained to servers or workstations that contain Anthem data or Business Associate discovers that Anthem data is being used, copied, or destroyed inappropriately.
 - (iii) Business Associate experiences an attack or the compromise of a server or workstation containing Anthem information requiring that it be taken offline.
 - (iv) Unauthorized access or disclosure has occurred involving Protected Health Information, which is an obligation under the HIPAA Privacy Rule.
 - c) Unsuccessful Security Incidents. Except as noted in C.(e) below, the parties acknowledge and agree that this section constitutes notice by Business Associate to Anthem of the ongoing existence and occurrence of attempted but Unsuccessful Security Incidents (as defined below) for which no additional notice to Anthem shall be required. "Unsuccessful Security Incidents" shall include, but not be limited to, pings and other broadcast attacks on Business Associate's firewall, port scans, unsuccessful log-on attempts, denials of service and any combination of the above, so long as no such incident results in unauthorized access, use or disclosure of PHI.
 - d) Breach of Unsecured Protected Health Information. A Breach of Unsecured Protected Health Information includes any Breach as defined in the HITECH act or regulations adopted pursuant thereto.
 - e) Medicare Supplier Reporting Requirements –To the extent that Business Associate is subject to any Center for Medicare and Medicaid ("CMS") incident reporting requirements (including applicable timeframes for such reporting) as detailed in the services agreement between Anthem and Business Associate (including any amendments, exhibits or addenda), Business Associate shall comply with all such reporting requirements, in addition to those imposed hereby.
2. **Breach.** Without limiting the rights of the parties elsewhere set forth in the Agreement or available under applicable law, if Business Associate breaches its obligations under this Agreement, Anthem may, at its option:
- a) Exercise any of its rights of access and inspection under paragraph 4 of section A of this Agreement
 - b) Require Business Associate to submit to a plan of monitoring and reporting, as Anthem may determine appropriate to maintain compliance with this Agreement and Anthem shall retain the right to report to the Secretary of HHS any failure by Business Associate to comply with such monitoring and reporting; or
 - c) Immediately and unilaterally, terminate this Agreement and/or any other agreements between the parties, without penalty to Anthem, and with or without an opportunity to cure the breach. Anthem's remedies under this Section and set forth elsewhere in this Agreement or in any other agreement between the parties shall be cumulative, and the exercise of any remedy shall not preclude the exercise of any other. If for any reason Anthem determines that Business Associate has breached the terms of this Agreement and such breach is not curable or if curable, has not been cured, but Anthem determines that termination of this Agreement and/or any other agreements between the parties is not feasible, Anthem may report such breach to the U.S. Department of Health and Human Services.

3. **Mitigation.** Business Associate agrees to mitigate to the extent practicable, any harmful effect that is known to Business Associate of any security incident related to PHI or any use or disclosure of PHI by Business Associate in violation of the requirements of this BA Agreement. To the extent Anthem incurs any expense Anthem reasonably determines to be necessary to mitigate any Breach or any other non-permitted use or disclosure of Individually Identifiable Information, Business Associate shall reimburse Anthem for such expense.

D. Compliance with Standard Transactions.

1. If Business Associate conducts in whole or part Standard Transactions, for or on behalf of Anthem, Business Associate will comply, and will require any Subcontractor or agent involved with the conduct of such Standard Transactions to comply, with each applicable requirement of 45 C.F.R. Part 162 for which HHS has established Standards. Business Associate will comply by a mutually agreed date, but no later than the date for compliance with all applicable final regulations, and will require any Subcontractor or agent involved with the conduct of such Standard Transactions, to comply, with each applicable requirement of the Transaction Rule 45 C.F. R. Part 162. Business Associate agrees to demonstrate compliance with the Transactions by allowing Anthem to test the Transactions and content requirements upon a mutually agreeable date. Business Associate will not enter into, or permit its Subcontractors or agents to enter into, any trading partner agreement in connection with the conduct of Standard Transactions for or on behalf of Anthem that:
 - a) Changes the definition, data condition or use of a data element or segment in a Standard Transaction.
 - b) Adds any data elements or segments to the maximum defined data set;
 - c) Uses any code or data element that is marked “not used” in the Standard Transaction’s Implementation Specification or is not in the Standard Transaction’s Implementation Specification; or
 - d) Changes the meaning or intent of the Standard Transaction’s Implementation Specification.
2. **Concurrence for Test Modification to Standard Transactions.** Business Associate agrees and understands that there exists the possibility that Anthem or others may request from HHS an exception from the uses of a Standard in the HHS Transaction Standards. If this request is granted by HHS, Business Associate agrees that it will participate in such test modification.
3. **Incorporation of Modifications to Standard Transactions** Business Associate agrees and understands that from time-to-time, HHS may modify and set compliance dates for the Transaction Standards. Business Associate agrees to incorporate by reference into this Agreement any such modifications or changes.
4. **Code Set Retention (Only for Plans).** Both parties understand and agree to keep open code sets being processed or used in the Agreement for at least the current billing period or any appeal period, whichever is longer.
5. **Guidelines and Requirements.** Business Associate further agrees to comply with any guidelines or requirements adopted by Anthem consistent with the requirements of HIPAA and any regulations

promulgated thereunder, governing the exchange of information between Business Associate and the Anthem.

E. Obligations upon Termination.

1. **Return or Destruction.** Upon termination, cancellation, expiration or other conclusion of the Agreement, Business Associate will if feasible return to Anthem or destroy all PHI, in whatever form or medium (including in any electronic medium under Business Associate's custody or control), that Business Associate created or received for or from Anthem, including all copies of and any data or compilations derived from and allowing identification of any Individual who is a subject of the PHI. Business Associate will complete such return or destruction as promptly as possible, but not later than 30 days after the effective date of the termination, cancellation, expiration or other conclusion of Agreement. Business Associate shall destroy all PHI in accordance with any guidance set forth by the Secretary of HHS and/or any other government agency or other entity to whom HHS delegates such authority Business Associate will identify any PHI that Business Associate created or received for or from Anthem that cannot feasibly be returned to Anthem or destroyed, and will limit its further Use or Disclosure of that PHI to those purposes that make return or destruction of that PHI infeasible and will otherwise continue to protect the security any PHI that is maintained pursuant to the security provisions of this Agreement for so long as the PHI is maintained. Within such 30 days, Business Associate will certify in writing to Anthem that such return or destruction has been completed, will deliver to Anthem the identification of any PHI for which return or destruction is infeasible and, for that PHI, will certify that it will only Use or disclose such PHI for those purposes that make return or destruction infeasible.
2. **Continuing Privacy and Security Obligation.** Business Associate's obligation to protect the privacy and security of the PHI it created or received for or from Anthem will be continuous and survive termination, cancellation, expiration or other conclusion of this Agreement, so long as the data is maintained.

F. General Provisions.

1. **Definitions.** Except as otherwise provided, the capitalized terms in this Agreement have the meanings set out in 45 C.F.R. Parts 160-164, as may be amended from time to time. The term Protected Health Information ("PHI") includes any information without regard to its form or medium, gathered by Business Associate in connection with Business Associate's relationship with Covered Entity that identifies an individual or that otherwise would be defined as Protected Health Information under HIPAA.
2. **Amendment.** From time to time local, state or federal legislative bodies, boards, departments or agencies may enact or issue laws, rules, or regulations pertinent this Agreement. In such event, Business Associate agrees to immediately abide by all said pertinent laws, rules, or regulations and to cooperate with Anthem to carry out any responsibilities placed upon Anthem or Business Associate by said laws, rules, or regulations.
3. **Conflicts.** The terms and conditions of this Agreement will override and control any conflicting term or condition of any other agreement between the parties with respect to the subject matter herein. All non-conflicting terms and conditions of the said other agreement(s) remain in full force and effect.

4. **Owner of PHI.** Anthem is the exclusive owner of PHI generated or used under the terms of the Agreement.
5. **Subpoenas.** Business Associates agrees to relinquish to Anthem control over subpoenas Business Associates receives with regard to PHI belonging to Anthem.
6. **Disclosure of De-identified Data.** The process of converting PHI to De-identified Data (DID) is set forth in 45 C.F.R Part 164.514. In the event that Anthem provides Business Associate with DID, Business Associate shall not be given access to, nor shall Business Associate attempt to develop on its own, any keys or codes that can be used to re-identify the data. Business Associate shall only use DID as directed by Anthem.
7. **Creation of De-identified Data.** In the event Business Associate wishes to convert PHI to DID, it must first subject its proposed plan for accomplishing the conversion to Anthem for Anthem's approval, which shall not be unreasonably withheld provided such conversion meets the requirements of 45 C.F.R. Part 164.514. Business Associate may only use DID as directed or otherwise agreed to by Anthem.
8. **Assignment/Subcontract.** Anthem shall have the right to review and approve any proposed assignment or subcontracting of Business Associate's duties and responsibilities arising under the Agreement, as it relates to the Use or creation of PHI (or DID if applicable).
9. **Audit.** Anthem shall have the right to audit and monitor all applicable activities and records of Business Associate to determine Business Associate's compliance with the requirements relating to the creation or Use of PHI (and DID, if applicable) as it relates to the privacy and security sections of this Agreement.
10. **Intent.** The parties agree that there are no intended third party beneficiaries under this Agreement.
11. **Indemnity.** Business Associate will indemnify and hold harmless Anthem and any Anthem affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted or prohibited Use or Disclosure of PHI or other breach of this Agreement by Business Associate or any Subcontractor, agent, person or entity under Business Associate's control.
 - a) **Right to Tender or Undertake Defense.** If Anthem is named a party in any judicial, administrative or other proceeding arising out of or in connection with any non-permitted or prohibited Use or Disclosure of PHI or other breach of this Agreement by Business Associate or any Subcontractor, agent, person or entity under Business Associate's control, Anthem will have the option at any time either (i) to tender its defense to Business Associate, in which case Business Associate will provide qualified attorneys, consultants and other appropriate professionals to represent Anthem's interests at Business Associate's expense, or (ii) undertake its own defense, choosing the attorneys, consultants and other appropriate professionals to represent its interests, in which case Business Associate will be responsible for and pay the reasonable fees and expenses of such attorneys, consultants and other professionals.
 - b) **Right to Control Resolution.** Anthem will have the sole right and discretion to settle, compromise or otherwise resolve any and all claims, causes of actions, liabilities or damages against it,

notwithstanding that Anthem may have tendered its defense to Business Associate. Any such resolution will not relieve Business Associate of its obligation to indemnify Anthem under Section F.11 of this Agreement.

IN WITNESS WHEREOF, Anthem and Business Associate execute this Agreement in multiple originals to be effective on the date of Business Associate's Signature below:

_____	_____ Anthem, Inc.
Name of Business Associate	
By: _____	By: _____
Signature	Signature
_____	_____
Printed Name	Printed Name
_____	_____
Title	Title
_____	_____
Date	Date

EXHIBIT B
Medicare Advantage and
Medicare Part D Regulatory Exhibit

Effective [INSERT EFFECTIVE DATE], the following Medicare Advantage and Medicare Part D terms and conditions shall be incorporated into the attached Agreement between [INSERT ANTHEM ENTITY NAME] and its commonly owned and controlled affiliates (herein referred to as “Anthem”) and [INSERT SUPPLIER NAME] (herein referred to as “Supplier.”) These provisions shall only apply to services provided by Supplier to or for Anthem’s Medicare Advantage and/or Medicare Part D plans, including those plans for members dually eligible for Medicare and Medicaid in accordance with and pursuant title XVIII of the Social Security Act (Act) (specifically, but not limited to, Social Security Act Parts C and Part D), and any subsequent amendments or relevant provision in the Act and applicable regulations. In the event that there is a conflict between the attached agreement and these Medicare Advantage and Medicare Part D terms and conditions, the Medicare Advantage and Medicare Part D terms and conditions shall control, but only as they relate to services provided to Covered Individuals enrolled in Anthem’s Medicare Advantage and/or Medicare Part D plans.

A. Definitions:

1. **Downstream Entity:** Any party that enters into a written arrangement, acceptable to CMS, with persons or entities involved with the MA benefit, below the level of the arrangement between [Anthem entity name] and [Supplier name] a first tier entity. These written arrangements continue down to the level of the ultimate provider of both health and administrative services.
2. **First Tier Entity:** Any party that enters into a written agreement, acceptable to CMS, with [Anthem entity] or applicant to provide administrative services or health care services for a Medicare eligible individual under the MA program.
3. **Related Entity:** Any entity that is related to [Anthem entity] by common ownership or control and 1. Performs some of the [Anthem] entity’s management functions under contract or delegation. 2. Furnishes services to Medicare enrollees under an oral or written agreement; or 3. Leases real property or sells materials to [Anthem entity] at a cost of more than \$2,500 during the contract period.

B. Terms:

1. **Federal Funds.** Supplier acknowledges that payments Supplier receives from Anthem to provide services to Medicare Advantage and/or Medicare Part D enrollees are, in whole or part, from Federal funds. Therefore, Supplier and any of its subcontractors may be subject to certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, 42 C.F.R. 423.100, 42 C.F.R. Part 422, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Americans With Disabilities Act; the Rehabilitation Act of 1973 and other regulations applicable to recipients of Federal Funds.
2. **Confidential Information.** Supplier recognizes that in the performance of its obligations under this Agreement it may be party to Anthem’s proprietary, confidential, or privileged information, including, but not limited to, information concerning Anthem’s members. Supplier agrees that, among other items of information, the identity of, and all other information regarding or relating to

any of Anthem's customers is confidential. Supplier agrees to treat such information as confidential and proprietary information of Anthem, and all such information shall be used by Supplier only as authorized and directed by Anthem pursuant to this Agreement, and, unless required by law, shall not be released to any other person or entity under any circumstances without express written approval of Anthem. During and after the term of this Agreement, Supplier shall not disclose or use any of the information described in this Section for a purpose unrelated to the terms and obligations of this Agreement. Further, Supplier agrees to abide by all Federal and State laws regarding confidentiality and disclosure of Medicare Advantage and/or Medicare Part D enrollee information. In addition, Supplier agrees to abide by the confidentiality requirements established by Anthem and CMS for the Medicare Advantage and/or Medicare Part D program.

2.1 To the extent applicable, [Supplier] will comply with the confidentiality and enrollee record accuracy requirements, including: (1) abiding by all Federal and State laws regarding confidentiality and disclosure of medical records, or other health and enrollment information, (2) ensuring that medical information is released only in accordance with applicable Federal and State law or pursuant to court orders or subpoenas, (3) maintaining the records and information in an accurate and timely manner, and (4) ensuring timely access by enrollees to the records and information that pertain to them. [42 C.F.R. §§422.504(a)(13) and 422.118.]

3. **Inspection of Books and Records.** In accordance with, but not limited to, 42 C.F.R. 422.504(i) and/or 42 C.F.R. 423.505(i), Supplier acknowledges that Anthem, Health and Human Services department (HHS), the Comptroller General, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Supplier, or its first tier, downstream and related entities, including but not limited to subcontractors or transferees involving transactions related to Anthem's Medicare Advantage contract through ten (10) years from the final date of the contract period or from the date of the completion of any audit, or for such longer period provided for in 42 CFR §422.504(e)(4) or other applicable law, whichever is later. For the purposes specified in this provision, Supplier agrees to make available Supplier's premises, physical facilities and equipment, records relating to Anthem's Covered Individuals, including access to Supplier's computer and electronic systems and any additional relevant information that CMS may require. Supplier acknowledges that failure to allow HHS, the Comptroller General or their designees the right to timely access under this section can subject Facility to a \$15,000 penalty for each day of failure to comply.
4. **Independent Status.** Supplier is an independent contractor and nothing contained in this Agreement shall be construed or implied to create an agency, partnership, joint venture, or employer and employee relationship between Supplier and Anthem. At no time shall either party make commitments or incur any charges or expenses for or in the name of the other party except as otherwise permitted by this Agreement.
5. **Subcontractors.** In accordance with, but not limited to, 42 C.F.R. 422.504(i)(3)(ii) and/or 42 C.F.R. 423.505(i)(3), Supplier agrees that if Supplier enters into subcontracts to perform services under the terms of the Agreement, Supplier's subcontracts shall include an agreement by the subcontractor to comply with all of the Supplier obligations in this Medicare Advantage and Medicare Part D Regulatory Exhibit and applicable terms in the attached Agreement. In addition, Supplier will insure that such subcontractors understand that Anthem retains the necessary control and oversight over Supplier and all downstream subcontractors.

6. **Federal and State Laws.** Consistent with, but not limited to, 42 C.F.R. 422.504(i)(4) and 422.504(i)(3)(iii) and/or 423.505(i)(4) and 423.505(i)(3)(iii) Supplier agrees to comply, and to require any of its subcontractors to comply, with all applicable Federal and State laws, regulations, CMS instructions, and policies relevant to the activities to be performed under the Agreement, including but not limited to, the Medicare Marketing Guidelines for Medicare Managed Care Clients, and any requirements for CMS prior approval of materials. Further, Supplier agrees that any services provided by the Supplier or its subcontractors to or on behalf of Anthem's Medicare Advantage and/or Medicare Part D enrollees will be consistent with and will comply with Anthem's Medicare Advantage and/or Medicare Part D contractual obligations.
7. **Compliance Program.** Anthem maintains an effective Compliance Program and Standards of Business Conduct, and requires its employees to act in accordance therewith. Anthem will provide a copy of its then current Standards of Business Conduct to Supplier upon request. Consistent with the preceding and to the extent applicable, Anthem and its subcontractors may be required to monitor for Fraud, Waste and Abuse consistent with CMS guidance. To the extent applicable, Supplier acknowledges that certain CMS guidance on Fraud, Waste and Abuse may be implicated by the Agreement and agrees to take appropriate actions to identify and/or monitor for such activities, including but not limited to producing Supplier's plan to monitor for Fraud, Waste and Abuse.

7.1 Validation of Compliance. Supplier agrees to provide documentation at least annually, as required by Anthem, demonstrating compliance with the CMS guidance as outlined in part in this Exhibit. In addition, the required monitoring form is attached hereto as Attachment 1. The parties acknowledge that Attachment 1 may be amended by Anthem, from time to time, on an annual basis or as needed to comply with CMS oversight and monitoring requirements.

8. **Hold Harmless.** In accordance with, but not limited to, 42 C.F.R. 422.504(i) and 422.504(g)(1) and (2) and/or 423.505(i) and 423.505(g), Supplier agrees that in no event, including but not limited to non-payment by Plan, insolvency of Plan or breach of the Agreement, shall Supplier bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a Medicare Advantage and/or Medicare Part D enrollee for covered services provided pursuant to the Agreement. This provision does not prohibit the collection of supplemental charges or Copayments made in accordance with the terms of the Medicare Advantage and/or Medicare Part D enrollee's benefits.

8.1 Dual Eligible Cost Sharing. Supplier further agrees that for those individuals who are enrolled in Medicare Advantage and/or Part D and who are eligible for some form of Medicaid benefit (Dual Eligible enrollees), that Supplier will not bill the enrollee for cost sharing that is not the Dual Eligible enrollee's responsibility and will ensure that such Dual Eligible enrollees will not be held liable for Medicare Parts A and B cost sharing when the State is liable for the cost sharing. In addition, Supplier agrees to accept the reimbursement by Anthem as payment in full, or, if applicable, to bill the the appropriate State source.

9. **Ineligible Persons.** Supplier warrants and represents that at the time of entering into this Agreement and monthly thereafter when providing services to or for the benefit of Medicare Advantage and/or Medicare Part D members under this Agreement, neither he/she/it nor any of his/her/its employees, contractors, subcontractors or agents are ineligible persons identified on the General Services Administrations' List of Parties Excluded from Federal Programs (available through the internet at

<https://www.epls.gov/>) and the HHS/OIG List of Excluded Individuals/Entities (available through the internet at <http://exclusions.oig.hhs.gov/>). Supplier agrees to sign a certification consistent with the meaning and requirements of this provision as required by Anthem.

In the event Supplier or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose his/her/its ineligible person status, Supplier shall have an obligation to (1) immediately notify Anthem of such ineligible person status and (2) immediately remove such individual from responsibility for, or involvement with, Anthem's business operations related to this Medicare Advantage and Medicare Part D attachment.

Anthem retains the right to provide notice of immediate termination of the Agreement to Supplier in the event it receives notice of Supplier's ineligible person status.

- 10. Conflict of Interest.** To the extent required by CMS or Anthem, Supplier agrees to certify that it will require its managers, officers and directors responsible for the administration or delivery of Medicare Advantage and/or Part D benefits to sign a conflict of interest statement, attestation, or certification at the time of hire and annually thereafter certifying that the manager, officer or director is free from any conflict of interest in administering or delivering Medicare Advantage and/or Part D benefits.
- 11. Illegal Remunerations.** Supplier specifically represents and warrants that activities to be performed under the Agreement are not considered illegal remunerations (including kickbacks, bribes or rebates) as defined in § 1128B(b) of the Social Security Act.
- 12.** [THIS PROVISION CAN BE DELETED IF THE BASE AGREEMENT ADDRESSES THIS TYPE OF INDEMNIFICATION] **Indemnification for Non-compliance.** Supplier agrees to indemnify and hold Anthem harmless from and against any and all liabilities, claims and expenses connected therewith, including reasonable attorneys fees, arising from any acts or omissions of Supplier, not specifically authorized or directed by Anthem, violating or resulting in an investigation under § 1128B(b) of the Social Security Act or any other Federal or State law or regulation.
- 13. Termination-Regulatory Issues.** In accordance with, but not limited to, 42 C.F.R. 422.504(i)(5) and/or 423.505(i)(5), if during the term of the Agreement, Anthem concludes that it is necessary to cancel any of the activities to be performed under this Agreement in order to comply with Federal or State laws, regulations, policies, or for any other purpose to comply with CMS Anthem may, at its discretion, cancel the activity and be relieved of any related obligations under the terms of the Agreement. If Anthem or Supplier concludes that it is necessary to reorganize or restructure any of the activities to be performed under this Agreement in order to comply with Federal or State laws, regulations, or policies, Anthem or Supplier may request to renegotiate such terms.
- 14. Oversight Responsibility.** Supplier acknowledges that Anthem shall oversee and monitor Supplier's and all of Supplier's subcontractors' providing Services under this Agreement. Accordingly, Anthem will regularly review the performance of Supplier and, if applicable, Supplier's subcontractors, as part of its normal operations to confirm ongoing compliance and to ensure any identified corrective actions are undertaken and effective. Supplier further acknowledges that Anthem is ultimately responsible to CMS for the performance of such services and that Anthem shall oversee and is accountable to CMS for the functions and responsibilities described in the Medicare Advantage and Medicare Part D regulatory standards and ultimately responsible to CMS for the performance of all services.

14.1 To the extent applicable, Supplier's credentialing process must be approved and monitored by the Plan.

15. **Revocation.** Supplier agrees that Anthem has the right to revoke this agreement if CMS or Anthem determines that Supplier or any of its independent contractors or subcontractors has not performed the services satisfactorily and/or if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner. Such revocation shall be consistent with the termination provisions of the Agreement.
16. **Approval of Materials.** Any printed materials, including but not limited to letters to Anthem's members, brochures, advertisements, telemarketing scripts, packaging prepared or produced by Supplier or any of its subcontractors pursuant to this Agreement must be submitted to Anthem for review and approval at each planning stage (*i.e.*, creative, copy, mechanicals, blue lines, etc.) to assure compliance with Federal, state, and Blue Cross/Blue Shield Association guidelines. Anthem agrees its approval will not be unreasonably withheld or delayed.
17. **Medicare Advantage and Medicare Prescription Drug Plan - Compliance Training, Education and Communications.** In accordance with, but not limited to 42 C.F.R. 422.503(b)(4)(vi)(C)&(D) and 42 C.F.R. 423.504(b)(4)(vi)(C)&(D) Supplier agrees and certifies that it, as well as its employees, subcontractors, downstream entities, related entities and agents who provide services to or for Anthem's Medicare Advantage and/or Part D Covered Individuals or to or for Anthem itself shall participate in CMS required fraud waste and abuse training and general compliance training, education and/or communications annually or as otherwise required by applicable law, and must be made a part of the orientation for a new employee, new first tier, downstream or related entity and for all new appointments of a chief executive, manager, or governing body member. Supplier or its subcontractors or Downstream Entities can complete the CMS training module located on the CMS Medicare Learning Network ("MLN") or incorporate the exact content of the CMS training into Providers existing compliance training and/or systems. If necessary and upon request, Anthem or its designee can make such compliance training, education and lines of communication available to Supplier in either electronic, paper or other reasonable medium. Supplier shall be responsible for documenting applicable employee's, subcontractor's, downstream entity's, related entity's and/or agent's attendance and completion of such training on an annual basis. Supplier shall provide such documentation to Anthem annually and as required to support a Anthem or CMS audit. In addition, the training requirement set forth herein is not required for providers or suppliers who have met the fraud, waste and abuse certification requirements through enrollment into the Medicare program, as those providers and/or suppliers are deemed to have met that portion of the fraud waste and abuse training required by CMS.
18. **Audit.** Supplier agrees to comply with any and all requests for Compliance documentation, as set forth in section 7 above, in order to support a CMS audit request. Supplier must provide all requested documentation demonstrating compliance with all CMS regulations and/or Anthem requirements for first tier, downstream and/or related entities.
19. **Prompt Payment.** [ALTERNATE - CAN DELETE IF THERE ARE EQUIVALENT PROMPT PAYMENT TERMS IN THE BASE AGREEMENT OR DELETE FIRST SENTENCE ONLY IF ONLY THAT PORTION IS CONTAINED IN THE BASE AGREEMENT] To the extent applicable under law as related to claims for medical or pharmacy services, Anthem agrees to make best efforts to pay Supplier within __ days of receipt of an undisputed invoice. Should Supplier

enter into any downstream agreements with any subcontractors to provide services under this Agreement, Supplier agrees to have a prompt payment provision as negotiated by Supplier and the subcontractor.

21. [IN ADDITION IF APPLICABLE]Delegated Activities. If Anthem has delegated activities to Supplier, then Anthem will provide the following information to Supplier and Supplier shall provide such information to any of its subcontracted entities:

- a. A list of delegated activities and reporting responsibilities;
- b. Arrangements for the revocation of delegated activities;
- c. Notification that the performance of the contracted and subcontracted entities will be monitored by Anthem;
- d. Notification that the credentialing process, if applicable, must be approved and monitored by Anthem; and
- e. Notification that all contracted and subcontracted entities must comply with all applicable Medicare laws, regulations and CMS instructions.

22. [IN ADDITION IF APPLICABLE]Delegation of Provider Selection. In addition to the responsibilities as set forth in section 21 above, to the extent that Anthem has delegated selection of the providers, contractors, or subcontractor to Supplier, Anthem retains the right to approve, suspend, or terminate any such arrangement.

EXHIBIT C
FEDERAL PROGRAM COMMERCIAL ITEM ADDENDUM

This Addendum is hereby incorporated into the Agreement. The provisions of this Addendum apply to commercial items and/or services provided to National Government Services, Inc. and/or the Anthem Federal Employees Health Benefits Program.

The clauses herein are applicable to contracts for Commercial Items. "Commercial Item" has the meaning contained in Federal Acquisition Regulation 2.101, definitions. "Subcontract" includes transfer of commercial items between divisions, subsidiaries or affiliates of the Vendor at any tier [(Section 5.60 Subcontracts for Commercial Items OCT 2015) (FAR 52.244-6)].

The following Federal Acquisition Regulation Clauses referenced in this document are incorporated by reference with the same force and effect as if they were given in full text:

FAR/CFR Reference	Clause	Effective Date	Threshold
52.202-1	Definitions	Nov 2013	>\$150,000
52.203-3	Gratuities	Apr 1984	>\$150,000 or Contract is for personal services
52.204-9	Personal Identity Verification of Contractor Personnel	Jan 2011	Contractor will have access to GOV facilities and/or systems
52.203-6 (Alt I)	Restrictions on Subcontractor Sales to the Government	Sep 2006	>\$150,000
52.203-13	Contractor Code of Business Ethics and Conduct	Oct 2015	> \$5,500,000 and more than 120 days in duration
52.203-15	Whistleblower Protections Under the American Recovery and Reinvestment Act of 2009 - if the subcontract is funded under the Recovery Act.	Jun 2010	Contract funded under the Recovery Act
52.203-19	Prohibition on Requiring Certain Internal Confidentiality Agreements or Statements	Jan 2017	All Contracts
52.204-21	Basic safeguarding of covered contractor information systems.	Jun 2016	All Contracts
52.204-23	Prohibition on Contracting for Hardware, Software, and Services Developed or Provided by Kaspersky Lab and Other Covered Entities	Oct 2018	All Contracts
52.209-7	Updates of Information Regarding Responsibility Matters	Jul 2013	>\$550,000
52.219-8	Utilization of Small Business Concerns	Nov 2016	>\$700,000 with subcontracting opportunities
52.222-21	Prohibition of Segregated Facilities	Apr 2015	All Contracts
52.222-26	Equal Opportunity	Sep 2016	Total value of all Federal work > \$10,000
52.222-29	Notification of Visa Denial	Apr 2015	>\$3,500 for items or >\$2,500 for services
52.222-35	Equal Opportunity for Veterans	Oct 2015	> \$100,000
52.222-36	Affirmative Action for Workers with Disabilities	Jul 2014	> \$15,000
52.222-37	Employment Reports on Veterans	Feb 2016	>\$150,000
52.222-40	Notification of Employee Rights Under the National Labor Relations Act	Dec 2010	>10,000

52.222-50	Combating Trafficking in Persons	Mar 2015	All Contracts
52.222-54	Employment Eligibility Verification	Oct 2015	>\$3,500 and Non-COTS
52.222-55	Minimum Wages under Executive Order 13658	Dec 2015	All Contracts
52.222-62	Paid Sick Leave under Executive Order 13706	Jan 2017	All contracts subject to the Service Contract Labor Standards statute
52.223-18	Encouraging Contractor Policy to Ban Text Messaging While Driving	Aug 2011	All Contracts
52.224-3	Mandatory Privacy Training	Jan 2017	All Contracts
52.225-26	Contractors Performing Private Security Functions Outside the United States	Oct 2016	All Contracts performed in area of contingency or combat operations
52.232-33	Payment by Electronic Funds Transfer-Central Contractor Registration	Jul 2013	All Contracts
52.232-40	Providing Accelerated Payments to Small Business Subcontractors	Dec 2013	All Subcontracts with Small Business Concerns
52.233-4	Applicable Law for Breach of Contract Claim	Oct 2004	All Contracts
52.244-5	Competition in Subcontracting	Dec 1996	>\$150,000 and not Firm-Fixed-Price
52.244-6	Subcontracts for Commercial Items	Nov 2017	All Contracts
52.247-64	Preference for Privately Owned U.S. Flag Commercial Vessels	Feb 2006	Contracts that may involve ocean transportation of supplies
41 CFR	Contractor shall abide by the requirements of 41 CFR §§ 60-1.4(a), 60-300.5(a) and 60-741.5(a). These regulations prohibit discrimination against qualified individuals based on their status as protected veterans or individuals with disabilities, and prohibit discrimination against all individuals based on their race, color, religion, sex, sexual orientation, gender identity, or national origin. Moreover, these regulations require that covered prime contractors and subcontractors take affirmative action to employ and advance in employment individuals without regard to race, color, religion, sex, sexual orientation, gender identity, national origin, protected veteran status or disability.	Mar 2014	All Contracts

Full text of CFR provisions may be found here: <http://farsite.hill.af.mil/>

In the event of a conflict between the terms of this Addendum and other terms in the Agreement, the terms of this Addendum shall control.

##End of Addendum##

EXHIBIT D**Diversity Supplier Compliance**

The Supplier agrees to comply fully with Anthem's Supplier Diversity Initiative, as further described in the Guidelines for Prospective Suppliers (found at https://www.antheminc.com/cs/groups/wellpoint/@wp_suppliers/documents/wlp_assets/d19l/mji2/~edisp/pw_e226860.pdf) and any participation plan that may have been submitted to Anthem. The following certified diverse suppliers will be participating in this Contract.

Diverse Suppliers	Phone	Email	Anthem Name	Scope of Goods and/or Services	Utilization Date	Amount or Percent

The Supplier must obtain the approval of Anthem's Supplier Diversity Director before changing any Supplier Diversity participation plan submitted in connection with this Agreement.

EXHIBIT E**STATE MEDICAID ATTACHMENTS**

The following Exhibits are applicable to all of the services performed by Supplier/Licensors for any member enrolled in a Medicaid Program in the particular state to which the Exhibit pertains. Notwithstanding the foregoing, all provisions contained in the Exhibits may not be applicable to certain services provided by administrative services Suppliers/Licensors as certain provisions are applicable solely to Providers of medical services. Only those provisions applicable to the specific services provided by Supplier/Licensors shall be deemed to be incorporated into the Agreement. State-specific regulatory requirements may be added/updated from time to time without need for additional amendment. In the following documents, “Subcontractor”, “Contractor” and “Vendor” refer to the “Supplier” or “Licensor” under the Agreement.

Exhibit E-1	California Medicaid Subcontract Exhibit (09.06.17)
Exhibit E-2	Florida Medicaid Subcontract Exhibit (09.06.17)
Exhibit E-3	Georgia Medicaid Exhibit (06.02.17)
Exhibit E-4	Medicaid Exhibit Indiana HHW HIP HCC (09.28.16)
Exhibit E-5	Iowa Medicaid Exhibit (06.29.17)
Exhibit E-6	Kansas Medicaid Subcontract Exhibit (08.01.17)
Exhibit E-7	Medicaid Exhibit Kentucky (08.28.17)
Exhibit E-8	Medicaid Exhibit Louisiana (07.07.17)
Exhibit E-9	Medicaid Exhibit Maryland (04.25.15)
Exhibit E-10	Medicaid Exhibit Nevada (05.28.14)
Exhibit E-11	New Jersey Medicaid Subcontract Exhibit (07.01.17)
Exhibit E-12	New York Medicaid Requirements (08.31.15)
Exhibit E-13	Medicaid Exhibit South Carolina (07.10.17)
Exhibit E-14	Medicaid Exhibit Tennessee – Enrollee Contact (08.10.17)
Exhibit E-15	Medicaid Exhibit Tennessee – No Enrollee Contact (08.10.17)
Exhibit E-16	Medicaid Tennessee BAA – Utilize for all TN Vendors (11.02.16)
Exhibit E-17	Medicaid Exhibit Texas & Affiliates (Seton) (06.22.17)
Exhibit E-18	Virginia Medicaid Requirement (08.03.17)
Exhibit E-19	Medicaid Exhibit Washington (08.29.17)
Exhibit E-20	District of Columbia Specific Requirements (07.27.17)
Exhibit E-21	West Virginia Medicaid Requirements (09.08.16)
Exhibit E-22	Medicaid Exhibit Wisconsin (10.29.15)

EXHIBIT F**Required Information Security Controls**

As part of Anthem's commitment to the protection of Confidential Information, Anthem has established its information security requirements for its suppliers as outlined in this Required Information Security Controls Exhibit ("Exhibit"). The Exhibit shall be effective as of the date the party identified in the attached Agreement (herein "Supplier") first receives, maintains, transmits, accesses or otherwise comes into contact with Anthem Confidential Information. The requirements are intended to describe the minimum standard for physical, technical and, administrative controls affecting Confidential Information in relation to the services Anthem has retained Supplier to provide (herein "Services").

Definitions

Anthem Confidential Information (or Confidential Information), as may be defined in underlying agreements, is further clarified for purposes of this Exhibit to mean any data that is subject to applicable state and federal data security and privacy laws, regulations and guidance, including personally identifiable information and protected health information and any data that contains Anthem trade secrets, proprietary, competitive or sensitive information or systems information that could negatively impact Anthem if made public.

Incident. An occurrence that actually or potentially jeopardizes the confidentiality, integrity, or availability of an information system or the information the system processes, stores, or transmits or that constitutes a violation or imminent threat of violation of security policies, security procedures, or acceptable use policies.

Event. Any observable occurrence in a system and/or network that may indicate than an incident is occurring or has occurred.

1. Compliance

- 1.1. Supplier will comply with all applicable state and federal data security laws, regulations and guidance, and shall abide by all required security controls as stated herein, based upon the nature of the Services provided, the data involved, and/or the location where such Services are rendered. Supplier is responsible for understanding which state and federal laws apply to the Services and the data in scope for the agreement.
- 1.2. Supplier is responsible for its subcontractors. For subcontractors who collect, transmit, share, store, control, process, manage or access Anthem Confidential Information, Supplier is responsible for assessing and monitoring subcontractor control environments for compliance with Anthem's standards as documented in this Exhibit. Supplier shall ensure that any of its subcontractors having greater than incidental access to Anthem Confidential Information shall also be contractually bound to meet or exceed these information security provisions.

2. Information Security Program

- 2.1. Supplier must maintain a written Information Security Program ("WISP") including documented policies, standards, and operational practices that meet or exceed the requirements and controls set forth in this Exhibit to the extent applicable to the Services, and identify an individual within the organization responsible for its enforcement. Supplier's WISP shall address, at a minimum, all security requirements as listed in this Exhibit, as amended from time to time, and comply with all state and federal data security and privacy laws applicable to Anthem. This documentation will be reviewed by Supplier's security official, or its designee, at least annually and shall be updated periodically with changes to organization, technology, or Services. When implementing security controls Supplier shall take a risk-based approach. Any control exceptions which represent risk will be formally documented, monitored, and periodically reviewed.
 - 2.1.1. Supplier's WISP shall be made available to and reviewed by Anthem or Anthem's representative prior to Supplier having access to any Anthem Confidential Information. At Anthem's request and at no cost to Anthem, Supplier shall make commercially reasonable modifications to its WISP or to its data security controls in order to conform to the requirements set forth in this Exhibit, and Anthem reserves the right, in its sole discretion, to terminate Supplier's access to Confidential Information until such time as Supplier has made such modifications to its WISP or data security controls. Supplier shall notify Anthem of any changes to systems, facilities or WISP controls affecting Anthem Confidential Information. This notification should set forth in detail how such changes which will impact Confidential Information.
- 2.2. Supplier shall apply appropriate sanctions against workforce members who fail to comply with security policies and procedures.
- 2.3. Supplier shall have processes and procedures in place so that information security events will be reported through appropriate communications channels as quickly as possible. Such processes and procedures for event reports must be tested, reviewed and updated, by Supplier periodically. All employees, contractors and third party users shall be made aware of their responsibility to report any information security events prior to being granted access to any Anthem Confidential Information. If at any time during the Agreement, Supplier becomes aware of an information security event or that it or any of its subcontractors will or do not meet the obligations described within this Exhibit, Supplier will immediately notify the Anthem Cybersecurity Incident Response Team at csirt@anthem.com.
- 2.4. Supplier shall periodically conduct an accurate and thorough assessment of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of sensitive data (including Anthem Confidential Information). The assessment must be reviewed by Supplier's security official and used to inform the Supplier's information security program.
- 2.5. Upon request, the Supplier shall identify the security official who is responsible for the development and implementation of the policies and procedures.

3. Right to Assess, Audit, & Certify

- 3.1. Anthem, or its designated subcontractors, may assess the design, implementation, and operating effectiveness of Supplier's compliance with this Exhibit.
- 3.2. Upon request, Supplier shall complete a security controls assessment conducted by Anthem ("Security Assessment"). Anthem may require additional Security Assessments in connection with Statements of Work for new or additional Services. To the extent that the Security Assessment identifies any risks or deficiencies for which remediation is required, such remediation requirements or compensating controls (and the timeframes within which they must be successfully implemented) will be set forth in an attachment to this exhibit or the applicable Statement of Work. Supplier's failure to complete any remediation requirements set forth in an attachment to this exhibit or the applicable Statement of Work within the required timeframe shall be deemed to be a material breach of the Agreement.
- 3.3. Certification in the HITRUST Common Security Framework (CSF) is required.
 - 3.3.1. If the Supplier has a HITRUST (HITRUST) Common Security Framework (CSF) Certification applicable to the Services and/or applications in scope for the engagement as of the Effective Date and maintains it throughout the engagement, then that HITRUST certification will be accepted in lieu of the Security Assessment only. Anthem may ask questions specifically related to the protection of Anthem Confidential Information if needed after review of documentation supporting the HITRUST CSF Certification. Provided, however, that Supplier's HITRUST Certification does not waive Anthems rights to assess under Section 3.1 of this Exhibit.
- 3.4. For Suppliers without a HITRUST CSF certification at the time of engagement:
 - 3.4.1. SUPPLIER SHALL (I) COMPLETE AND PROVIDE TO ANTHEM A HITRUST CSF SELF-ASSESSMENT REPORT NO LATER THAN 90 DAYS AFTER THE EFFECTIVE DATE; AND
 - 3.4.2. OBTAIN AND PROVIDE TO ANTHEM A HITRUST CSF VALIDATED REPORT NO LATER THAN 18 MONTHS AFTER THE EFFECTIVE DATE; AND
 - 3.4.3. OBTAIN AND PROVIDE TO ANTHEM A HITRUST CSF CERTIFICATION AND ASSOCIATED DOCUMENTATION, INCLUDING BUT NOT LIMITED TO COMPLETE VALIDATED REPORTS AND CORRECTIVE ACTION PLANS, NO LATER THAN 24 MONTHS AFTER THE EFFECTIVE DATE.
- 3.6. If Supplier has begun the process of obtaining a HITRUST CSF Certification before the Effective Date, then Supplier represents and warrants to Anthem that all corrective action plans that are necessary to obtain a HITRUST CSF Validated Report and/or HITRUST CSF Certification and that have been identified to Supplier prior to the Effective Date shall be communicated to Anthem and documented as an attachment to this exhibit.
- 3.7. Supplier shall promptly (and in any event with 30 days of identification) report to Anthem Information Security at AnthemVendorInfoSec@anthem.com any findings through HITRUST engagement that materially impact Anthem Confidential Information and associated corrective action plans identified during a self-assessment or any third party assessment, including any assessment related to Supplier's independent certification / attestation. Supplier will provide Anthem with any further information associated with such findings, as reasonably requested by Anthem.
- 3.9. If at any time during the engagement, the HITRUST CSF Certification is withdrawn for

any reason, Supplier will contact AnthemVendorInfoSec@anthem.com within 24 hours of learning of the issue to provide information and remediation plans regarding the withdrawal.

- 3.10. From time to time Supplier may be requested to respond to, inform and provide updates regarding specific high risk security gaps or exposures that exist for new or emerging security vulnerabilities that are made publicly known for systems, applications, hardware devices, etc. In all instances Supplier will provide a response to any inquiry within 5 business days, and will provide specific details as to the questions asked to ensure that Anthem can appropriately evaluate the risk or exposure to Anthem Confidential Information.

4. Encryption

- 4.1. Where required by Anthem, Supplier shall apply encryption methodology that, at minimum, conforms to the Federal Information Processing Standards Publication 140-2 Security Requirements for Cryptographic Modules and applicable state and federal regulations ("Approved Encryption").
- 4.2. In instances where Anthem Confidential Information is stored, hosted, or processed in a cloud computing environment Anthem must control the encryption key.
- 4.3. Cryptographic key management procedures must be documented and include references to key lifecycle management (including provisioning, distribution, and revocation) and key expiration dates.
- 4.4. Access to encryption keys must be restricted to named administrators. Encryption keys must be protected in storage. Example methods of acceptable key storage include encrypting keys or storing encryption keys within a hardware security module (HSM). Data-encrypting keys should not be stored on the same systems that perform encryption/decryption operations.
- 4.5. Anthem Confidential Information must be encrypted while in transit and at rest across at least the following types of assets:
- 4.6.1. Public shared networks
 - 4.6.2. Non-wired networks
 - 4.6.3. Cloud services
 - 4.6.4. Desktop and portable computing devices
 - 4.6.5. Mobile devices
 - 4.6.6. Portable media
 - 4.6.7. Back-ups
 - 4.6.8. 'Plug & play' storage devices

5. Network and Systems Security

- 5.1. Supplier shall utilize and maintain a commercially available, industry standard malware detection program which includes an automatic update function to ensure detection of new malware threats.
- 5.2. An intrusion detection or prevention system which detects and/or prevents unauthorized activity traversing the network will be maintained.

- 5.3. Supplier shall have technical controls to detect, alert, and prevent the unauthorized movement of data from Supplier's control (commonly referred to as Data Loss Prevention).
- 5.4. Networks or applications that contain Anthem Confidential Information must be separated from public networks by a firewall to prevent unauthorized access from the public network.
- 5.5. At managed interfaces, network traffic is denied by default and allowed by exception (i.e., deny all, permit by exception).
- 5.6. Supplier shall establish security and hardening standards for network devices, including Firewalls, Switches, Routers, Servers, and Wireless Access Points (baseline configuration, patching, passwords, access control).
- 5.7. Web content filtering must be in place to restrict external webmail, instant messaging, file sharing and other data leak vectors for any Supplier Personnel with direct or indirect access to Anthem Confidential Information.
- 5.8. Quarterly vulnerability scans must be performed, and intrusion detection and identity management systems must be installed and monitored on all systems and components that handle, process, or store Anthem Confidential Information. Upon request, report summaries, including confirmation of remediation for vulnerabilities identified as high- or medium-risk, must be provided to Anthem.
- 5.9. At a minimum, Supplier shall engage a qualified third party to perform annual penetration testing of Supplier's networks containing Anthem Confidential Information. The scope of the penetration testing must, at a minimum, include all internal/external systems, devices and applications that are used to process, store, or transmit Confidential Data, physical security controls for all applicable facilities, and social engineering tests. Supplier must provide Anthem with summary results and a remediation plan at Anthem's request.
- 5.10. Suppliers providing products or Services related to Anthem's members through Anthem member portal or mobile applications, especially those which are internet-facing, or use Anthem domains, are subject to Anthem Information Security's Application Security Program scanning and assessments. Supplier agrees to remediate vulnerabilities identified during this process in a manner and timeline acceptable to Anthem.
- 5.11. Supplier shall ensure that no unencrypted Anthem Confidential Information is stored in any system that is internet facing.

6. System and Application Controls

- 6.1. All Anthem Confidential Information must be securely stored at all times to prevent loss and unauthorized access or disclosure.
- 6.2. Laptop and workstation systems that access Anthem Confidential Information remotely must utilize endpoint protection which includes a personal firewall and anti-malware protection.
- 6.3. Operating systems and application software used must be currently supported by the manufacturer.
- 6.4. Current versions of operating system and application software must be maintained, and patches applied in a timely manner for all systems and applications that receive, maintain, process, or otherwise access Anthem Confidential Information.

- 6.5. Anthem Confidential Information must not be used in any non-production environment such as testing or quality assurance unless de-identification of the data has been performed. In the event that de-identification is not practical or feasible, compensating controls must be in place protecting the data to the same level of protection as afforded to the production environment.
- 6.6. Anthem Confidential Information must be segmented from non-Anthem Information so that appropriate controls are in place to identify the data as Anthem's in all instances, including backup and removable media, and to appropriately restrict access only to users authorized to view the data. Logical separation must allow data to be deleted when it is no longer required.
- 6.7. Logical controls, virtual machine zoning, virtualization security and segregation must be in place to help prevent attacks and exposure in multi-tenancy environments containing Anthem Confidential Information.
- 6.8. Supplier shall maintain an asset management system which records the movement of hardware and electronic media and any persons responsible therefore.

7. Software Development Lifecycle

- 7.1. Supplier must use industry standards such as BSIMM, NIST, OWASP, etc. to build in security for its Systems Development Lifecycle (SDLC).
- 7.2. Supplier must use both an automated and manual source code analysis tool to detect and remediate security defects in code prior to production deployment.
- 7.3. Supplier must have policies and procedures in place to triage and remedy reported bugs and security vulnerabilities for the products/Services it provides to Anthem.
- 7.4. Supplier must have controls in place to prevent unauthorized access to its or Anthem's application, program, or object source code and ensure that access is restricted to authorized Personnel only.
- 7.5. National identifiers or Social Security Numbers must not be utilized as User IDs for logon to applications.

8. Data Destruction

- 8.1. All Anthem Confidential Information, whether such information is in paper, electronic or other form, requires secure disposal or destruction when no longer required. When requested by Anthem or upon the termination or expiration of the Agreement, Supplier must return to Anthem a valid copy of its Confidential Information. After receiving confirmation from Anthem that it has received the valid copy, Supplier must delete Anthem Confidential Information on its systems using security techniques consistent with accepted standards such as NIST 800-88 Guidelines for Media Sanitization. If media containing Anthem Confidential Information is to be reused then that device shall be sanitized according to NIST SP 800-88 Guidelines for Media Sanitization before it may be used by Supplier for any purpose.

9. Physical Controls for the Protection of Anthem Confidential Information

- 9.1. All Anthem Confidential Information received or created in paper form must be protected from viewing by unauthorized persons.
- 9.2. A clean desk policy will be enforced to ensure proper safeguarding of all hard copy Anthem Confidential Information.
- 9.3. Visitor logs documenting all individuals who are not employed by Supplier or Supplier's subcontractors who gain access to the facility where Anthem Confidential Information is processed will be maintained.
- 9.4. Anthem Confidential Information will not leave control of the Supplier without the written approval of Anthem.
- 9.5. Servers, enterprise data storage devices, backup tapes and media, and other computing devices that contain Anthem Confidential Information used to support network communications must be located in a secure and restricted access location within the facility.
- 9.6. Monitoring cameras (e.g., CCTVs) must monitor ingress and egress to sensitive areas within the facility. The monitoring equipment (e.g. CCTV) feed must be monitored either internally or externally by a qualified team. Alerting procedures must be defined and notification performed to qualified Supplier personnel. Processes for retention and review of security logs (e.g. access and visitor logs, CCTV) must be in place.

10. Access Control

- 10.1. Prior to gaining access to Anthem Confidential Information, workforce members will have appropriate background checks completed in compliance with state and federal law.
- 10.2. Security awareness training will be completed prior to access being granted to Anthem Confidential Information, and then completed on an annual basis going forward so long as access to Anthem Confidential Information continues. This training should include, at a minimum, guidance on defending against malware, protecting passwords, monitoring and reporting system notifications, social engineering, and handling sensitive data.
- 10.3. Physical and logical access will be granted to the minimum Anthem Confidential Information necessary to meet the requirements of the user's scope of responsibilities.
- 10.4. Access reviews will be performed at least quarterly for privileged user accounts and twice annually for non- privileged user accounts.
- 10.5. Only those individuals providing Services to Anthem, or those who are responsible for administering or managing systems that contain Anthem Confidential Information, shall be authorized to access systems containing Anthem Confidential Information.
- 10.6. All users that are no longer required or authorized to access Anthem Confidential Information or systems that contain Anthem Confidential Information must have access promptly disabled.
- 10.7. Access to Anthem Confidential Information and systems that contain Anthem Confidential Information must be access controlled through the use of individual user IDs and passwords that meet healthcare industry standard complexity rules and password lifetimes.
- 10.8. If it is suspected a password has been compromised, the password must be immediately changed or reset.

- 10.9. Processes must be in place to create the audit trails capable of determining who has accessed Anthem Confidential Information and/or systems that contain Anthem Confidential Information.
- 10.10. Remote access to systems or networks that contain Anthem Confidential Information must use multi-factor authentication and a connection with Approved Encryption as defined in Section 4 of this Exhibit.
- 10.11. Upon request, Supplier shall provide reports within 48 hours for:
 - 10.11.1. List of all individuals with access to Anthem Confidential Information and/or systems that contain Anthem Confidential Information and the level of access granted;
 - 10.11.2. List of activity associated with any user ID who has access to Anthem Confidential Information.
- 10.12. Supplier workforce will not access or permit other third parties, except for third parties expressly authorized by Anthem, to access Anthem Confidential Information transported by Supplier in the provision of Services.
- 10.13. Account management capabilities, such as account lockouts for unsuccessful login attempts, defined inactivity times, remote access allowances, specific success and failure events, and management of elevated privilege accounts must be enforced.
- 10.14. All identity credentialing, authentication, authorization, and access control events must be logged and those logs are subject to periodic audit. At a minimum, the logs of all specified success and failure events associated with identity and access management in the computing environment it manages must be produced. These logs must then be archived for at least twelve months. These archived logs must be searchable and/or discoverable.

11. Offshore Security Requirement

- 11.1. Anthem Confidential Information is not permitted to be hosted or stored offshore. Offshore locations may be utilized for the processing of data. However, all data must reside on servers located in the United States for the duration of the processing.
- 11.2. Offshore locations will not receive, maintain, process, or otherwise access data backups of Anthem Confidential Information.
- 11.3. Offshore workstation computers must adhere to baseline system security requirements defined by Anthem which enforce the most restrictive mode consistent with operational requirements. All unnecessary services, features and networks must be disabled on workstations used to support Anthem operations, including but not limited to:
 - 11.3.1. Disabling workstations from simultaneously connecting to the Anthem network and other networks (split tunneling);
 - 11.3.2. Disabling access to non-Anthem instant messaging (IM) clients;
 - 11.3.3. Disabling access to non-Anthem email systems;
 - 11.3.4. Disabling access to the Internet;
 - 11.3.5. Disabling user access to local workstation storage or Supplier network storage (such as that to which Anthem Confidential Information or screenshots could be copied);
 - 11.3.6. Disabling access to printers.

- 11.4. Wireless access is prohibited from being used to access Anthem Confidential Information from offshore locations.
- 11.5. All work from offshore locations must be performed in Anthem-approved facilities.
- 12. Enterprise Standards Governance**
 - 12.1. Anthem Confidential Information must not be placed into a cloud computing environment without review and approval by Anthem's Enterprise Standards Governance group.
 - 12.2. If upon review by Anthem's Enterprise Standards Governance, items are identified for remediation, such remediation must be completed in agreed upon timeframes.
- 13. Contingency Planning**
 - 13.1. Supplier will have a documented Business Continuity and Disaster Recovery plans in place that include information security controls. Such plans will be tested at least annually.
- 14. Incident Response**
 - 14.1. Supplier will have a documented Incident Response Plan. Such plan will be tested at least annually.
 - 14.2. Incident response roles and responsibilities must be clearly outlined between Supplier and Anthem as appropriate.
- 15. Payment Card Industry Data Security Standard**
 - 15.1. If, in performing Services to or on behalf of Anthem, Supplier acts as a Merchant or payment card processor as defined by the Payment Card Industry Data Security (PCI DSS) standard, then Supplier agrees to comply with the applicable PCI DSS requirements.
- 16. Litigation Holds**
 - 16.1. The Supplier must provide a detailed mechanism for how litigation holds will be implemented. This will include how metadata will be created, accessed, and stored in a cloud environment.
- 17. No Sale of Anthem Confidential Information Permitted**
 - 17.1. The sale of Anthem Confidential Information, or derivatives thereof, especially Anthem member data (such as PHI, PII, or PCI data) is prohibited. For clarification, this prohibition applies regardless of whether or not the data has been de-identified.

EXHIBIT G**Qualified Health Plan
Regulatory Exhibit**

The following Qualified Health Plan terms and conditions shall be incorporated into the Agreement. These provisions shall only apply to services provided by Vendor to or for Health Plan's "Qualified Health Plans" as defined in and in accordance with 45 CFR Parts 155 and 156, and any subsequent amendments or relevant provision in the regulations.

Federal Requirements - Applicable to all Health Plans that are Qualified Health Plans

1. **Qualified Health Plans.** Vendor acknowledges that payments Vendor receives from Health Plan may be used to provide services to Qualified Health Plan Covered Individuals. Therefore, Vendor and any of its subcontractors may be subject to certain laws that are applicable to individuals and entities providing services to Qualified Health Plans, including but not limited to, 45 CFR §§155.1210 and 156.340. Vendor agrees to comply with the requirements of 45 CFR §§155.1210 and 156.340, including but not limited to those set forth in the following sections of this Exhibit.
2. **Maintenance of Books and Records.** In accordance with 45 CFR §§155.1210 and 156.340, Vendor agrees that it will maintain all books and records related to its provision of services to Qualified Health Plans for ten (10) years.
3. **Inspection of Books and Records.** In accordance with, 45 CFR §§155.1210 and 156.340, Vendor acknowledges that the State where Health Plan is located, the Department of Health and Human Services (HHS), the Office of Inspector General, State regulatory agencies, or their designees have the right to timely access to inspect, evaluate and audit any books, contracts, medical records, patient care documentation, and other records of Vendor, or its first tier, downstream and related entities, including but not limited to subcontractors or transferees involving transactions related to Health Plan's Qualified Health Plans through ten (10) years from the final date of the contract period or from the date of the completion of any audit. For the purposes specified in this provision, Vendor agrees to make available Vendor's premises, physical facilities and equipment, records relating to Health Plan's Covered Individuals, including access to Vendor's computer and electronic systems and any additional relevant information that the State, HHS, OIG or their designees may require.
4. **Subcontractors.** In accordance with, 45 CFR §§155.1210 and 156.340, Vendor agrees that if Vendor enters into subcontracts to perform services under the terms of the Agreement, Vendor's subcontracts shall include an agreement by the subcontractor to comply with all of the Vendor obligations in this Qualified Health Plan Regulatory Exhibit and applicable terms in the attached Agreement. Such subcontract shall specify the delegated activities and reporting requirements.
5. **Termination-Regulatory Issues.** In accordance with 45 CFR §§155.1210 and 156.340, if during the term of the Agreement, the Health Plan concludes that it is necessary to cancel any of the activities to be performed under this Agreement in order to comply with Federal or State laws, regulations, or policies applicable to Qualified Health Plans, Health Plan may, at its discretion, cancel the activity and be relieved of any related obligations under the terms of the Agreement. If Health Plan or Vendor concludes that it is necessary to reorganize or restructure any of the activities to be performed

under this Agreement in order to comply with Federal or State laws, regulations, or policies applicable to Qualified Health Plans, Health Plan or Vendor may request to renegotiate such terms.

6. **Revocation.** Vendor agrees that Health Plan has the right to revoke this Agreement for its Qualified Health Plans if HHS, the applicable State regulatory agency or Health Plan determines that Vendor or any of its independent contractors or subcontractors has not performed the services satisfactorily and/or if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner. Such revocation shall be consistent with the termination provisions of the Agreement.

State-Specific Requirements

The following additional provisions apply if and only to the extent that Vendor provides services to or for Qualified Health Plans in the specified state.

Connecticut - If Vendor is a “Material subcontractor”, Vendor will comply with all of the applicable provisions of the contract between Health Plan and the State Exchange Board. “Material subcontractor” means “any entity from which Health Plan procures or re-procures, or proposes to subcontract with for the provision of, all or part of its administrative services for any major program area or function that relates to the delivery of care including but not limited to behavioral health, claims processing, or pharmacy benefit and/or actuarial support.”

Nevada - Vendor agrees that if it receives from or creates for Health Plan, as a Qualified Health Plan in the State of Nevada, any PHI (protected health information) or PII (personally-identifiable information), Vendor will implement reasonable and appropriate safeguards to protect such PHI or PII. Prior to any Vendor employee or agent receiving or having access to any PHI or PII, Vendor must first have entered into a business associate agreement with Health Plan.

New York - Vendor agrees that all work performed by it for Health Plan must be in accordance with the terms of this contract between Health Plan, as a Qualified Health Plan, and the State of New York (the “QHP Contract”), including, without limitation, the confidentiality provisions set forth therein. Under no circumstances shall Vendor subcontract any of its duties or obligations under the Agreement without the prior written approval and knowledge of the Health Plan and New York Department of Health.

Vendor shall promptly notify Health Plan in writing of any inquiry, audit, investigation, litigation, claim, examination or other proceeding involving Vendor, or any of its personnel, that is threatened or commenced by any regulatory agency or other party that a reasonable person might believe could materially affect the ability of Vendor to perform in accordance with the terms set forth in the Agreement or in the QHP Contract. Vendor shall provide such notice within ten (10) days of the date when Vendor learns of such action/event. Vendor acknowledges that Health Plan is obligated to notify the State of New York of such actions/events under the terms of the QHP Contract. Vendor shall comply with the State of New York's reasonable requests for information relating to the reported action/event; provided, however than any such exchange of information shall be subject to compliance with law and shall not occur to the extent prohibited by order of the court, administrative agency, or other tribunal or regulatory authority having jurisdiction over the matter or by the laws and regulations governing the action.

EXHIBIT G-“###”**West Virginia State-Specific Requirements - Subcontractors**

As a subcontractor under the contract (hereafter referred to as the “Medicaid Contract”) between UNICARE Health Plan of West Virginia, Inc. (hereafter referred to as the “Contractor”) and the West Virginia Department of Health and Human Resources Bureau for Medical Services (“BMS”) for the provision of risk-based comprehensive health services to enrollees in the West Virginia Mountain Health Trust program or any other similar program (“Medicaid Managed Care Program”) administered by BMS (hereafter referred to as “Members”, “Covered Individuals”, or “Covered Population”), the Subcontractor agrees to abide by all applicable provisions of the terms of the Medicaid Contract, including but not limited to the following.

:

1. The subcontract may not terminate legal liability of the Contractor under this contract including, but not limited to, Section 6 of this Contract. No terms of this Agreement are valid which terminate legal liability of the Contractor in the Medicaid Contract to assure that all activities under the Medicaid Contract are carried out.
2. The Subcontractor agrees to participate in and contribute required data to Contractor’s quality improvement and other assurance programs as required in the Medicaid Contract.
3. The Subcontractor agrees to abide by the terms of the Medicaid Contract for the timely provision of emergency and urgent care. Where applicable, the Subcontractor agrees to follow those procedures for handling urgent and emergency care cases stipulated in any required hospital/emergency department Memorandums of Understanding or other written agreements signed by the Contractor in accordance with the Medicaid Contract.
4. The Subcontractor agrees to submit Contractor utilization data in the format specified by the Contractor, so the Contractor can meet BMS specifications required by Medicaid Contract.
5. The Subcontractor agrees to comply with all non-discrimination requirements in Medicaid Contract. The Subcontractor 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 Subcontractor agrees that a breach of this certification is a violation of Equal Opportunity in Federal employment. In addition, the Subcontractor 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.

6. The subcontractor agrees that:
 - a. The State, CMS, the HHS Inspector General, the Comptroller General, or their designees have the right to audit, evaluate, and inspect any books, records, contracts, computer or other electronic systems of the subcontractor, or of the subcontractor's contractor, that pertain to any aspect of services and activities performed, or determination of amounts payable under the MCO's, PIHP's, or PAHP's contract with the State.
 - b. The subcontractor will make available, for purposes of an audit, evaluation, or inspection under paragraph (c)(3)(i) of this section, its premises, physical facilities, equipment, books, records, contracts, computer or other electronic systems relating to its Medicaid enrollees.
 - c. The right to audit under paragraph (c)(3)(i) of this section will exist through 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.
 - d. If the State, CMS, or the HHS Inspector General determines that there is a reasonable possibility of fraud or similar risk, the State, CMS, or the HHS Inspector General may inspect, evaluate, and audit the subcontractor at any time.
 - e. 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 shall be responsible for overseeing the organization's compliance program and its compliance with the requirements under the contract.
 - f. The 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 subcontractors must have in place internal controls, policies, and procedures to prevent and detect fraud and abuse (FWA). The subcontractor must have a formal Medicaid compliance plan with clear goals, assignments, measurements, and milestones
7. The Subcontractor, for purposes of audit, must provide the Contractor, BMS, the Secretary of the U.S. Department of Health and Human Services and his/her designated agent, and any other legally authorized governmental entity or their authorized agents access to all materials and information pertinent to the services provided under this Contract, at any time, until the expiration of 10 (ten) years from the completion date of this Contract as extended. The Subcontractor 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 Subcontractor agrees 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 year post Contract period, or until final resolution of all pending audit questions and litigation. During the Contract period, access to these items will be provided to the Contractor, BMS 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 period, delivery of and access to the listed items will be at no cost to the Contractor or State.

- a. MCO and subcontractors must provide reasonable facilities and assistance for the safety and convenience of the persons performing inspections. BMS and authorized agents will request access in writing, except in case of suspected fraud and abuse. 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.
 - b. In the event that right of access is requested, MCO or 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 effort.
 - c. The subcontractor must maintain books and records relating to West Virginia's Medicaid managed care program services and expenditures, including reports to BMS and source information used in report preparation. These reports include but are not limited to financial statements, records relating to quality of care, and medical records. MCO and subcontractors must provide, at no cost to BMS or a designee, prompt, reasonable, and adequate access to any records, books, documents, papers, and files related to performance under the contract. The subcontractor agrees to permit inspection of records, which will be conducted in accordance with federal and state laws and regulations regarding confidentiality. The subcontractor and MCO are required to submit information to BMS in a manner that maintains the confidentiality of involved parties. The subcontractor must comply with the record retention requirements of Title 45, Sections 74.21 through 74.23 (45 CFR 74.21 through 74.23). Such records, with the exception of medical records and member and provider quality assurance and quality improvement records when confidentiality is protected by law, are the property of BMS.
8. 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, must be retained for at least 10 (ten) years from the date of expiration or until 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 completion of the action and resolution of all issues which arise from it, or until the end of the regular-ten year period, whichever is later. The Subcontractor agrees to retain the source records for its data reports for a minimum of 10 (ten) years, and must have written policies and procedures for storing this information.
 9. The subcontract must maintain an appropriate record system for services to enrolled recipients. The Subcontractor agrees to the requirements for maintenance and transfer of medical records stipulated in Medicaid Contract. Subcontractor agrees to make medical records available to Members and their authorized representatives within ten (10) working days of the record request.
 10. The Subcontractor agrees that all information that is obtained through performance under this contract, including, but not limited to, information relating to applicants or recipients

of BMS programs, is confidential to the extent that confidential treatment is provided under state and federal law, rules, and regulations. The Subcontractor further agrees to ensure confidentiality of family planning services in accordance with Medicaid Contract, except to the extent required by law, including but not limited to, the West Virginia Freedom of Information Act.

11. The Subcontractor agrees not to create barriers to access to care by imposing requirements that are inconsistent with the provision of Medically Necessary and covered Medicaid services.
12. The Subcontractor agrees to inform its providers, agents, and subcontractors of referral, preauthorization or other approval requirements applicable to the Medicaid Managed Care Program and to ensure compliance with such requirements. Additionally, the Subcontractor agrees to hold any Member harmless for charges for any service covered under the Medicaid Contract. This includes those circumstances where the provider fails to obtain necessary referrals, preauthorizations, or fails to perform other required administrative functions.
13. MCO must include provisions against the risk of insolvency and assure that neither enrollees nor BMS are held liable for debts in the event of MCO's insolvency or the insolvency of any subcontractors. The Subcontractor agrees not to bill a Member or BMS for Medically Necessary services covered under the Medicaid Contract and provided during the Member's period of Contractor enrollment. This provision shall continue to be in effect even if the Contractor becomes insolvent. However, if a Member agrees in writing in advance of receiving the service to pay for a non-Medicaid covered service, then the Contractor, or Contractor's agents or subcontractors may bill the Member. In the event that the Subcontractor enters into one or more subcontracts, the Subcontractor will ensure that each such subcontractor agrees not to bill a Member or BMS for Medically Necessary services covered under the Medicaid Contract and provided during the Member's period of Contractor enrollment and that this provision shall continue to be in effect even if the Subcontractor becomes insolvent.
14. The Subcontractor must forward to the Contractor medical records, within ten (10) working days of the Contractor's request.
15. If the Subcontractor is a primary care provider, the Subcontractor shall promptly provide or arrange for the provision of all services required under the Participating Provider Agreement. This provision shall continue to be in effect for periods for which payment has been made even if the Subcontractor becomes insolvent until such time as the Member is withdrawn from assignment to the Subcontractor.
16. If the Subcontractor is a primary care provider, the Subcontractor agrees, except in the case of death or illness, to notify the Contractor at least sixty (60) days in advance of his or her disenrollment from the Medicaid Managed Care Program and agrees to continue care for his or her panel Members for up to thirty (30) days after such notification, until another PCP is chosen or assigned.

17. The Contractor agrees to use best efforts to pay the Subcontractor within thirty (30) days of the receipt of a claim for covered services rendered to a covered Member unless there is a signed agreement with the Subcontractor that states another timeframe for payment that is acceptable to that Subcontractor.
18. Notwithstanding any other provision to the contrary, the obligations of West Virginia shall be limited to annual appropriations by its governing body for the purposes of the subcontract.
19.
 - a. Subcontractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by state law relating to discrimination in employment, except when there is a bona fide occupational qualification reasonably necessary to the normal operation of the Subcontractor. The Subcontractor agrees to posting in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.
 - b. The Subcontractor, in all solicitations or advertisements for employees placed by or on behalf of the Subcontractor, will state that such Subcontractor is an equal opportunity employer.
 - c. Notices, advertisements, and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.
20. During the performance of this agreement, the Subcontractor agrees to (i) provide a drug-free workplace for the Subcontractor's employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Subcontractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition; and (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Subcontractor that the Subcontractor maintains a drug-free workplace.
21. The Subcontractor warrants that it is eligible to participate in the Medicaid Managed Care Program. Subcontractor agrees to notify Contractor immediately in writing of any change in Subcontractor's eligibility for such program. The Subcontractor agrees to indemnify and hold harmless the State of West Virginia, its agencies (including, without limitation, BMS), officers, and employees from and against:
 - a. Any claims or losses for services rendered by any subcontractor, person or firm performing or supplying services, materials, or supplies in connection with the Subcontractor's performance of the contract. The activities of the Enrollment broker and the Fiscal Agent do not constitute the Subcontractor's performance;
 - b. 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 Subcontractor, its officers, employees, or subcontractors in the performance of the contract;
- c. Any claims or losses resulting to any person or entity injured or damaged by the Subcontractor, 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;
 - d. Any failure of the Subcontractor, its officers, employees or subcontractors to observe State and Federal laws, including but not limited to labor and minimum wage laws.
22. The Subcontractor, its officers, employees, subcontractors, or any other agent of the Subcontractor in performance of this agreement will act in an independent capacity and shall not hold themselves out to be officers or employees of the State of West Virginia or of BMS.
23. The Subcontractor covenants that it, its officers or members, employees or subcontractors shall not acquire any interest, direct or indirect which would conflict or compromise in any manner or degree with the performance of its services under this Agreement.
24. The Subcontractor shall 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 Subcontractor shall submit to the Department a disclosure form as provided in 45 CFR 93.110 and Appendix B to 45 CFR Part 93, 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.
25. The Subcontractor shall 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. Work performed under this contract must conform to the federal requirements set forth in Title 45, CFR Part 75 and Title 42, Part 434, including all applicable requirements for subcontracts as required by 42 CFR 434.6. The Subcontractor shall also 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 Patient Protection and Affordable Care Act (PPACA), P.L. 111-148, enacted on March 23, 2010, and the Health Care and Education Reconciliation Act of 2010 (HCERA), P.L. 111-152, enacted on March 30, 2010, Title VI of the Civil Rights Act of 1964, 45 CFR Part 80, as applicable, 7 CFR Part 7, as applicable, Section 504 of the Rehabilitation Act of 1973, Americans with Disabilities Act of 1990, as amended, Age Discrimination Act of 1975, Title IX of the Education Amendments of 1972, Food Stamp Act of 1977, Executive Order 11246 and 41 CFR Part 60, Executive Order 13279 and 45 CFR Part 87

and 7 CFR Part 16, and the Immigration Reform Control Act of 1986. The Subcontractor shall report to the Contractor and/or BMS any data necessary to comply with the program integrity and drug rebate provisions set forth in PPACA and HCERA, including the collection of National Drug Codes (NDC) on physician-administered drugs (e.g., J-code services).

26. The Contractor, the State of West Virginia, CMS, the Office of the Inspector General, and any other legally authorized governmental entity shall monitor the Subcontractor's performance on an ongoing basis and subject it to formal review according to a periodic schedule established by BMS, consistent with industry standards or West Virginia laws and regulations. Additionally, BMS, the United States Department of Health and Human Services, the State of West Virginia, CMS, the Office of the Inspector General, and any other legally authorized governmental entity are, in accordance with the terms set forth in this Section, authorized to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under the subcontract at any time. When deficiencies or areas for improvement are identified, the Contractor and the Subcontractor must take corrective action. The activities and report responsibilities delegated to the Subcontractor may be revoked in whole or in part or other sanctions may be invoked if the Subcontractor does not satisfy standards set forth herein or take the corrective action set forth herein. The Subcontractor must agree to comply with a monitoring plan developed by the MCO.
27. As a subcontractor to the Contractor under its contract with BMS, the Subcontractor further agrees as follows:
- a. The Subcontractor agrees that the following are ineligible physicians/groups/providers:
- i. Entities convicted of a criminal offense related to delivery of Title XVIII, Title XIX, or Title XXI services.
 - ii. Entities convicted of payment abuse.
 - iii. Entities convicted of fraud or other financial misconduct.
 - iv. Entities convicted of obstructing an investigation.
 - v. Entities convicted of offenses relating to controlled substances.
 - vi. Entities terminated from the Title XIX Program.
 - vii. Entities terminated from the Title XXI Program.
 - viii. Entities that meet the following criteria:
 1. An individual/entity that is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation 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/entity that is an affiliate, as defined in the Federal Acquisition Regulation, of an individual/entity that meets the requirements of subsection a.viii.A above.

The affiliate relationship is described as follows:

 - A director, officer, or partner of the individual/entity
 - A person with beneficial ownership of five percent or more of the individual's/entity's equity.

- A person with an employment, consulting or other arrangement with the Subcontractor who performs any part of Subcontractor's obligations under its contract with Contractor.

Please refer to the Federal Debarment List located at: www.sam.gov or for a listing of federally debarred and suspended individuals/entities and the Federal List of Excluded Individuals/ Entities (LEIE) database, available at http://www.oig.hhs.gov/fraud/exclusions/exclusions_list.asp.

- b. The Subcontractor certifies that neither it nor its principals nor any of its subcontractors are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from entering into this Attachment by any Federal agency or by any department, agency or political subdivision of the State. For purposes of this Attachment, "principal" means an officer, director, owner, partner, key employee, or other person with primary management or supervisory responsibilities, or a person who has a critical influence or substantive control over Subcontractor's operations.
 - c. The Subcontractor agrees to comply with requirements set forth in 42 CFR 455.100 through 455.106 (regarding disclosure by subcontractors of ownership and control information and disclosure of information on a subcontractor's owners' and other persons' conviction of criminal offenses against Medicare, Medicaid, or Title XX services program) and will agree to provide required disclosures at the time of initial contract, upon contract renewal, and/or upon request by the Contractor. The Subcontractor further agrees to notify the Contractor within 14 days of any changes to the required disclosures except that the Subcontractor shall notify Contractor immediately after it receives notice of any such convictions, deferred adjudications and all types of pretrial diversion programs as set forth in 42 CFR 455.106.
28. All subcontracts must be in writing and the Subcontractor shall assure that all subcontracts shall comply with the provisions of the Medicaid Contract, and shall include any general requirements of the Medicaid Contract that are appropriate to the service or activity identified. The subcontract shall specify the activities and report responsibilities delegated to the subcontractor and provide for revoking said delegation or imposing other sanctions if the subcontractor's performance is inadequate. The subcontract shall ensure that the MCO is held accountable and liable for any functions and responsibilities that it delegates to any subcontractor.
29. The Subcontractor shall comply with and shall ensure that its subcontractors comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191), and the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 et. seq. The Subcontractor and its subcontractors must treat all information that is obtained through the performance of the services included in this Agreement 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 recipients of BMS programs. The Subcontractor and its subcontractors shall not use any such information obtained except as necessary to the proper discharge of the Subcontractor's and/or its subcontractor's obligations and securing of the Subcontractor's rights hereunder or the subcontractor's

rights under any subcontract with Subcontractor. Notwithstanding anything stated to the contrary in the Business Associate Agreement by and between UniCare and Subcontractor, Subcontractor agrees to the following notification requirements in the event of a breach of PHI:

i. Notification of Breach. The Subcontractor shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology, immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and, unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or <https://apps.wv.gov/ot/ir/Default.aspx>.

ii. The Subcontractor shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Subcontractor shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

iii. The Agency will coordinate with Subcontractor to determine additional specific actions that will be required of the Subcontractor for mitigation of the Breach, which may include notification to the individual or other authorities. All associated costs shall be borne by the Subcontractor. This may include, but not be limited to costs associated with notifying affected individuals.

iv. If the Subcontractor enters into a subcontract relating to the Agreement where the its agent receives PHI as described herein, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

30. The Contractor must prohibit the subcontractor from engaging in direct marketing to enrollees that is designed to increase enrollment in a particular health plan, if applicable. The Subcontractor and its subcontractors shall comply with 42 CFR 438.104 and are prohibited from engaging in direct marketing to enrollees that is designed to increase enrollment in a particular managed care organization. The prohibition does not constrain the Subcontractor from engaging in permissible marketing activities consistent with broad outreach objectives and application assistance.

31. The Subcontractor may not interfere with or place any liens upon the State's right or the Contractor's right, acting as the State's agent, to recovery from third party resources.
32. The Subcontractor shall comply with 42 CFR 422.128 and West Virginia Health Care Decisions Act relating to advance directives.
33. Neither the Subcontractor nor its subcontractors may collect copayments from Members for missed appointments.
34. If the Subcontractor provides the services of physicians to Members, each such physician's minimum policy limits for professional liability insurance shall be equal to \$1,000,000 per occurrence and \$3,000,000 in the aggregate.
35. If the Subcontractor provides services of emergency services providers to Members, the emergency services provider shall educate Members on the amount of his or her copayment for non-emergency services provided in the emergency department prior to providing non-emergency services. The emergency services provider must be required to provide a Member with the name and location of an available and accessible alternative non-emergency services provider.
36. The Subcontractor must report to the Contractor all provider-preventable conditions associated with Covered Services provided to Members.
37. If the Subcontractor receives annual Medicaid payments of at least \$5 million (cumulative from all sources), the Subcontractor must comply with Section 6032 of the Deficit Reduction Act of 2005. The Subcontractor must: 1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the Subcontractor. 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). 2. Include as part of such written policies detailed provisions regarding the Subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse. 3. 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 Subcontractor's policies and procedures for detecting and preventing fraud, waste, and abuse.
38. [Use this if UniCare is paying claims] The Contractor shall pay all clean claims for Covered Services rendered by the Subcontractor to a Member within 30 calendar days of receipt, except to the extent the Subcontractor has agreed to later payment in writing. The date of receipt is the date that the Contractor received all documentation necessary to pay the claim, as indicated by its date stamp on the claim or other documentation, and date of payment is the date of the check release or other form of payment release to the Subcontractor. The Contractor shall pay interest in accordance with the Medicaid Contract requirements for the period in which the clean claim remains unpaid beyond the

30-day period. Interest owed to the Subcontractor shall be paid on the same date as the claim.

[Use this if the Subcontractor is paying claims] The Subcontractor shall pay all clean claims for Covered Services rendered by its subcontractor to a Member within 30 calendar days of receipt, except to the extent the subcontractor has agreed to later payment in writing. The date of receipt is the date that the Subcontractor received all documentation necessary to pay the claim, as indicated by its date stamp on the claim or other documentation, and date of payment is the date of the check release or other form of payment release to the subcontractor. The Subcontractor shall pay interest in accordance with the Medicaid Contract requirements for the period in which the clean claim remains unpaid beyond the 30-day period. Interest owed to the subcontractor shall be paid on the same date as the claim.

- 39.A Subcontract, or any other agreement in which the Contractor 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, agreed upon in compliance with contract obligations and the Contractor must allow the BMS or its authorized agents to examine the Subcontract or agreement and all related records
- a. The subcontract must specify any activities to be performed by the subcontractor that are related to third party liability requirements, if applicable
40. The BMS reserves the right to require the replacement of any subcontractor found by the BMS to be unacceptable and unable to meet the requirements of the Contract and to object to the selection of a subcontractor.
41. The Contractor must notify the BMS of all legal proceedings, actions, and events relating to the Contractor or its subcontractors, affiliates, including parent companies. At a minimum, the following matters must be disclosed:
- a. whistleblower or qui tam actions, complaints, or litigation;
- b. class-action complaints or lawsuits;
- c. legal actions or governmental investigations, alleging fraud or the possibility of fraud;
- d. bankruptcy proceedings or petitions where the Contractor, or its subcontractors, affiliates, including parent companies, are named as a debtor;
- e. any litigation, mediation, arbitration, between the Contractor and its subcontractor; and
- f. criminal actions brought against the Contractor, or its subcontractors, affiliates, including parent companies.

The Contractor must provide written notification within 30 (thirty) calendar days after becoming aware of a matter.

42. Enrollee written materials must be readable at the 6th grade level and easily understood. Materials must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or

have limited reading proficiency. Additionally, all enrollees and potential enrollees must be informed that information is available in alternative formats and how to access those formats. The subcontractor must establish a methodology for identifying the prevalent non-English languages spoken by enrollees and potential enrollees throughout the State, make available written information in each prevalent non-English language, and make oral interpretation services available. These services must be free of charge to each potential enrollee and enrollee. This applies to all non-English languages, not just those that the state identifies as prevalent.

- a. Subcontractor should notify enrollees and potential enrollees that oral interpretation is available for any language and written information is available in prevalent languages, and how to access those services. 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.
 - b. Written materials must include taglines in the prevalent non-English languages and large print (a font size no smaller than eighteen (18) point) explaining the availability of written translation or oral interpretation and the toll-free and TTY/TDY telephone number of MCOs
43. The Contractor and 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."
- All work performed by the Contractor or a subcontractor under this Contract must be performed exclusively within the United States. No payments shall be made for services or items by the Contractor or a subcontractor to any entity or financial institution outside of the United States.
- All information obtained by the Contractor or a subcontractor under this Contract must be stored and maintained within the United States.
44. The Contractor is responsible for any damages, penalties, or disallowances imposed on the State or Contractor arising from any non-compliance or non-performance related to the delivery of the covered services or deliverables under this Contract by the Contractor, its subcontractors or agents.
45. The subcontract must require a written notice of intent to be furnished by the Contractor or its subcontractor in case of the subcontract termination for any reason. A written notice of intent must be given within the following timeframes:

1. 90 days prior to the termination date of a subcontract for systems operations or reporting;
2. 30 days prior to the termination date of a subcontract for administrative services; and
3. 30 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.)

4. Upon non-renewal or termination of the subcontract, the subcontractor must turn over or provide copies to MCO or BMS, or to a designee of BMS, all documents, files, and records relating to persons receiving services and to the administration of this contract that BMS may request.
-
46. The Contractor and Subcontractor must provide safeguards that restrict the use or disclosure of information concerning enrollees to purposes directly connected with the administration of this contract. To this end, the Contractor and Subcontractor must establish 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 Contractor 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.
 47. All contractors or subcontractors 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 must be confidential and may not be released without the written consent of the covered persons or responsible party, except as specified below.
 - i) 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 Contractor. This provision also applies to specialty providers who are retained by the Contractor to provide services that are infrequently used or are of an unusual nature. This also allows for transfer of information (written or verbal) to BMS staff and to BMS subcontractors.
 - ii) Written consent is not required for the transmission of medical record information to physicians or facilities providing emergency care, or to the Contractor, its staff, contracted providers, or its contractors that are providing cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation.
 - iii) Written consent is required for the transmission of the medical record information of a former enrollee to any physician not connected with the Contractor, except as set forth in (ii) above.
 2. The extent of medical record information to be released in each instance must 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.

48. The subcontract or subcontractor disclosure forms must provide the definition of ownership per 42 CFR § 455.101. The subcontractor must agree to keep all information current at all times by informing the Contractor in writing within 35 days of any ownership and control changes to the original information.
49. The subcontract or disclosure forms must request the subcontractor to disclose information on ownership and control. A subcontractor that is a business entity, corporation or a partnership must disclose the name, DOB, SSN and address of each person who is a person with ownership and control interest or a partner, officer, director or a managing employee (the Contractor must document whether the control interest is direct or indirect.) The address for corporate entities must include as applicable: primary business address, every business location and P.O. Box address, and tax ID.
50. The subcontract or disclosure forms must request the tax ID for those subcontractors in which the Contractor subcontractor (if entity) has a 5 percent or more interest.
51. The subcontractor or disclosure forms must request information on interrelationship of persons. Specifically, whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the Contractor has a 5 percent or more interest is related to another person with ownership or control interest in Contractor as a spouse, parent, child, or sibling
52. Subcontractor must certify that the subcontractor and its owners, persons with control interest, managing employees, partners, directors, and officers 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. Subcontractor must certify 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. Subcontractor must verify certified information through: GAS-EPLS, HHS-OIG LEIE, State Exclusion List.
53. Subcontractor must certify that the subcontractor and its owners, persons with control interest, managing employees, partners, directors, and officers 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. Subcontractor must certify 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. Subcontractor must verify certified information through: GAS-EPLS, HHS-OIG LEIE, and State Exclusion List.
54. The Subcontractor may notify the Contractor immediately at the time it receives notice

that any action is being taken against a subcontractor 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.

55. The Subcontractor agrees to fully comply at all times with the requirements of 45 CFR Part 76, relating to eligibility for federal agreements and grants.
56. The subcontract or subcontract disclosure forms must request the subcontractor, its owners, persons with control interest, provider agents, officers, partners and managing employees 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. In addition, the subcontractor may notify the Contractor immediately at the time it receives notice of such conviction.
57. The subcontract must specify that operational information, including correspondence, documentation of ongoing or outstanding issues, operations support documentation, and operational information regarding Subcontractors as part of MCO Transition.
58. The subcontract must stipulate that the Subcontractor must satisfy all Readiness Review requirements prior to the Subcontractor(s) operational start date.
59. The subcontract must prohibit billing enrollees any amount greater than would be owed if the MCO provided the services directly, if applicable. Enrollees must be held harmless for the costs of all Medicaid-covered services provided except for applicable cost-sharing obligations.
60. The subcontract must require reducing payments to the network providers by the amount of the member's copay, regardless of whether the provider successfully collects the copay. The Subcontractor or providers may not routinely waive required co-pays.
61. The subcontract must provide that the Subcontractor or its providers may not charge co-pays to the following MCO members:
 - Members under age 21 ;
Pregnant women (including the 60-day postpartum period following the end of pregnancy);
 - American Indians and Alaska Natives;
Members in hospice care;
 - Members who have met their annual maximum limit for the cost-sharing obligations.
62. The subcontract must provide that the subcontractor or its providers may not charge co-pays to the following MCO services:
 - Emergency services;
 - Family planning services;
 - Pregnancy-related services;
 - Services furnished to women who are receiving medical assistance on the basis of

- the breast or cervical cancer eligibility group;
- Preventive services for the members under age 18 ;
- Services for provider-preventable conditions; and
- Any additional members or services excluded under the State Plan authority.

The subcontract must require compliance with the enrollee grievance, appeal, and fair hearing procedures and timeframes

63. The Subcontractor shall have written policies and procedures for maintaining the confidentiality of data, including medical records/enrollee information and adolescent/STD appointment records. The policies must be in accordance with the privacy requirements in 45 CFR parts 160 and 164, upon their effective dates, to the extent applicable. All enrollee information, medical records, data and data elements collected, maintained or used in the administration of this contract must be protected from unauthorized disclosure.
64. Subcontractors must comply with all applicable Federal and State laws, including the HIPAA Privacy and Security Rule governing the use and disclosure of protected health information.
65. The MCO must explain the definition of “Convicted” in the disclosure form per 42 CFR 1001.2, which includes all convictions, deferred adjudications, and all types of pretrial diversion programs.
66. The Subcontract must comply with the SMDL 06-024. If the entity receives annual Medicaid payments of at least \$5 million (cumulative, from all sources), requiring the Subcontractor: 1. 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). 2. Include as part of such written policies detailed provisions regarding the network provider’s policies and procedures for detecting and preventing Fraud, Waste, and Abuse. 3. 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 Fraud, Waste, and Abuse.
67. The Subcontract must follow marketing requirements.
68. The Subcontract must specify procedures and criteria for terminating the contract, including a requirement that the contractor promptly supply all information necessary for the reimbursement of any outstanding Medicaid claims.
69. The subcontract covering behavioral services must be rendered by providers within the scope of their license and in accordance with all state and federal requirements.

70. The subcontract must require that a subcontractor has in place, and follows, written policies and procedures for processing requests for initial and continuing authorizations of services
71. The subcontract 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 with the following service levels:
 - 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
 - The call abandonment rate does not exceed five percent (5%) of total calls for the reporting period.

Supplemental Document 4.1-2: Sample Performance Indicator Report and GeoAccess Map

Supplemental Document 4.1-2 includes the following:

- Supplemental Document 4.1-2a: Sample VSP PI Report
- Supplemental Document 4.1-2b: Sample VSP GeoAccess Report
- Supplemental Document 4.1-2c: Sample SKYGEN PI Report
- Supplemental Document 4.1-2d: Sample SKYGEN GeoAccess Report

Performance Indicator Report**VSP****WV Medicaid****Q3 - 2019**

	Jul	Aug	Sep	Qtr 3 2019
Provider Network				
Total Number of Vision Providers	155	154	152	154
Total Number of Optometrists	147	146	144	146
Total Number of Ophthalmologists	8	8	8	8
Member Call Center Statistics				
Total Call Volume	121	110	109	340
Number of Calls Answered	75	66	67	208
Number of Calls Abandoned	0	0	0	0
Abandonment Rate	0.00%	0.00%	0.00%	0.00%
Blocked Call Rate	0.00%	0.00%	0.00%	0.00%
Average Speed of Answer/Average Wait Time	:03	:04	:03	:03



Accessibility Analysis - Driving Distance

Unicare of West Virginia

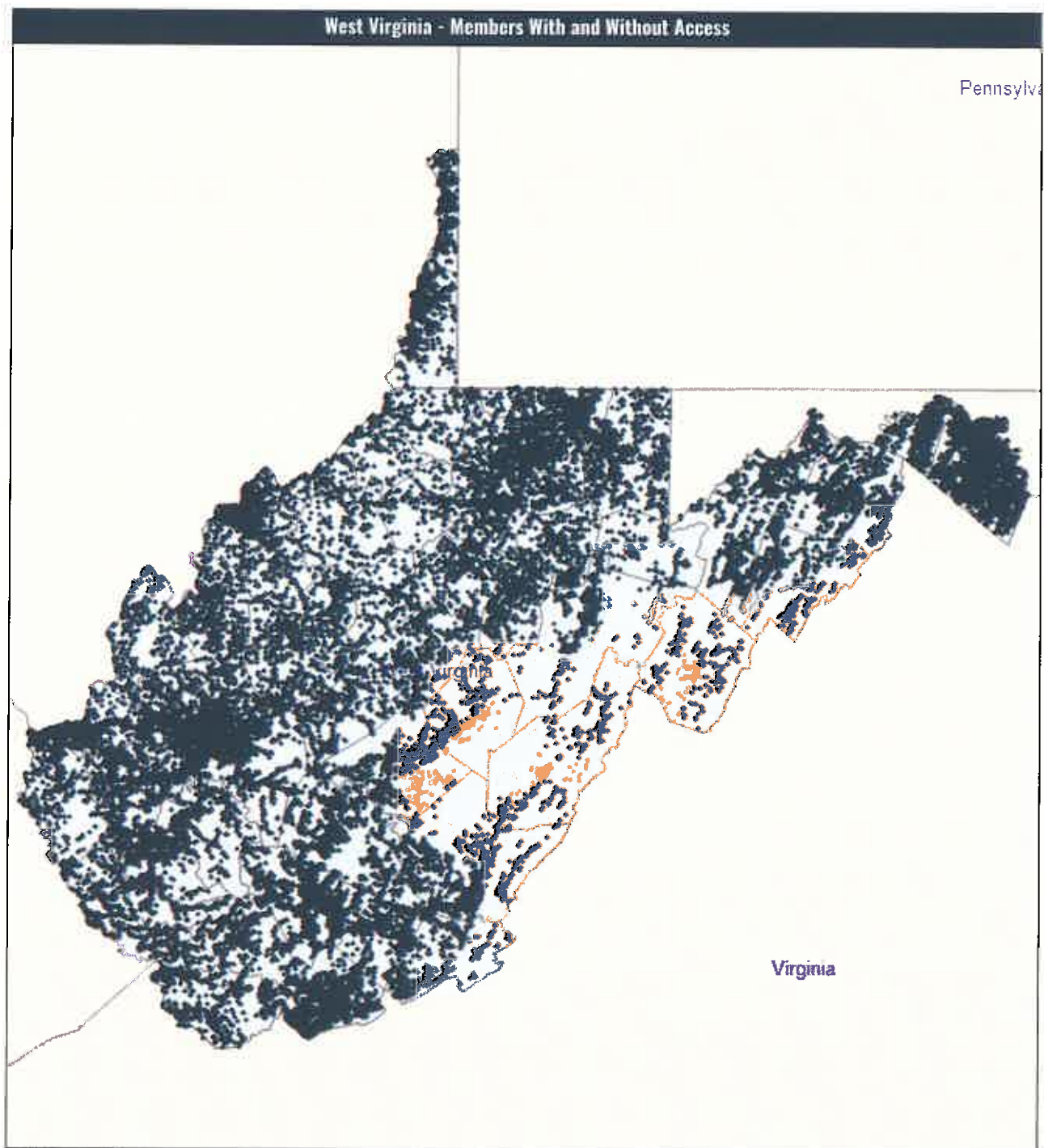
January 30, 2020

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West Virginia - Members With and Without Access

2

Map



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January 30, 2020

1 in 30

Employee Group

Unicare of WV (West Virginia)

Doctor Group

Medicaid Independent

145,307 member locations

◀ With access (143,733)

◀ Without access (1,574)

The Access Standard is defined as (Unicare of WV (West Virginia)) members accessing:

1 (Medicaid Independent) provider in 30 miles

Service Areas

◻ West Virginia

36.11 miles

Performance Indicator Report**Skygen USA
WV Medicaid
Qtr 3-2019**

	Jul	Aug	Sep	Qtr 3 2019
Provider Network				
Total Number of Dental Providers	670	676	672	672
Total Number of Endodontists	10	10	10	10
Total Number of Oral Surgeons	48	48	49	49
Total Number of Orthodontists	43	43	42	42
Total Number of Pediatric Dentists	33	33	33	33
Total Number of Periodontists	3	3	4	4
Total Number of Prosthodontists	3	3	3	3
Member Call Center Statistics				
Total Call Volume	291	278	219	788
Number of Calls Answered	290	277	216	783
Number of Calls Abandoned	0	1	0	1
Abandonment Rate	0%	0%	0%	0%
Blocked Call Rate	0%	0	0	0%
Average Speed of Answer/Average Wait Time	2	3	3	3
Member Appeals/Complaints/Grievances				
Number of member non-medical necessity authorization denials	36	41	34	111
Number of Member Appeals	2	2	4	8
Member Appeal Resolution Time	13 days	2 days	6 days	7 days
Percent of Member Appeals	0%	0%	0%	0%
Percent of Member Appeals Upheld	100%	100%	75%	92%
Percent of Member Appeals Overtuned	0%	0%	25%	25%
Provider 1st Level Appeals/Complaints/Grievances				
Number of Provider Complaints/Grievances	0	0	0	0
Vendor Complaint Turnaround Time	NA	NA	NA	NA
Number of Provider Clinical Appeals	1	1	4	35
Provider Appeal Resolution Time	8 days	10 days	17 days	12 days
Percent of Provider Appeals	0%	0%	0%	0%
Percent of Provider Appeals Upheld	0%	0%	50%	50%
Percent of Provider Appeals Overtuned	100%	100%	50%	83%



Dental Geo Access Report

October 5, 2019

*Created with the Quest Analytics Suite
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Members With and Without Access

Access Overview

October 5, 2019

Access Analysis

Generals 1 in 30 minutes

Employee Group

Members

Provider Group

Generals

Access Map

Member locations

- With access
- Without access

Service areas:

- West Virginia
- West Virginia

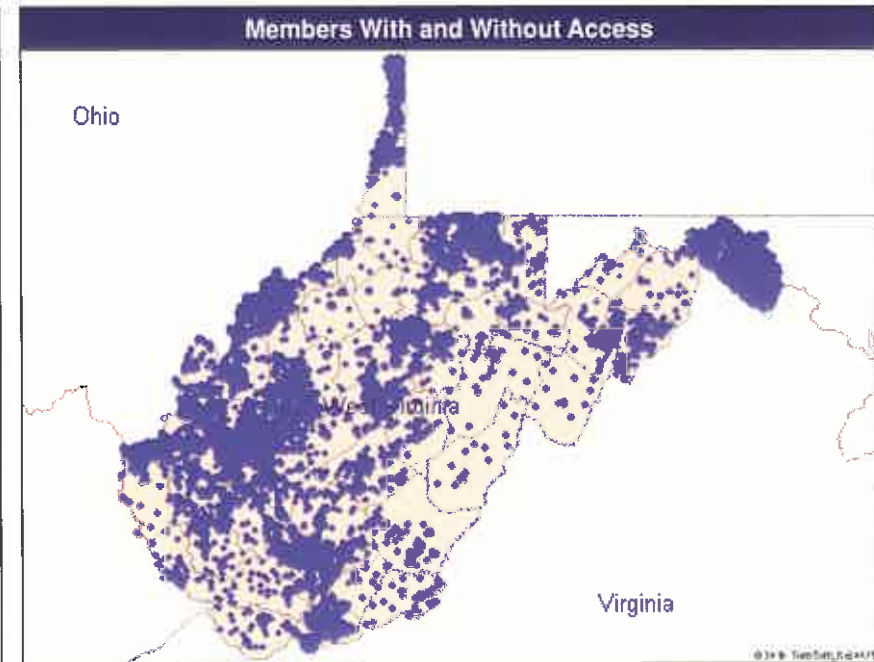
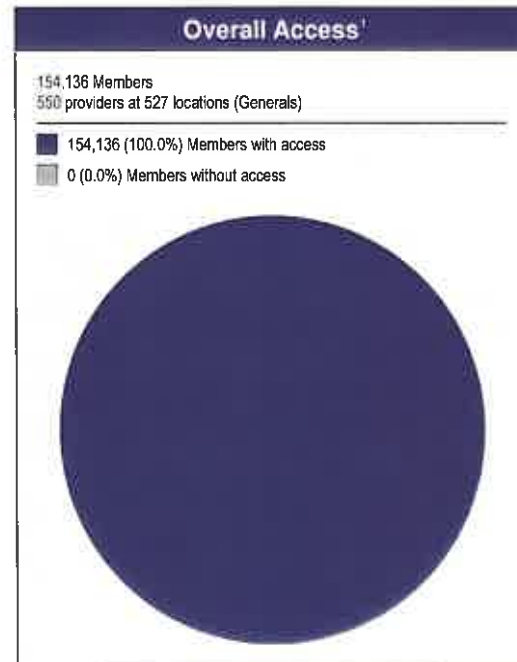
1 in = 62.86 miles

Comparison Graph

Percent of members with access to a choice of providers over miles

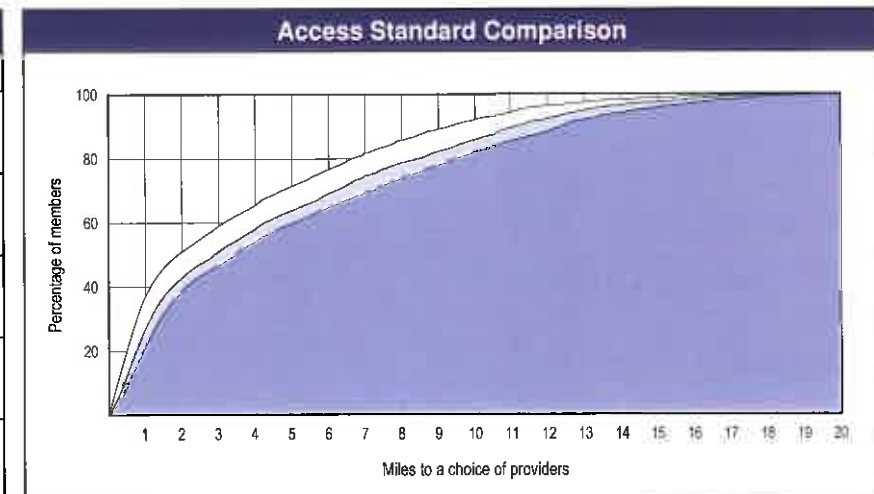
- 1st closest
- 2nd closest
- 3rd closest

¹ The Access Standard is defined as members (Members) having:
• Providers (Generals) - 1 within 30 minutes



Times	
	Average
Time to 1st closest provider	3.9 mins
Time to 2nd closest provider	4.9 mins
Time to 3rd closest provider	5.7 mins

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2. Key Staff and Resumes

Key staff consist of the Vendor's senior leadership for Mountain Health Trust Managed Care Procurement project. These resources are responsible for providing leadership, and creating the standards and processes required for the successful implementation, operation, and maintenance of the program. Resumes for key staff named in the Vendor proposal should indicate the role of the staff on the Mountain Health Trust Managed Care Procurement project, and demonstrate how each staff member's experience and education will contribute to successful implementation and operations. The Vendor's proposed key staff should be available for an in-person interview upon the Department's request.

To ensure successful operations for this contract, the project should be led by key staff identified in the list below:

- Chief Executive Officer/Chief Operating Officer
- Contract Liaison/MHT Administrator
- Chief Financial Officer
- Compliance Officer
- Medical Director
- Behavioral Health Medical Director
- Medical Management Director
- Care Management Director
- Quality Director
- Program Integrity Lead
- Network Development Director
- Provider Relations Director
- Information Technology Director
- Member Services Director
- Claims Payment Director
- Encounter Data Integrity Manager
- Community Engagement Director

- MHT Member Advocate
- Dental Director

The CEO/COO and CFO positions are not required to be dedicated full-time to this project.

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

3.1 Resumes

The Vendor should complete Table 11 and embed resumes of all proposed key staff as part of their bid. Each resume should demonstrate experience relevant to the position proposed. If applicable, each resume should include work on projects cited under the Vendor's corporate experience, and the specific functions performed on such projects. This section should include the following:

- Resumes (not exceeding two pages each) for key staff and support staff members assigned to this project, including their licenses, credentials, and experience. The Department considers key staff resumes as a key indicator of the Vendor's understanding of the skill sets required for each staffing area. Resumes should be in 12-point font, and double-sided.
- A letter of intent for each proposed staff member not currently employed by the Vendor. Each letter of intent should be signed by the named individual, indicating that the individual is willing to accept employment if the Vendor is awarded the contract.

Key Staff and Resumes

We provide the completed Table 11, which outlines our key staff's experience related to their proposed role, along with résumés for each.

Table 11: Resumes for Proposed Key Staff

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Tadd Haynes	Chief Executive Officer	Tadd, a native West Virginian, is a health care executive with a 15-year history of progressive leadership roles in administration and operations at UniCare serving West Virginians. He is currently Chairman of the West Virginia Association of Health Plans, and has built strong, collaborative relationships with our stakeholders, including community organizations, providers, and Department of Health and Human Resources (DHHR) staff. As our current CEO, Tadd will continue to oversee all aspects of the contract, provide direction and leadership to our health plan staff, and make key financial, operational, and contractual decisions for our health plan. He holds a Master of Public Health, with focus areas of Maternal/Child Health and Health Policy.	2005–Present
Barbara Wessels	Contract Liaison/MHT Administrator	As a West Virginia native, Barbara has built long-standing relationships and is highly skilled at coordinating with schools, community agencies, local health departments, and other State agencies to help connect Medicaid members with complementary services that make sure their needs are met. She has over 20 years of experience in health care, working with low-income populations, and cultural sensitivity. She joined UniCare in 2014, where she has overseen the Contract and worked directly with staff and the DHHR Health Innovation Collaborative. Prior to UniCare, Barbara oversaw the Medicaid program and statewide strategy for Aetna's West Virginia membership. She holds a Bachelor's in Communication and a Master's degree in Management and Leadership.	2014–Present
Kevin Dean	Chief Financial Officer	Kevin is a health care finance executive who brings over 18 years of experience working in Managed Care finance. He has a strong background and knowledge in finance, health plan operations, and leadership with a proven record of implementing cost-effective processes, including developing a cost reduction plan for \$22 million annually across West Virginia Medicaid operations. For the last six years, he has overseen UniCare's financial operations. Kevin is a native West Virginian who holds a Master of Public Administration in Health Management and Finance.	2014–Present

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Richard Chapman	Compliance Officer	Richard is a seasoned Compliance executive with almost three decades of experience in West Virginia health care and 18 years in leadership roles for West Virginia health plans. He currently oversees our West Virginia compliance program and brings a wealth of knowledge, including regulatory compliance, performance and operational audits, fraud and abuse investigations, identification of process gaps, and correction action plans. In addition, Richard has a strong background in quality, and has trained Quality Assurance Analysts and conducted quality reviews. He is a native West Virginian who holds a Master of Science in Strategic Leadership.	2019–Present
Sanjoydeb Mukherjee, MD	Medical Director	With over 20 years of clinical experience, Dr. Mukherjee has spent his career focused on providing care the most vulnerable through his work at rural critical access emergency care centers and inner city clinics. Since 2018, he has held the role of Medical Director for UniCare, where his expertise in the emergency and urgent care medicine fields, adult and child trauma treatment, and substance use/trauma arenas contributed to driving our fully integrated model of care. He is a West Virginia-licensed physician with extensive pediatric experience. We are actively recruiting for an additional full-time West Virginia-licensed and -based Medical Director to join Dr. Mukherjee in overseeing clinical activities.	2018–Present
Jorge Cortina, MD	Behavioral Health Director	Dr. Cortina is a West Virginia-licensed physician with 20 years experience working to improve health care for West Virginia veterans and Medicaid members. He has exceptional leadership skills, overseeing clinical programs and services, with specialized knowledge in trauma and substance use services. Dr. Cortina is a Distinguished Fellow of the American Psychiatric Association and is the elected representative of the West Virginia District Branch of the APA representing West Virginia psychiatrists at the National APA Assembly.	2016–Present
Angela Hobbs, RN-BSN	Medical Management Director	Angela is a West Virginia-licensed RN who has over 12 years of utilization management, case management, prior authorization, and medical necessity review. Since joining UniCare in 2018, she is responsible for the operations of the utilization management program, including oversight and management of processing referrals and prior authorization requirements. She holds a Bachelor of Science in Nursing.	2018–Present
Ryan Kinder, RN-BSN	Care Management Director	Ryan brings more than a decade of experience serving West Virginians, including six years overseeing care management program operations, which includes developing care plans to fully coordinate members' care and address their needs and goals. Ryan is a West Virginia-licensed RN that brings strong clinical and communication	2014–Present

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		skills, including assessments, care management, and care planning. He holds a Bachelor of Science in Nursing.	
Anita Blackburn, RN, CCM	Care Management Director	Anita is a licensed registered nurse with over 25 years of nursing experience plus extensive knowledge and skills across care management, disease management, and utilization management, with specialized knowledge in behavioral health (BH) and substance use disorders. She is skilled in all aspects of care coordination, including providing one-on-one support to members and in developing, implementing, coordinating, monitoring, and evaluating care plans to make sure members receive health care across the continuum.	2015–Present
Victoria Warner, MPH, LPN, CMCN	Quality Director	Victoria is a Certified Managed Care Nurse and Licensed Practice Nurse. She is a native West Virginian who joined UniCare in 2015 and oversees our quality assurance program and related activities such as data collection and reporting, NCQA and HEDIS measures, and overseeing quality initiatives to drive improved outcomes in West Virginia. She holds a Master's in Public Health.	2015–Present
Rick Levock	Program Integrity Lead	A native West Virginian, Rick brings nearly two decades of experience across program integrity and Medicaid fraud investigation. He currently serves as the Program Integrity Lead for UniCare, which includes acting as the Program Integrity liaison for DHHR. Prior to joining UniCare, Rick spent 18 years with Health Management Systems, where he worked across Third Party Liability (TPL) contracts for West Virginia, Virginia, and the District of Columbia. Rick brings invaluable knowledge and skills including project development and implementation, TPL recovery, cost avoidance, and regulatory compliance. (We are actively recruiting for a West Virginia-based, dedicated Program Integrity Lead.)	2019–Present
Terri Roush	Network Development Director	Terri has over 16 years of experience working with West Virginia Medicaid providers. She joined the UniCare Provider Network team in 2004 and oversees all aspects of the network development and contracting activities for physical and BH services. Terri is a West Virginia native who holds a Bachelor's degree in Health Service Administration.	2004–Present
Elizabeth Daniel	Provider Relations Director	Elizabeth brings almost a decade of health care experience and over five years of UniCare Provider Relations experience. In her role as Provider Relations Director, she is responsible for interfacing with the provider community and supports ongoing provider relationships across West Virginia. She keenly understands claims, provider network and development, and managed care processes. She is a native West Virginian who holds a Bachelor's in Business Management.	2015–Present

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Michele Carrera	Information Technology Director	Michele has nearly three decades of information technology knowledge and 15 years of health care industry experience providing IT solutions. She has directly supported West Virginia in a variety of roles for almost 10 years. (We are actively recruiting for a West Virginia-based, dedicated Information Technology Director.)	2011–Present
Richard Grooms	Member Services Director	Richard is a West Virginia native with over 12 years of health care experience. His experience includes leading call center operations for Medicaid members and providers. Prior to joining UniCare in 2016, Richard was the liaison to DHHR and MCOs for SKYGEN. He holds a Bachelor of Science in Marketing.	2016–Present
Chris Kearney	Claims Payment Director	Chris has over 20 years of health care experience, plus expert knowledge on the claims process. He directly supports our West Virginia Medicaid claims operations and has a demonstrated history of planning, implementing, and leading claims initiatives that assure timely, accurate, and efficient processing and adjudication. Has also assisted in developing and executing strategies to streamline the claims process, build stronger relationships with the provider community, and increase both member and provider satisfaction. Chris holds a Master of Healthcare Administration. (We are actively recruiting for a West Virginia-based, dedicated Claims Payment Director.)	2013–Present
Tracey Welch	Encounter Data Integrity Manager	Tracey has over 20 years of experience in the health care solutions field leading business and IT functions for encounters-related activities. For more than three years, she has overseen all West Virginia encounters activity and is a subject matter expert on encounters. She has a demonstrated history of planning, implementing, and leading initiatives that assure timely, accurate, and efficient reporting. She holds a Bachelor's in Business Economics. (We are actively recruiting for a West Virginia-based, dedicated Encounter Data Integrity Manager, and will hire the most qualified candidate to meet DHHR approval.)	2011–Present
Natalie Robinson	Community Engagement Director	Natalie is a West Virginia native with over 10 years of experience in for marketing, public relations, and community engagement activities. She joined UniCare in 2012 and uses her deep understanding of West Virginia's population as well as State and federal regulations to oversee the development of all marketing materials. She holds a Bachelor of Arts in Communications, and recently earned a Diversity and Inclusion Certificate from Cornell University.	2011–Present
Stephanie Harper	MHT Member Advocate	Stephanie is a dedicated health care professional who brings more than a decade of experience serving low-income populations in the health care system and across a diverse range of cultures and backgrounds, including children, youth, and families. Since joining UniCare in 2015,	2015–Present

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
		Stephanie uses her strong knowledge of West Virginia's Medicaid, BH programs, trauma-informed care, and integration and coordination across the system of care to interact with the public and make sure members are referred and connected to appropriate resources. Stephanie is a native West Virginian who holds a Bachelor of Arts in Psychology.	
Jarrell Martin II, DDS	Dental Director	As a licensed, practicing dentist for the last eight years, and owner of the largest Medicaid and CHIP pediatric and adult practices in Kanawha County, Jarrell is keenly aware of the need for continued integration of dental services in our community. He has been an active participant in the provider panels to help identify, design, and implement solutions for patients. Jarrell is also accustomed to working with a diverse range of patients — both children and adults — to provide comprehensive oral health care. He has managed his own dental practice and is accustomed to all aspects of administering dental services.	Letter of Intent is provided

Tadd Haynes — Chief Executive Officer

Qualifications

Tadd is an accomplished health care executive with a history of progressive leadership roles in administration and operations at UniCare serving West Virginia Medicaid. He currently serves as the CEO and Plan President of UniCare Health Plan of West Virginia, Inc., where he has a proven track record of leading initiatives that drive improved quality and outcomes, stronger relationships with West Virginia communities, and effective stewardship of Medicaid funds. He is also currently Chairman of the West Virginia Association of Health Plans. He holds a Master of Public Health, with focus areas of Maternal/Child Health and Health Policy from West Virginia University.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2005–Present

CEO and Plan President (2018–Present)

- Spearheads operations for West Virginia's largest Medicaid managed care plan, with responsibility for overall delivery of the program and for making key contractual, financial, administrative, and operational decisions
 - Maintains accountability for UniCare's profit and loss, overseeing operating gain, growth, cost of care commitments, revenue, and quality accreditation goals
 - Oversees a multidisciplinary staff responsible for all aspects of plan operations, including Quality Management, Claims Payment, Provider Relations/Contracting, Community Relations, Medical Management, and Compliance
 - Aligns strategy to achieve business goals and build a culture of accountability with people who are results-driven, innovative, and committed to excellence
- Maintains positive relationships and acts as the key liaison to DHHR
 - Fosters strong ties with community and State agencies, acting as the representative on behalf of the plan meetings and interactions with legislators, regulators, and key decision makers

Chief Operating Officer (2015–2018)

- Provided day-to-day oversight, under leadership of the CEO, of UniCare's operations, including medical management, provider relations, member services, claims payment, and quality management
- Oversaw medical performance for health services and clinical decision-making aspects of programs
 - Developed, directed, and implemented clinical and non-clinical activities that positively affected health care quality cost and outcomes

Director, Medicaid Field Operations (2013–2015)

- Directed fiscal and day-to-day operations for a significant and diverse product portfolio, including specialty products and complex provider contracting arrangements of significant revenue value
 - Administered UniCare's medical services to make sure that members received the most appropriate care and that services were delivered cost-effectively

Program Manager/Outreach Specialist (2005–2013)

- Managed project implementations, cost of care initiatives, and marketing and health promotion staff
- Maintained responsibility for advocating for members, marketing, and building and delivering health education programs

Thomas Memorial Hospital

2003–2005

Intake and Assessment Counselor

- Conducted initial patient interviews in a clinical psychiatric setting

- Worked with physicians to determine most appropriate course of treatment and established initial diagnosis
- Coordinated referrals to various partial hospitalization and outpatient psychiatric and substance use disorder programs as well as community resources
- Conducted pre-certification procedures with insurance companies to obtain authorization for patient treatment

Education and Credentials

West Virginia University

- Master of Public Health, Focus areas of Maternal/Child Health and Health Policy, 2006–2009

University of Charleston

- Bachelor of Arts, Psychology, 1995–1999

Affiliations

- Current Chairman and former Vice Chairman of the West Virginia Association of Health Plans

Barbara Wessels — Contract Liaison/MHT Administrator

Qualifications

Barbara brings more than a decade of managed care experience overseeing West Virginia programs and Contract requirements, implementing strategic initiatives to serve members, and spearheading marketing and communications. Since 2014, she has served our West Virginia Medicaid members, working to break down barriers and identify ways to positively impact their health outcomes. As a West Virginia native, Barbara has built long-standing relationships and is highly skilled at coordinating with schools, community agencies, local health departments, and other State agencies to help connect Medicaid members with complementary services that make sure their needs are met. She advocates for members and was instrumental in a policy change for smoking cessation to increase access for members by removing limits on visits. Prior to UniCare, Barbara oversaw the Medicaid program and statewide strategy for Aetna's West Virginia membership. She holds a Master of Science in Leadership and Management.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2014–Present

Contract Liaison/MHT Administrator

- Identifies opportunities to positively impact member health, UniCare's reputation, and financial well-being of health plan through coordinated outreach, data analysis, and extensive knowledge of the health care industry
- Functions as a primary contact for beneficiary advocacy groups and work with these groups to identify and correct beneficiary access barriers
- Investigates and resolves access and cultural sensitivity issues identified by MCO staff, State staff, providers, advocate organizations, and beneficiaries
- Leads strategic planning efforts, builds relationships, and actively collaborates with stakeholders, including School-Based Health Centers and Communities in Schools
- Directs plan communications, trains staff, and leads cross-functional projects for continuous improvement — implementing programs and strategies to promote health and wellness, and enhance quality, member satisfaction, and provider satisfaction
- Researches applicable subject matter practices and remains aware of industry trends
- Manages relationships and partners with entities with statewide and regional focus
- Works with complex information and assimilates into common language, and prepares and delivers presentations and reports
- Provides input to MCO management on how provider changes will affect member access and quality/continuity of care; develop/coordinate plans to minimize any potential problems
- Reviews all informational materials to be distributed to members

Kay Casto & Chaney PLLC

2007–2014

Director of Marketing & Recruiting Coordinator

- Maintained responsibility for all aspects of communication and marketing, including customer service and relationship building, planning, implementing and evaluating communication strategies to increase market share, brand awareness, and firm image using sponsorships, surveys, competition analysis, website, events, media relations, and advertising
- Completed requests for proposals, trained staff and attorneys, managed relationships with vendors

- Served as a Recruiting Coordinator for associates and summer clerks; supervised, coached, and mentored summer clerks while managing project loads, schedules, and events

Aetna/Coventry of West Virginia (Carelink)

1999–2006

Medicaid Program Manager

- Oversaw all aspects of the plan's Medicaid program (2005 to 2006), with responsibility for all aspects of membership growth, statewide expansion, regulatory compliance, collaboration with state agency and community organizations, and maintaining program accreditation
- Played a key role in expanding markets for commercial, Medicaid and Medicare products, improving brand awareness, and compliance with state and federal regulations
- Monitored grievances and appeals
- Hired, trained, evaluated, and mentored a team of employees
- Developed and managed marketing, printing, and advertising budget and managed outside vendor relationships
- Accomplishments include:
 - Growth in net commercial membership of 1.4%/retention of group clients averaged 91%
 - Print initiative resulting in \$200,000 annual local plan savings
 - Medicaid Advertising Campaign "Join Our Team" featuring Doc Bear
 - Commercial Campaign "As Unique as You"

CAMC Health System

1991–1999

Director of Marketing

- Developed, implemented, and evaluated marketing initiatives with responsibility for increasing market share, building brand awareness, corporate image, contract negotiation, and program operations
- Managed marketing, printing, and advertising budget and managed outside vendor relationships
- Managed 13 marketing and advertising employees, including creative team
- Also performed duties of Director of Public Affairs: arranged press coverage, responded to media calls, and maintained working relations with media. Supervised spokesperson and four additional public relations professionals and production of eight newsletters.

Education

Western Governors University

- Master of Science, 2019–2020
- Management and Leadership

University of Charleston

- Bachelor of Arts, Communication, 1983–1987

Kevin Dean — Chief Financial Officer

Qualifications

Kevin is a health care finance executive who brings an 18-year tenure developing and directing a range of financial activities for managed care. He has a strong background and knowledge in finance, health plan operations, and leadership with a proven record of implementing cost-effective processes, including developing a cost reduction plan for \$22 million annually across West Virginia Medicaid operations. For the last six years, Kevin has overseen UniCare's health plan operations serving 154,000 members. He is a native West Virginian who holds a Master of Public Administration in Health Management and Finance.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2014–Present

Chief Financial Officer

- Oversees financial operations for UniCare's local Medicaid health plan serving 154,000 members across West Virginia
- Spearheads a cost reduction initiative to identify cost savings across the organization
- Collaborated on development, implementation, and management of a provider incentive plan designed to improve quality scores and maximize return of premium withhold from the State
- Developed suite of financial modeling and standard financial reports and created finance educational workshops and presentations for staff
- Played an integral role as a key staff member, which includes substantially expanding the number full-time employees

UnitedHealthcare Group

2001–2014

National Director, Intersegment Finance (2007–2014)

- Played an instrumental role in operationalizing national field finance reorganization, including reorganization of staff and responsibilities among local, national, and corporate staff, development of standard reporting packages shared with staff at all matrix levels and providing detailed variance analyses for individual markets
- Managed internal revenue/service exchange process of over \$5 billion annually
- Interfaced actively with field finance staff of approximately 20 and corporate finance staff of approximately 200
- Provided financial management and analysis services for Fortune 20 health insurance corporation within highly-complex matrix environment
- Supervised staff of up to 25 in various locations throughout the country, and communicated with a range of finance staff, both in local field operations and in corporate headquarters
- Developed corresponding forecasting tools, comparing monthly results to budget and prior forecasts, assisting in the development of current forecasts

National Director, Acquisition Integration (2005–2007)

- Integrated acquired entities into the finance department, which included participation in due diligence, regulatory approval processes, staff realignment, synergy tracking, and functional assimilation

National Director, Field Support (2004–2005)

- Collaborated with national corporate and field finance staff on development and implementation of a \$1.2 billion budget, including specific product-line and major/minor market designations, as well as the implementation of online budgeting and forecasting tool, and Essbase data repository reporting system

Divisional Finance Manager (2001–2003)

- Developed monthly financial reporting package, including standardized schedules and ad hoc reporting, for monthly health plan performance meetings (Financial Oversight Committee) attended by local executive staff as well as key national leadership for the seven Northeast Region health plans
- Implemented reporting function in four additional health plans
- Developed corresponding forecasting tools, comparing monthly results to budget and prior forecasts and assisting in the development of current forecasts, approximately four times per year

Education

New York University, Robert F. Wagner Graduate School of Public Service

- Master of Public Administration, Health Management and Finance, 1996

Georgetown University, College of Arts and Sciences

- Bachelor of Arts, Cum Laude, Government/Economics, 1989

Affiliations

- Healthcare Alumni Advisory Council: Charter member advising Program Director on curriculum, marketing, and admissions strategies

Richard Chapman — Compliance Officer

Qualifications

Richard is a seasoned Compliance executive with almost three decades of experience in West Virginia health care and 18 years of experience in leadership roles for West Virginia health plans. He brings a wealth of knowledge that includes regulatory compliance, performance and operational audits, fraud and abuse investigations, identification of process gaps, and correction action plans. In addition, Richard has a strong background in quality, and has trained Quality Assurance Analysts and conducted quality reviews. He currently oversees our West Virginia compliance program. He holds a Master of Science in Strategic Leadership.

Professional Experience

UniCare Health Plan of West Virginia, Inc. Compliance Officer

2019–Present

- Leads, champions, monitors, and oversees the Medicaid Compliance program for West Virginia
- Leads compliance monitoring to identify process gaps, validate compliance levels, map processes, draft corrective actions/remediation plans, oversee implementation of corrective actions, and prepare reports/presentations
- Monitors the performance of the health plan in meeting regulatory and contractual standards
- Conducts all activities required pursuant to the Medicaid Compliance Strategic Work Plan
- Leads complex investigations and documents findings
- Develops strategic plans, makes recommendations to leadership, and designs/implements annual compliance plan
- Develops strong relationships with key leaders to identify and address compliance risks and failures and manage action plans designed to fully mitigate risk(s)

Carefirst (BlueCross BlueShield) Performance Audit Manager

2002–2019

- Interviewed, hired, and managed performance audit staff; managed the Section budget and performed all other administrative functions associated with the effective management of the team (which includes providing oversight and direction to audit supervisors to ensure established team performance goals are met, staff adherence to corporate policies, and that all departmental and corporate deadlines are met)
- Planned, approved, directed all performance and operational audits relating to the CareFirst Federal Employee Program (FEP) business, in compliance with (1) Plan Incentive Performance guidelines established by the FEPDO, BCBSA, and Office of Personnel Management and (2) applicable Federal regulations
- Reviewed and approved all performance/operational audit plans of FEP and was directly accountable for the reliability and integrity of the results
- Accountable for ensuring that the Claims Audit Monitoring Tool developed by the Association for tracking FEPDO and OPM global audits was updated consistently in order to provide management information timely and accurately
- Assessed compliance risk, identified root cause of compliance exceptions, and developed correct action plans to ensure effective internal controls were in place

Carefirst (BlueCross BlueShield)

2000–2002

Operations Trainer

- Conducted effective training for new hires/existing personnel as related to claims processing, customer service, adjustments, and enrollment functions
- Performed management functions for trainees assigned to classroom including counseling, warning, developing plans of action, dismissal, preparing weekly performance statistics, and preparing progress reports to prepare the student for transition to the operational area
- Led and motivated teams of Training Quality Assurance Analysts who supported the training classes, including interviewing, hiring, training, developing, and completing performance appraisals
- Created lesson plans, objectives, detailed training modules, and classroom schedules
- Performed extensive post-payment quality reviews/audits of claims reviewed and released for payment by Training Quality Assurance Analyst

UnitedHealthcare Group

1992–2000

Trainer/Team Advisor for Member Services

- Managed member services unit for a 75,000 beneficiary-based national contract. Responsible for the overall direction, coordination, and evaluation of this unit
- Performed Quality Review/Auditing and provided feedback on a weekly/monthly basis for a unit of customer service representatives to ensure the staff met corporate goals
- Interviewed hired, trained employees; planned, assigned, and directed work; performance appraisals; rewarded and disciplined employees; addressed complaints and resolved problems
- Trained employees on all systems and software utilized by the department. This included development of training programs, as well as presentation of training to the staff
- Performed provider audits, which were initiated by members of the medical review staff and the account administrators for providers who appeared to have an abusive billing pattern

Education

University of Charleston

- Master of Science in Strategic Leadership, 2015

West Virginia University Institute of Technology

- Bachelor of Arts in Business Management, 2012

Sanjoydeb Mukherjee, MD — Medical Director (Interim)

Qualifications

A West Virginia-licensed physician with over 20 years of clinical experience, Dr. Mukherjee has spent his career focused on providing care to the most vulnerable through his work at rural critical access emergency care centers and inner city clinics. Since 2018, he has held the role of Medical Director for UniCare, where his expertise in the emergency and urgent care medicine fields, adult and child trauma treatment, and substance use/trauma arenas contribute to developing our fully integrated whole-person model of care. His strategic initiatives will include focusing on Population Health and SDOH to bring a better coordinated effort to positively impact members and improve outcomes by removing barriers to services and supports.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2018–Present

Medical Director

- Oversees medical and care management activities for UniCare’s Medicaid members, in collaboration with senior clinical leaders and reporting to the Chief Executive Officer, Tadd Haynes
- Leads, develops, and directs clinical and non-clinical activities that impact health care quality cost and outcomes
- Oversees and participates in Quality Assurance and Performance Improvement Committee activities
- Serves as a liaison to DHHR in responding to requests and attending necessary meetings
- Manages clinical programs and initiatives, and maintains responsibility for expanding health system collaborations and advancing the efforts of UniCare in creating valuable partnerships with providers and community organizations

University of Kentucky

2019–Present

Assistant Professor

- Serves as an instructor for the Department of Emergency Medicine and leads medical students in their emergency medicine clerkship
- Provide coverage for the ER at the University of Kentucky Chandler Hospital and Good Samaritan Hospital

Compass Emergency Physicians

2005–2019

Emergency Physician

- Progressed into leadership role (Emergency Physician Lead) and focused on improving patient outcomes by participating on the Sepsis Management Improvement as well as the ER to Inpatient Throughput, Utilization Management, and Credentials Committees
- Served as an emergency physician providing direct care to a diverse range of patients across rural and inner city settings for St. Elizabeth Medical Center
- Served on the Executive Board from 2016 to 2017, contributing expertise to policy making and direction for the organization

Marshall Emergency Services Associates

2004–2005

Medical Director

- Served as Medical Director, overseeing day-to-day clinical operations, for an ER (with a volume of 23,000) at Berea Community Hospital

Baptist Minor Medical Centers

1998–2000

Physician

- Served a diverse range of children and adults across multiple urgent care locations in Tennessee
- Additional experience includes serving in the United States Navy, Branch Medical Clinic at Naval Support Academy Mid-South (1998–2000)

Education and Training

University of Louisville

- Doctor of Medicine
- Bachelor of Arts in Biology

University of Kentucky

- Resident, Department of Emergency Medicine, 2001–2005
- Pediatrics Internship, 2000–2001
- Preliminary Surgery Internship, 1995–1995

License and Certification

- Licensed by the West Virginia and Kentucky Boards of Medicine

Affiliations

- Member of the American College of Emergency Physicians
- Member of the American Association of Emergency Medicine

Dr. Jorge Cortina, MD, DFAPA — Behavioral Health Medical Director

Qualifications

Dr. Cortina is a West Virginia-licensed physician who has been working to improve health care delivery to West Virginia veterans and or Medicaid members for the past 20 years. He has exceptional leadership skills, with decades of overseeing clinical programs and services as well as specialized knowledge in trauma and substance use services. Dr. Cortina is a Distinguished Fellow of the American Psychiatric Association (DFAPA) and is the elected representative of the West Virginia District Branch of the APA, representing West Virginia psychiatrists at the national APA Assembly. He brings a proven track record overseeing BH initiatives and program for Medicaid, driving the integrated of whole-person health, and working towards the Triple Aim of improved care, population health, and cost-effectiveness.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2016–Present

Behavioral Health Medical Director

- Provides day-to-day guidance, support, and leadership with regard to clinical functions
- Supports leadership in ensuring the clinical integrity of a broad spectrum of clinical programs
 - Partnered with the Anthem Foundation to support West Virginia University's implementation of Project ECHO® (Extension for Community Healthcare Outcomes) Planned and selected facilities and assessed outcomes for field-based case management
- Identifies and participates in opportunities for innovation to increase effectiveness and quality
 - Member of the Treatment and Research Subcommittee to the Governors Committee working on the State Plans to address the SUD epidemic
 - Member of Office of Drug Control Policy State Advisory Committee working with Shatterproof on SUD provider rating system

Independent Physician Expert

2001–2016

Behavioral Health Physician Advisor/Expert

- Acted as a physician advisor for Medicaid Behavioral Health Service Organizations (MBHOs), including Magellan, Focus, Sentara, APS, Humana, and Green Spring

Veterans Affairs Mid-Atlantic Network

2001–2016

Service Line Coordinator for Geriatrics and Extended Care

- Spearheaded geriatric and extended care programs in West Virginia as well as North Carolina and Virginia; programs included Veteran Affairs (VA) and community nursing homes home care, palliative care, and outpatient clinics for frail and disabled veterans across the network
- Chaired the VA subcommittee responsible for making recommendations to the National Veterans Health Administration (VHA) Mental Health Steering Committee on how to integrate BH/SUD services into primary care that contributed to the establishment of the Primary Care Mental Health Integration program/model in VHA
- Led the systems redesign for Veterans Mid-Atlantic Integrated Service Network from 2014 to 2016
- Served as a physician representative on the Veteran Mid-Atlantic Network Survey Readiness team, conducting annual visits to facilities to review compliance with standards established by Joint Commission, VHA, OSHA, and other regulatory and oversight entities
- Provided consultation to the VHA Office of Medical Inspector from 2007 to 2015, serving as subject matter expert in geriatrics, psychiatry, and hospice and palliative medicine

- Oversaw VA national operations of Ethics Consultation, Preventive Ethics, and Ethical Leadership programs
- Supported the development and implementation of Integrated Ethics across the VHA (Integrated Ethics is a comprehensive approach to managing ethics in health care organizations)

Hampton Veterans' Affairs Medical Center

1992–2002

Associate Chief of Staff for Geriatrics and Extended Care

- Held various progressive roles that included staff psychiatrist (1992–1997) and Associate Chief of Staff for Geriatrics and Extended Care, Veterans' Affairs Medical Center (1997–2001)
- Served as administrator for all geriatrics and extended care programs at the Hampton Veterans Affairs of Virginia medical center, including a 120-bed Extended Care and Rehab Center, 200-bed Residential Treatment Center, Palliative Care programs, Home and Community Care programs, and the Physical Medicine and Rehab Service
- Acted as the psychiatrist providing inpatient withdrawal management and BH services at the Hampton Veterans Medical Center; responsible for 160-bed residential program for Veterans with SUDs

Education

University of Virginia School of Medicine

- Medical Doctor, 1986

University of Virginia Health Sciences Center

- Resident, Department of Behavioral Medicine and Psychiatry
- MD DFAPA, 1986–1990 (Chief Resident, 1989–1990)

License and Certification

- Licensed by the West Virginia Board of Medicine, Current
- Licensed by the Commonwealth of Virginia Board of Medicine, Current
- Diplomat of the National Board of Medical Examiners
- Certification in Psychiatry, American Board of Psychiatry and Neurology (ABPN)
- Certification in Addictions Psychiatry, ABPN
- Certification in Geriatric Psychiatry, ABPN
- Certification in Hospice and Palliative Medicine, ABPN

Affiliations

- Distinguished Fellowship, American Psychiatric Association (2003–Present)
- Assembly Representative, West Virginia District Branch of the American Psychiatric Association (2019–2021)
- Participant, Governor's Council on Substance Abuse Prevention and Treatment Opioid/Substance Use Taskforce (2018–2019)
- Participant, Bureau of Medical Services, MCO Collaboration on Substance Use Disorder Among Medicaid Members (2019)

Angela Hobbs, RN-BSN — Medical Management Director

Qualifications

Angela Hobbs brings more than 12 years of experience, including utilization and case management, prior authorization, and medical necessity review. She additionally has 10 years of experience in training and teaching of staff nurses in various clinical settings, medical necessity review, case management, and utilization management. Angela's role includes overseeing the referrals process and prior authorization requirements. In addition to her managed care and UM experience, she has worked extensively with a diverse range of patients to provide compassionate nursing care.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2018–Present

Medical Management Director

- Manages continued stay review nurses in review of medical necessity using MCG Care Guidelines®
- Spearheads daily utilization management rounds with focus on the most at-risk members and those with high lengths of stay
- Maintains responsibility for reporting functions on team operations, including productivity and turnaround time to ensure contractual obligations are met
- Participates in various cost of care ideation committees and initiatives for reducing readmissions after discharge, with strong focus on discharge planning
- Manages non-clinical administrative support staff and daily team operations

West Virginia Family Health

2017–2019

Case Manager

- Oversaw outreach to West Virginia Medicaid members, including assessment and evaluation for potential discharge needs, barriers, and community resources available
- Managed caseloads of 60 members with 40 actively engaged in case management
- Focused on pediatric population with CSHCN program and private duty nursing cases

APS Healthcare/Kepro

2015–2017

Medical Utilization Management/RN Clinical Supervisor

- Managed nursing staff and oversaw daily operations for the prior authorization department, including case assignments, training needs, research, and development of criteria and productivity standards to meet deliverables in each review area
- Ensured proper staffing and delegation of specific projects and tasks as needed
- Collaborated with appropriate staff, physician reviewers, and consultants with respect to prior authorization decisions and review
- Conducted case audits of staff to ensure proper clinical guidelines and criteria are used for medical necessity reviews

West Virginia Medical Institute

2007–2015

Lead Prior Authorization Review Nurse

- Interacted with staff, physicians, and vendors as part of the prior authorization and medical review process
- Maintained standards for confidentiality and protected health information

- Documented clinical indications for various medical equipment, testing, or procedures while applying InterQual® criteria in the medical review process
- Collaborated with appropriate staff and physician reviewers with respect to prior authorization decisions and reviews
- Provided information to staff about potential problems and possible appropriate plans of action

Charleston Surgical Hospital

2005–2007

Registered Nurse – Recovery Room Nurse/Medical Surgical Unit Nurse

- Provided direct nursing care in general recovery, immediate post-operative care, and extensive monitoring of patients

St. Francis Hospital

2004–2008

Registered Nurse – Telemetry Unit/Medical Surgical Unit

- Provided direct nursing care and monitored patients as a floor nurse and rotation charge nurse in a telemetry or medical surgical setting

Acordia National

1990–2000

Senior Customer Service Representative and Claims Examiner

- Completed medical claims processing according to Third Party Administrator Benefit Plans, coordination of benefits with various commercial and private insurance policies, processing medical and dental claims according to policy coverage and benefit plan
- Trained new employees, designed review templates for claims examiners, claims processing, and payment
- Provided customer service focused on benefit plan interpretation, coverage guidelines, and claims payment while discussing with providers of service and plan members

Education

University of Charleston

- Bachelor of Science Nursing, 2004

License and Certification

- State of West Virginia RN License, 2005

Ryan Kinder, RN-BSN — Care Management Director

Qualifications

A licensed RN, Ryan brings more than a decade of experience serving West Virginians, including six years as a Care Manager, which includes developing care plans to fully coordinate members' care and address their needs and goals. In addition to his case management experience, he also brings a wealth of experience and skills providing direct patient care as a nurse. Ryan brings strong clinical and communication skills, including assessments, care management, and care planning.

Professional Experience

UniCare Health Plan of West Virginia, Inc. **Care Management Director**

2014–Present

- Works with members to make sure they have access to services appropriate to address their health needs, which includes conducting assessments to identify individual needs and to develop an individualized care plan to address objectives and goals as identified during assessment
- Implements care plan by facilitating authorizations/referrals as appropriate within benefits structure or through extra-contractual arrangements
- Coordinates care by connecting them with internal and external resources to meet their needs
- Monitors and evaluates the effectiveness of a member's care plan and modifies as necessary so that it continues to meet their strengths, preferences, and goals
- Interfaces with Medical Directors and Physician Advisors on the development of care plans
- Assists in problem-solving with providers, claims, or service issues

HealthSmart Casualty Claims Solutions **Disability Nurse Case Manager**

2013–2014

- Coordinated and managed trauma disability claims, and assisted in assessment, planning, implementation, coordination, monitoring, and evaluation of appropriate health, wellness, and disability management programs to augment recovery and return to the highest level of function

CAMC Memorial Division **Surgery Expediter (2012–2013)**

2006–2014

- Managed surgical attendants and maintained surgical flow through short turnover times between cases and transport of patients to surgery
- Tracked attendant assignments and maintained cleanliness for patient safety

Surgery Charge Nurse (2010–2012) **Surgical Nurse (2007–2013)**

- Provided direct patient care, maintained surgical flow of the operating room and staffing for all cases
- Managed staff breaks and shift relief, and monitored patient attendants and their duties to ensure the surgical area was clean and safe for patient care; delivered preoperative and perioperative care
- Performed scrub nurse and circulating nurse duties, which included the following prior to start of surgery: positioning, prepping, draping, and catheter insertion

Medical/Surgical and Behavioral (2006–2007)

- Provided direct patient care, with responsibility measuring and recording the PO intake and output
- Collected specimens; measured temperature, pulse, respirations, and blood pressure

Education

West Virginia University

- Bachelor of Science in Nursing, 2007

License and Certification

- State of West Virginia RN License, 2007

Anita Blackburn, RN, CCM — Care Management Director

Qualifications

Anita is a licensed registered nurse with over 25 years of nursing experience plus extensive knowledge and skills across care management, disease management, and utilization management, with specialized knowledge in BH and substance use disorders. She is skilled in all aspects of care coordination, including providing one-on-one support to members and in developing, implementing, coordinating, monitoring, and evaluating care plans to make sure members receive health care across the continuum.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2015–Present

Care Management Director

- Assures appropriate utilization of BH services through level of care determination, accurate interpretation/application of benefits, corporate medical policy, and cost-efficient, quality care
- Supports Care Managers with outreach to members; oversees staff assessing, developing, implementing, coordinating, monitoring, and evaluating care plans designed to optimize member health care across the care continuum and assuring member access to services appropriate to their health needs; and monitors and evaluates effectiveness of the care plan
- Collaborates with implementation, operations, claims, quality, and network education team members to provide excellent customer service and consultation to providers and members
- Provides education to team members regarding provider manuals and expectations

American Health Holding/Aetna

2013–2015

Behavioral Health and Substance Use Disorder Case Manager

- Reviewed medical necessity of inpatient and outpatient BH/SUD services according to Aetna and MCG Care Guidelines®
- Established rapport and built trusting relationships with members to provide education and support for the services they needed, making sure they fully understood the services available to them and how to access them through their plan

APS Healthcare

2010–2013

Behavioral Health and Substance Use Disorder Care Manager

- Reviewed for prior authorization of inpatient and outpatient BH services according to West Virginia Medicaid guidelines
- Held regular case discussions with providers regarding service utilization and CareConnection needs
- Assisted team members with updating utilization criteria, developing internal review protocols, and establishing individual recommendations for provider assistance and training related to best practices
- Assisted providers and subcontractors with claims and other issues

Sirona Health (formerly Intellicare)

2008–2010

Nurse Consultant

- Practiced computer-assisted expert nursing through inbound and outbound telephone interactions with patients whose physicians, hospitals, insurers, employers, or other sponsors/providers were clients
- Provided individualized direct patient care in accordance with policies, procedures, and established standards of nursing care and practice for two major clinical work types: telephonic triage and disease management

- Worked efficiently and assisted coworkers in daily use of program-specific and Microsoft applications

Wells Fargo TPA

2003–2008

Behavioral Health and Substance Use Disorder Case Manager

- Performed medical review activities to ensure the provision of safe, timely, appropriate, and necessary covered health care services to members
- Promoted effective resource management by directing member care to accessible cost-effective network providers and services at the appropriate level of care
- Facilitated timely discharge planning and continuity of care across health care settings

UnitedHealthcare Group, Optum Nurseline

1998–2003

Telephonic Triage Nurse

- Practiced computer-assisted expert nursing through inbound and outbound telephone interactions with patients whose physicians, hospitals, insurers, employers, or other sponsors/providers were clients
- Provided individualized direct patient care in accordance with policies, procedures, and established standards of nursing care and practice

Highland Hospital

1996–1998

Nursing Supervisor

- Monitored and assured appropriate patient to staff ratios
- Completed admission assessments
- Directed delegation of tasks to appropriate team members throughout the hospital setting
- Collaborated with patient care providers, physicians, and outside resources

River Park Hospital

1992–1996

Nurse Manager and Nursing Supervisor

- Managed and supervised programs and personnel for children and adolescent and adult units
- Provided nursing care within the scope of practice
- Delegated tasks to appropriate team members throughout the hospital setting

Raleigh General Hospital

1992–1992

Nurse Manager and Nursing Supervisor

- Provided total plan of patient care
- Maintained the standard of care for assigned patients through assessment, planning, implementation, and evaluation; assured appropriate care was given in a timely manner to all assigned patients
- Provided education to patients and families

Education

Bluefield State College

- Associate Degree in Nursing, 1992

License and Certification

- Multistate Compact RN License, 2018
- Commission for Case Manager (CCM), 2013

Victoria Warner, MPH, LPN, CMCN — Quality Director

Qualifications

Victoria is a Certified Managed Care Nurse and Licensed Practice Nurse with more than 10 years of experience serving Medicaid members in West Virginia on quality and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) initiatives. Specializing in social and BH sciences, she has a progressive history of roles with increasing responsibilities across quality, including data collection and reporting, NCQA, and HEDIS measures, and overseeing quality initiatives to drive improved outcomes in West Virginia. Victoria uses her strong communication skills to collaborate with internal staff across all areas to improve quality, and partners with Provider Relations staff to help address provider needs. She holds a Master's in Public Health.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2015–Present

Quality Director (2019–Present)

- Develops and maintains the quality improvement program as well as pertinent compliance plans, monitors adherence to plans, prepares status reports, conducts audits, identifies training and communication needs, and implements related programs
- Administers the quality improvement program, including overseeing accreditation activities, quality improvement projects, and provider performance (in collaboration with Provider Relations team)
- Actively participates in developing program recommendations and action plans; standardizes procedures and documentation within the health plan
- Makes sure all policies and procedures are updated as legislation or accreditation standards change
- Develops and delivers executive-level presentations and represents senior management on compliance issues and related committees
- Obtains and analyzes quality metrics, including BH and reports for care opportunities, supports practice implementation of care coordination and care management, identifies action plans for providers to implement to improve cost, quality, and the patient experience, and participates in design, development, and implementation of community learning forums
- Collaborates with Patient-centered Primary Care team — including, but not limited to, Engagement Manager, Clinical Liaison, Provider Contractors, and Network Relations Representatives — to meet provider and practice service needs

Behavioral Health Clinical Quality Compliance Administrator Sr. (2016–2019)

- Developed annual HEDIS data collection strategy to direct the planning, prioritization, approval, implementation, and compliance of ongoing external quality programs
- Established program governance, budget, and ensured program meets its stated objectives; provided leadership to program managers and project managers
- Provided subject matter expertise in response to day-to-day business issues; researched applicable subject matter practices and remained aware of industry trends
- Assured compliance with State and regulatory requirements
- Supported business strategies through an integrated portfolio of external client-facing programs, projects, and initiatives — this included managing external member-facing programs that required resources of multiple departments or business areas of the organization

Patient Centered Care Consultant (2015–2016)

- Obtained and analyzed quality metrics and reports for care opportunities, supported practice implementation of care coordination and care management, identified action plans for providers to implement to improve cost, quality, and the patient experience, and participated in design, development, and implementation of community learning forums
- Collaborated with Patient-centered Primary Care team to meet provider and practice service needs

Community Care of West Virginia, Pocahontas County

2014–2015

School-based Health, Care Manager

- Outreach Coordinator for pediatric populations for preventive health initiatives such as well-child checks and recommended childhood immunizations as well as gaps in care for preventive screenings
- Collaborated with other departments and agencies such as EPSDT, Vaccines for Children, and West Virginia Family Planning Program, and the West Virginia Office of Maternal, Child, and Family Health
- Assisted in the development of processes for improving quality measure and outcomes
- Served as a spokesperson for school-based health matters

Education

Capella University

- Master's in Public Health with Specialization in Social and Behavioral Sciences, 2018

Kaplan University

- Bachelor of Science in Health Care Administration, 2014

License and Certification

- Certified Managed Care Nurse – American Association of Managed Care Nurses
- West Virginia LPN Board Examination: Licensed Practical Nurse, 2010
- Certified Professional Coder, 2019

Rick Leveck — Program Integrity Lead (Interim)

Qualifications

A native West Virginian, Rick has nearly two decades of experience in program integrity. He currently serves as the Program Integrity Lead for UniCare, which includes acting as the Program Integrity liaison for DHHR. Prior to joining UniCare, Richard spent 18 years with Health Management Systems, where he worked across TPL contracts for West Virginia, Virginia, and the District of Columbia. Rick brings invaluable knowledge and skills including project development and implementation, TPL recovery, cost avoidance, and regulatory compliance.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2019–Present

Program Integrity Manager

- Serves as the Program Integrity (PI) liaison between Anthem and DHHR
- Serves as the primary Point of Contact (POC) and SME for PI's regulatory compliance deliverables, including audits, examinations and surveys, contract amendments and changes, RFIs, state meetings, regulatory requests, and reporting
- Works with West Virginia Medicaid health plan leadership to oversee the monitoring and enforcement of the fraud, waste, and abuse (FWA) compliance program for West Virginia
- Develops project plans and oversees project execution for implementations related to new requirements, issue management, and progress reporting
- Develops and maintains the Monitoring and Audit, and PI plans, processes, and reports in support of PI compliance
- Maintains oversight and ownership of all data gathering and submission of health plan regulatory reports for all PI functional areas
- Evaluates regulatory compliance and health care reform changes to determine potential impact and provides tailored response to Regulatory Compliance and Government Relations

Health Management Systems, Inc.

2001–2019

Program Director (2012–2019)

- Provided 18 years of dedicated Medicaid TPL cost recovery and savings project experience
- Facilitated the administration of TPL operations for multiple state Medicaid agency contracts specializing in TPL and Cost Avoidance Recovery programs
- Ensured compliance with all Medicaid project related government reporting guidelines and policies
- Managed daily processes and revenue generating activities, including responsibility for all TPL contracts performed in the states of Virginia and West Virginia
- Supported complex, deadline-driven operations by being highly focused and results-oriented
- Identified goals and priorities, and resolved issues within the initial stages
- Prepared all standard reporting (for example, weekly, monthly and quarterly reports, invoices, etc.)
- Performed various yield management activities, project data analysis, and quality review

Office/Program Manager (2006–2012)

- Coordinated activities of functional areas related to TPL recovery projects, including A/R, Trauma, Estates, HIPA, Medicaid Buy-in, Disallowances
- Supervised a staff of four responsible for meeting strict operational deadlines
- Directed day-to-day client communication

- Managed invoicing and quality assurance of Trauma, Estates, Credit Balances, Disallowances, Medicaid Buy-in presented on Casualty, Estates, and the HIPP programs to various organizations
- Accountable for the statewide Medicaid third party recovery effort maintaining the goal of 100% client satisfaction and generating over \$5 million per year in recoveries and millions more in cost avoidance savings

Case Director (2001–2006)

- Managed the TPL Trauma/Tort recovery project for the State of West Virginia, including Medicaid and CHIP
- Case management for General Torts or Personal injuries; Medical negligence and malpractice, auto accidents, and Workers' Compensation, valued at over \$10.4 million
- Enforced the state's assignment rights to recover Medicaid expenditures from trauma/tort TPL
- Identified potential recoveries through various referral methods, investigated all leads, valued claims, and established liens

City Mortgage Services

1999–2001

Loan Counselor

- Responsible for back-end loan collection on accounts 60, 90, 120+ days past due

Bowles, Rice, McDavid, Graff, & Love

1996–1999

Legal Assistant

- Workers' Compensation legal assistant for defense firm

Workers' Compensation Office of Judges

1992–1996

Legal Assistant Paralegal Writing Team

- Adjudicated and prepared written decisions on cases involving compensability, medical treatment, and temporary and permanent disability benefits

Terri Roush — Network Development Director

Qualifications

Terri is a seasoned Director with a strong history managing and developing comprehensive provider networks, supporting and training a diverse range of provider types and specialties, and making sure processes are streamlined and easy for providers. She has excellent communication and contract negotiation skills and is capable of handling all types of inquiries and complaints from providers and promptly finding resolutions.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2004–Present

Network Development Director (2017–Present)

- Directs the activities related to the development and maintenance of the company's physician and provider delivery system
- Oversees and directs efforts across a shared services platform related to provider performance to achieve market goals related to provider delivery system
- Oversees and directs efforts to align contracting strategy with medical management strategy
- Hires, trains, coaches, counsels, and evaluates performance of direct reports
- Oversees and directs efforts to resolve operational issues related to specific areas of responsibility
- Synchronized communications between network and cross-functional accountable areas
- Responsible for budget accountability
- Oversees and directs efforts to develop, coordinate, and review provider communications
- Served as committee member in cross-functional shared partner teams
- Develops provider networks that provide a competitive advantage

Manager, Network Relations (2014–2017)

- Oversaw activities related to development and maintenance of company's physicians and provider delivery system
- Responsible for provider network recruitment and retention. This included resolving operational issues, serving as a contact person for internal departments, developing and reviewing provider communications, and synchronizing communications between network and cross-functionally accountable areas
 - Built networks to serve the BH, ACA, and SSI expansion populations
- Managed and coordinated provider events, conferences, and workshops
- Managed seven direct reports and supported four additional associates
- Served as committee member in cross-functional partner teams

Senior Network Education Representative (2004–2014)

- Acted as liaison between UniCare, contracted and non-contracted providers, facilities, associations, and government organizations
- Was responsible for maintaining network satisfaction and building positive and collaborative relationships with providers
- Recruited and contracted providers to grow the existing provider network
- Proactively educated professional and institutional providers on the health plan's guidelines, policies, processes, billing, and reimbursement methodologies

- Conducted face-to-face education sessions and educational webinars with professional and institutional providers on a regular basis
- Identified, researched, and resolved provider concerns, claim, eligibility, authorization, provider database, and benefit inquiries
- Participated in and prepared material for statewide provider workshops, association meetings, and conferences
- Assisted multiple departments in additional education and troubleshooting techniques to resolve provider concerns
- Developed West Virginia educational material for the Member Call Center and conducted training sessions for Member Call Center and new employees

Moose Surgical & Hand Specialist, P.A.

2002–2004

Practice Manager

- Supervised multiple employees and coordinated the activities of all employees, assisted with the daily workflow of the practice, managed physicians' calendar, scheduled and obtained pre-certification for surgeries, and performed accounting functions to include accounts payable, accounts receivable, financial report, monthly, and annual budget
- Responsible for physician credentialing and re-credentialing, conducting HIPAA, OSHA, and policy and procedure staff education, and developing and implementing office policies and procedures
- Developed a HIPAA workbook

Education

West Virginia University Institute of Technology

- Bachelor of Science, Health Service Administration, 1998

Elizabeth Daniel — Provider Relations Director

Qualifications

Elizabeth brings almost a decade of health care experience and four years building and maintaining positive relationships with providers across West Virginia. She keenly understands claims, provider network and development, and managed care processes, and has successfully engaged high-volume providers to make sure UniCare maintains high satisfaction rates. In her role, Elizabeth develops training and monitors provider inquiries, complaints, and communications.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2015–Present

Provider Relations Director

- Directs the activities related to the development and maintenance of the company's physician and provider delivery system; researches and resolves various claims issues for providers
- Provides pertinent education to providers and billing agencies regarding multiple billing and coding topics
- Maintains schedule of provider education webinars and work with necessary departments (Quality, UM, CMAP) to ensure all materials are ready and distributed as needed
- Assists in maintaining provider network adequacy by recruiting necessary PCPs, specialists, and ancillary and hospital providers
- Attends and presents at provider workshops and events throughout the state
- Engages high-volume provider types (facility, FQHC, PCP) monthly to ensure issues are addressed timely
- Assists with cost of care initiatives target at provider network through outreach and interventions (specifically ER triage in acute care facilities)
- Participates in active outreach projects as assigned (Pay Holds per state guidelines, Approved Credentialing, Physician Assistant, After Hours & Appointment Availability Access)
 - Successfully worked with Princeton Community Hospital to resolve outstanding claims issues of 150+ while building a relationship and strengthening trust between the facility and UniCare
 - Completed Anthem's Aspiring Leadership program in April 2018
 - Concentrated efforts on the validation and management of provider demographic information
 - Mentor and train new staff
 - Consistently meet provider visit goals of 20 per month

Patient Centered Care Consultant (2015–2016)

- Assisted PCP network in increasing incentive payment
- Performed facility site reviews as part of the credentialing process
- Coordinated Clinic Days with PCP offices to close gaps in care

Raleigh General Hospital

2011–2015

Physician Practice Coordinator (2011–2015)

Billing Specialist (2009–2011)

- Managed and provided day-to-day support for 11 providers and 15 staff within six physician practices; daily duties included payroll, interviewing and hiring new employees, training, staffing schedules, and billing office oversight

- Assisted in the start-up of five new employed physician offices including credentialing and staffing as well as purchasing medical/office supplies
- Maintained effective practices while staying within the parameters of the budget
- Assisted with medical coding within the practices as needed for billing and pre-certification of procedures for urology, interventional pain management, interventional cardiology, and orthopedic surgery
- Handled coding and billing of procedures done by physicians and all follow-up related to the claim

Education

Mountain State University

- Bachelor of Science in Business Management with an emphasis in Health Service Administration, 2012

License and Certification

- Certified Professional Coder

Michele Carrera — Information Technology Director (Interim)

Qualifications

Michele brings almost three decades of information technology knowledge and 15 years of health care industry experience providing IT solutions. She is an IT expert with knowledge areas that span implementation, migrations, data security, EDI interface, encounters, customer service, business process architecture, analytics, and more. Michele is also an adept leader, who oversees a team of 22 resources and two management team members as part of working with state agencies to assure the integrity, security, and operability of systems, as part of serving members. Throughout her career, she has built trusted relationships with executive leadership, vendors, and other stakeholders.

Professional Experience

Anthem, Inc.

2011–Present

Director of Technology

- Serves as the Director of IT, overseeing a Customer Account Management team of 22 resources and two managers who act as health plan and state liaisons for information technology
- Acts as the IT primary POC for all company-wide initiatives that impact Anthem's Government Business Division
- Manages team responsible for all Medicaid proposal IT responses and state mandate work
- Oversees IT Strategy Account Managers, offering strategic IT support for growth projects for Medicaid and Medicare
- Acts as lead architect for Medicaid/Medicare migrations from legacy Anthem to Government Business Division platforms, which includes developing enhanced methodologies and practices, oversight of 14 domain area workgroup integration and solutions, and management of Migration Architect team and operating budget
- Facilitates large-scale solution summits and cross-functional gap analysis sessions

Director, IT Customer Account Manager and Director, Provider Lifecycle Management

- Northeast Region liaison between the State Medicaid ITS teams, health plans, and corporate IT
- Accountable for ITS customer satisfaction among our business partners and leaders across five states
- Supported the development of new business requirements, as well as technical solutions
- Developed trusted and reliable relationships
- Provided IT support for a variety of health plan operational needs
- Developed transition plans for health plan initiative projects in collaboration with ITS Growth leadership
- Managed operations and implementation projects for configuration/provider data activities
- Managed operational process improvement, quality, provider relationship management, pricing, and benefit configuration
- Managed 16 direct pricing/benefits configuration analysts, business analysts and report developer staff

Molina Healthcare/Unisys Corporation

2005–2011

Manager, Healthcare Analytics Software Engineering

- Managed Analytics department implementation work in Idaho, Maine, and West Virginia MMIS systems

- Managed staff of 17 software developers throughout the SDLC lifecycle for all CMS, state, and operational reports
- Led team of analysts tasked with leading JAD sessions to capture requirements and system design solution deliverables
- Contributed to RFP responses/reviews and estimates for the Analytics department
- Managing liaison for Decision Support/Utilization Management reporting subcontractor
- Graduate of the LEAP program (Leadership Excellence Acceleration Program) for mid-level leaders
- Completed federal months of corporate leadership training and projects for accelerated leaders in the Federal Division

ValueOptions, Inc.

2005

Business Intelligence Lead

- Oversaw conversion project for 200+ stored procedures, and over 1,000 Crystal Reports from Sybase to Oracle
- Led team of programmers, analysts, and testers for reporting and numerous offsite service centers
- Performed analysis, technical specification development, scripting, and testing of report requests
- Project Lead — HEDIS NCQA corporate-wide reporting requirements

Education

The American University, Washington, DC

- Master of Science, Computer Information Systems, 1992

University of Maryland

- Bachelor of Arts, Communication, 1989

License and Certification

- Systems Integration: Composite Application Development
- Mastering the Management of Iterative Development
- Principles of Modeling
- Mastering the Management of Iterative Development
- Techniques for Experienced Layer 3 Architects
- Principles of Analysis
- Certified Scrum Master
- Planning Agile Software Development Projects
- Leading Agile Teams and Agile Programming and Testing
- Six Sigma Lean White Belt

Richard Grooms — Member Services Director

Qualifications

Richard brings a strong history of serving West Virginia members and providers. He has over 10 years of experience with high-touch customer service teams that include leading call center operations for Medicaid members and providers, and handling complex or non-routine issue resolutions. Through use of reporting and analytics, he is able to increase engagement into appropriate programs and offerings and serve as a resource and educator on health care access-related inquiries. Prior to joining UniCare in 2016, Richard was the liaison to DHHR and MCOs for SKYGEN.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2016–Present

Member Services Director

- Collaborates with the senior management team within the business unit and the organization in bridging the gap between the current and desired business performance levels
- Manages several projects across departmental lines, and uses several systems (Teradata, Tableau, and Office)
- Develops the membership database and Tableau reporting used by several departments and provides insight into membership trends
- Managed and created several tools throughout the health plan that allowed for actionable information to be distributed to multiple teams and that spanned several platforms (Tableau, SharePoint, Access)

SKYGEN

2014–2016

Provider Relations Representative

- Responsible for building and maintaining appropriate relationships with members and providers by ensuring regular communications and timely problem resolution
- Constant contact with both members and providers to ensure dental health was not interrupted
- Maintained key relationships within Medicaid
- This would include a close relationship with the four MCOs at the time and DHHR
- Led and organized a committee of providers to handle any issues within the Medicaid contract
- Excelled in both account relationship and strategic roles
- Maintained key relationships with government and customer stakeholders
- Served as the Lead developer of the P.R.I.M.E. Committee workgroup initiative

CareFirst BlueCross BlueShield

2006–2011

Supervisor II

- Supervisor II in the West Virginia call center
- Supervised a team of 22 in the West Virginia call center
- Oversaw quality, monitored call statistics, and escalated issues
- Ensured that all SLAs are met while providing exemplary customer service
- Worked with both members and providers
- Created a specialized escalation process for the Provider Relations team that assisted with overall satisfaction
- Helped with tracking and resolving issues in a more efficient and effective manner

Education

West Virginia University

- Bachelor of Science, Marketing, 2002

Chris Kearney — Claims Payment Director (Interim)

Qualifications

Chris has over 20 years of health care industry experience, plus expert knowledge to support all aspects of the claims process. He directly supports our West Virginia Medicaid claims operations and has a demonstrated history of planning, implementing, and leading claims initiatives that assure timely, accurate, and efficient processing and adjudication. Has also assisted in developing and executing strategies to streamline the claims process, build stronger relationships with the provider community, and increase both member and provider satisfaction.

Professional Experience

Anthem, Inc.

2012–Present

Director II, Claims Appeals and Adjustments (2013–Present)

- Leads Medicaid claims operations across 20 markets, including front-end electronic data interchange, planning and governance, audits, new-day claims, adjustments, and appeals
- Drives strategic direction and assures claims processing and operations meet performance goals, contract requirements, and state and federal regulations
- Serves as a key contact for the health plan, state, and regulatory departments
- Identifies reporting specifications and develops claims-related reports, conducts data reviews, and oversees submission of various state-mandated reports
- Plans, directs, and coordinates all inventory management activities
- Supports claims-related projects, initiatives, system migrations, and implementations

Director, Account Management (2012–2013)

- Direct responsibilities included account management of the New York health plan — a health plan with membership in excess of 450,000
- Alignment of corporate and health plan departments to systematically implement strategic initiatives; coordination and facilitation of cross-functional issue resolution; analysis and root cause analysis to drive performance improvement initiatives; and ensuring compliance with state regulatory and contract requirements

The Kempsville Center

2009–2011

Universal Health Services (UHS), Administrator

- Direct responsibilities include the operations management and business development of 83-bed facility, with budget of more than \$18 million
- Developed new inpatient line of service; including operational development, physician recruitment, business development and marketing strategy, state and federal compliance, and Joint Commission accreditation; this service added \$4 million in additional net revenue
- Led organization's Quality Assurance program, ensuring ongoing organizational and operational improvement and maximizing efficiency
- Ensured ongoing compliance with organization/corporate policy, federal and state regulations, and accrediting body statutes
- Recruited and managed campus physicians, including recruitment of two additional physicians

Acadia Abilene

2001–2008

Chief Executive Officer (2007–2008)

Chief Operating Officer (2001–2007)

- Conceived, built, and operated Abilene Psychiatric Center (Acadia Abilene) and Abilene Psychiatric Associates. This inpatient hospital and multi-physician specialty clinic produced annual revenues of \$18 million and more than 125 employees. Daily management of hospital and physician clinic operations including strategic planning and business development, quality and process improvement, profit and loss management, medical billing, technology, human resources management, health information management, and plant operations
- Led system's Quality and Process Improvement program that monitored, analyzed, and implemented improvement initiatives for processes across the organization
- Successfully recruited eight doctors to underserved area and managed their contracts, credentialing and re-credentialing, negotiations and maintenance of third party insurance contracts, and outpatient and inpatient operations
- Cultivated external relationships to establish and grow clinic business and developed collaborative associations with numerous community agencies

Red River Hospital

2000–2001

Vice President of Strategic Planning & Marketing

- Responsible for all strategic planning, marketing, and sales efforts of 64-bed facility with revenues of \$15 million
- Developed additional lines of key service offerings, including Medicare and Medicaid programs, increasing patient days by 50% and revenues by more than \$5 million
- Strategically drove marketing efforts, resulting in an increase in admissions by 46%
- Increased net revenue through negotiation of insurance contracts and increased contractual adjustments by average of 5%, adding \$250,000 per annum directly to the bottom-line

Education

University of Kansas

- Master of Healthcare Administration, 1999

Loyola University of Chicago

- Bachelor of Arts, Psychology, 1995

Professional Certifications and Memberships

- ACHE, Member
- Health Care Administrators of Tidewater, Member
- Contributing Columnist "Mental Health Matters," Abilene Reporter News, 2004–2008
- Member, Community Investment Panel, United Way of Abilene, 2005–2008
- Chairman, Community Investment Committee Board, United Way of Abilene, 2006–2008
- Member, Abilene Mental Health Taskforce, 2003–2008
- Member, Abilene Jail Diversion Committee, 2004–2008

Tracey Welch — Encounter Data Integrity Manager (Interim)

Qualifications

Tracey has over 20 years of health care experience leading business and IT functions, including analytics, reporting, and extracts. She directly supports our West Virginia Medicaid encounters reporting operations and has a demonstrated history of planning, implementing, and leading initiatives that assure timely, accurate, and efficient reporting. Tracey brings strong strategic thinking and interpersonal skills to lead diverse teams, work closely with key leaders, and drive results. She serves as a SME on the encounters process to support health plan initiatives. She holds a bachelor's in Business Economics.

Professional Experience

Anthem, Inc.

2017–Present

Director of Reporting and Analysis, GBD Encounters

- Manages Central Region Medicaid market performance to assure compliance with timeliness, accuracy, and completeness, and oversees the analysis and execution of encounter remediation, which includes coordination for front-end billing enforcement and vendor action plans
- Spearheads reconciliations between financial data and encounter data with action plans to close gaps
- Helps assure the successful transitions and implementations of new markets
- Leads Health Plan Encounters Governance forum to calibrate on priorities and provide status on performance
- Sets strategic direction for the team and integrates new tools and processes to help improve monitoring processes
- Supports health plan initiatives and state audits as a SME on encounters
- Champions organizational health and strengthens regional relationships by demonstrating core values, keeping commitments, and engaging in activities to drive a high performing culture

Florida Blue, Jacksonville, FL

2011–2016

Sr. Manager, Enterprise Extracts

- Managed day-to-day functions of Ad Hoc Solutions team to provide internal and external customers with information from data warehouse and source systems
- Planned strategic direction for centralizing external extracts and approach to standardize formats, accelerate vendor implementations, and reduce operational costs
- Managed business and vendor relationships during requirements, testing, implementation, and maintenance
- Led execution of extracts for multiple projects, unplanned urgent requests, and ad hoc reports to support corporate and business initiatives
- Coordinated with cross-departmental leaders to provide information on multiple fronts (for example CARE/HEDIS, Network Access and Adequacy, Employer Groups, and Audit requests)
- Implemented analytic grouper tools to support provider profiling, medical cost management, ACOs, PCMHs, and other alternative payment arrangements
- Acted as Business Relationship Manager for Enterprise Analytics to champion strategic alignment between business, Analytics, and IT, and collaborate on new capabilities, business case development, and cost benefit analysis
- Reorganized department functions to increase automation, reduce administrative costs, and improve efficiency and effectiveness of the team

- Managed human resource activities for goals, performance management, career progression, and team building

MVP Health Care, Schenectady, NY

1996–2011

Informatics Director (2006–2011)

- Provided network and medical analytics to support the organization's executive decision-making across Medicaid, Medicare, and commercial lines of business
- Directed a centralized pool of analysts to produce a more consistent view of results as related to medical costs and trends, provider practice patterns, hospital reimbursement methodologies, and medical management policies
- Delivered standard medical expense reports by line of business, product and region with frequency, average cost, and PMPM that balanced to financial statements
- Supported medical cost containment activities with purview over projected and actual cost savings analysis
- Oversaw ad hoc reporting functions to provide timely and accurate information to customers across the organization

Manager (2001–2006)

- Addressed analytic needs to support finance, medical management, and networks
- Automated standard report packages to monitor membership, medical trends, radiology, etc.
- Managed operational reporting to state agencies (NYS Medicaid Encounter Data, VT Health Care Uniform Reporting and Evaluation System)
- Oversaw fee schedule analysis for physicians and contract analysis for facilities to support negotiations
- Provided ad hoc reporting to departments across the organization
- Led development of staff to understand business drivers and trends, identify relationships and patterns in the data, present information in a professional, user-friendly manner, and nurture relationship with customers

Analyst (1996–2001)

- Prepared monthly IPA Medical Management Reports with drill down into large variances to budget
- Built ad hoc reports, interpreted results, summarized key findings, and presented to business partners in Finance, Medical Management, Network, and Sales
- Coordinated monthly Reinsurance Notification reports and sent accruals to Finance
- Migrated reports from main frame to data warehouse environment

Education

State University of New York

- Bachelor of Science, Business Economics, 1987

Natalie Robinson — Community Engagement Director

Qualifications

Natalie is an experienced manager with knowledge across customer service, outreach, community engagement, and marketing to managed care stakeholders. She has exceptional skills nurturing community and client relationships, creating and executing unique events and initiatives, strategic planning, and collaborating with diverse teams to enrich existing programs, address complex issues, and find creative solutions. She leads a team of Community Engagement Representatives focused on membership growth and retention through the execution of creative marketing events and initiatives, providing services and referrals to members, staying abreast of marketing trends and competitor intel, and fostering authentic relationships with community leaders and key stakeholders for partnership development and sustainability. She holds a Bachelor of Arts in Communication, and recently earned a Diversity and Inclusion Certificate from Cornell University.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2012–Present

Community Engagement Director (2016–Present)

- Develops objectives, policies, and programs for marketing activity related to membership growth, retention, acquisitions, and business initiatives
- Establishes priority approaches and strategic planning to increase brand awareness and market share in targeted regions to improve on ROI for member acquisition and retention
- Ensures compliance with state and municipal laws, rules, and guidelines for marketing and outreach across the state. Initiate quality and compliance reviews on all marketing collateral, media, and marketing representative outreach
- Establishes and maintains high-level partnerships with national organizations, local and statewide key stakeholders to address needs, report trends, uphold accountability, and maintain a robust, positive rapport with members, partners, and government relations
- Researches market trends, incorporates best practices, and embarks on new, innovative ways to enhance member experience in order to maintain plan of choice among our constituents. Analyzes feedback from current members and makes adjustments when needed
- Aligns marketing events and initiatives to not only grow membership, but to also improve upon the health and wellness of the communities we serve by providing tailored events and resources that address community-specific health and wellness issues and/or SDOH
- Incorporates diversity and inclusive measures into marketing collaterals, sites, events, programing, and initiatives
- Supports business development initiatives to capture growth opportunities by providing research data and comprehensive marketing reports on partnerships, sponsorships, events, and initiatives that positively impact wins on new business RFP and state rebids
- Instrumental in leading the marketing team to successfully drive membership growth. Increased marketing engagement by 20% in target markets resulting in successfully retaining and growing market share in 2018 despite an overall decline month-over-month in eligible populations
- Established and implemented new signature events in selected markets that created relationships within new industries, increased brand awareness, membership growth, and partnership recruitment
- Created internal marketing SharePoint site to house important documents, post statewide events, collect internal feedback, and improve processes for interdepartmental collaborative work

- Nominated and Awarded by Plan President for Values in Action Award in 2017

Senior Outreach Specialist, Marketing (2012–2016)

- Responsible for carrying out health plan's marketing initiatives, event planning, community collaborations, and market research and analysis in the highest member, 10-county territory
- Led team in increased engagement rates and events, and new partnerships
- Provided direct support to the Marketing Director and maintained leadership role in training and mentoring all outreach staff on job responsibilities including presentations, scheduling, networking, and event planning and execution
- Created comprehensive monthly marketing team reports, meeting agendas, and market share analysis
- Conducted presentations on benefit and services to community members, stakeholders, and interdepartmental colleagues
- Served on various community boards, committees, and roundtables to provide advice and accountability to organizations as well as to stay abreast of community needs and to communicate changes within the company to community leaders and stakeholders
- Planned and executed annual Stakeholder Advisory Committee and the Member Engagement Committee to receive feedback on company initiatives and address partner and client needs
- Responsible for relaying updates to leadership and internal Medical Advisory Committee

Ferguson Manning Associates, East Market, Charleston, WV

2014–2015

Marketing & Communications (Contracted)

- Established and strengthened relationships with diverse suppliers who provide goods and services to West Virginia (and surrounding east market states) companies throughout the enterprise
- End-to-end logistic event planning and execution for supplier diversity marketing and engagement events for recruitment; provides marketing support and advice to existing clients when needed
- Drives company's marketing strategies to support diversity goals and objectives. Develops strategic plans and administrative budget
- Measure and track progress of all contracted marketing projects and provide timely follow-up with clients. Leads execution of variable projects within scope

Education

West Virginia University

- Bachelor of Arts, Communications, General Studies, 2017

Cornell University

- Diversity & Inclusion Certification, 2019

Stephanie Harper — MHT Member Advocate

Qualifications

Stephanie is a dedicated health care professional who brings more than a decade of experience serving low-income populations in the health care system and across a diverse range of cultures and backgrounds, including children, youth, and families. Stephanie strong knowledge of West Virginia's Medicaid, BH programs, trauma-informed care, and integration and coordination across the system of care. She also has a proven history developing and playing a key role in training, education, outreach, and initiatives aimed towards supporting youth and families. Stephanie also brings a decade of quality improvement activities, including gathering and reporting data for state agency reporting. She holds a Bachelor of Arts in Psychology.

Professional Experience

UniCare Health Plan of West Virginia, Inc.

2015–Present

MHT Member Advocate

- Provides outreach and education to a range of stakeholders for Medicaid membership, and stays abreast of policies and requirements regarding foster care, SNS, DHHR-BHMF and DHHR-BCF, Dual Diagnostic Treatment, Cultural Competency, and youth implementations
- Develops initiatives to serve members with substance use disorders and mothers of neonatal abstinence syndrome infants
- Seeks opportunities to support and provide trauma-informed training within communities and school systems and to also support teaching mindfulness in schools and residential rehab programs
- Attends and participates in advisory and specialized workgroup meetings to address the needs of children and youth
- Provides Administrative Services Only (ASO) training, community resource materials, desk guides, and technical assistance to all stakeholders

APS Healthcare Inc., dba KEPRO

2007–2015

Administrative Service Organization Family Support Educator, SNS Department

- Coordinated, created, and facilitated relevant consumer feedback focus groups and satisfaction activities statewide for youth, foster care, biological, foster-adoptive families and kinship relatives involved with Child Protective and Youth Services (receiving services from Psychiatric Residential Treatment Facility, shelters, ASO-SNS, BH Community and Residential services), in order to identify systemic issues thus improving the quality of care, service delivery, and communication within the system and program outcomes
- Analyzed data gathered, identified measurable factors to increase success of the program for Consumer Stakeholder reports, and submitted to DHHR
- Created and delivered trainings, user manuals, desk guides, PowerPoints, forums, and data analysis reports using effective technology for document preparation, electronic communication, presentation development/delivery and library keeping

West Virginia Mental Health Planning Council

2007–2009

Events Coordinator

- Served as Liaison for Chair and Committees, conducted regional stakeholder forums, reviewed block-grant data report analysis, and planned all events

Data Entry WVSU Institutional Research & Development Institute **2006–2007**

- Researched and conducted statistical analysis in support of the management decision-making process, and database quality control and changes for state (Higher Education Policy Commission), regional (Southern Regional Education Board), and federal (US Department of Education) reports

Education

West Virginia State University

- Bachelor of Arts, Psychology, Magna Cum Laude
- Global College of Natural Medicine Santa Cruz, CA
- Master Herbalist, Nutritional Consultant

License and Certification

- CPR and ACE renewals: 2015–Present
- Teacher Certification: Teaching Tai Chi for Arthritis & Fall Prevention — Sun Style, 2015
- PYP Certification: Prisons & Rehabs Trauma-Informed — Prison Yoga Project, 2015
- Tai Chi Chuan Instructor Promotion Certification — Yang Style, 2014
- Nutritional Consultant, 2008
- Emotional Freedom Techniques Certification I — LifeQuest International, 2008
- Holistic Health Practitioner — American Association of Drugless Practitioners, 2007

Jarrell Martin, II, DDS — Dental Director

Qualifications

As a licensed, practicing dentist for the last eight years, and owner of the largest Medicaid and CHIP pediatric and adult practices in Kanawha County, West Virginia, Jarrell Martin, DDS is keenly aware of the need for continued integration of dental services in our community. He has been an active participant in the provider panels to help identify, design, and implement solutions for patients. Jarrell is also accustomed to working with a diverse range of patients — both children and adults — to provide comprehensive oral health care. He has managed his own dental practice and is accustomed to all aspects of administering dental services.

Professional Experience

Martin, DDS, PLLC

2013–present

Owner and Practicing Dentist

- Provides comprehensive care for patients (both adult and pediatric), including diagnosis, treatment planning, patient education, operative procedures, extractions, and multidisciplinary care with specialists
- Participated in regular quarterly meetings with SKYGEN as part of a provider panel to find solutions to common problems within the Medicaid program
- Regularly met with SKYGEN field representatives and discussed suggestions to streamline the billing process
- Handled almost every aspect of patient billing in house; solely responsible for identifying errors within SKYGEN's billing system (errors, if left unchecked, would have resulted in lower quality of care for the Medicaid population)

WVU School of Dentistry

2011–2013

Assistant Professor

- Responsible for teaching classes under the supervision of the area dean
- Helped students fulfill their maximum potential in mastering course content
- Assessed student learning outcomes
- Assisted with articulation and curriculum development and review
- Served on college committees and participating in faculty governance including accreditation and student co-curricular activities

Cornerstone Care, Inc.

2012

Associate Dentist

- Rapidly grew patient base, establishing credibility by providing high-quality care
- Applied care when providing treatment, including composite fillings, simple extractions, space maintainers, stainless steel crowns, and pulpotomies
- Created comprehensive treatment plans based on conclusions drawn from dental history, chief complaints, oral examinations, and radiographs
- Participated in community oral health initiatives to promote proper oral hygiene to local students

Education

West Virginia University

- Doctor of Dental Surgery, 2011

- Bachelor of Arts, Chemistry, 2006
- Bachelor of Science, Biology, 2004

License and Certification

- Licensed by the West Virginia Board of Dentistry

Affiliations

- American Academy of Pediatric Dentistry
- Academy of General Dentistry
- Kanawha County Dental Society
- West Virginia Dental Association

MARTIN, DDS PLLC

January 30, 2020

Dear Tadd:

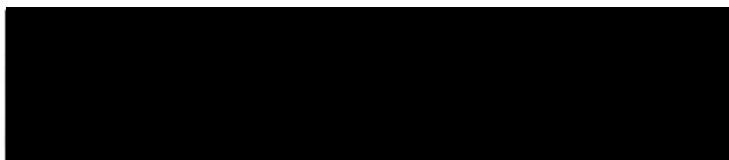
I am pleased to provide this letter indicating my intent to work with UniCare Health Plan of West Virginia, Inc. (UniCare) and support the dental activities for West Virginia's Mountain Health Trust Program, should UniCare be awarded a contract. I am honored to be included in UniCare's proposal as the key position of Dental Director, for which I will oversee the administration of dental services as part of the UniCare Whole Person Health model.

As a Practicing Dentist and Owner of the largest Medicaid and CHIP pediatric and adult practices in Kanawha county West Virginia, I am keenly aware of the need for continued integration of dental services in our community. I have been an active participant in the provider panels to help identify, design, and implement solutions for patients and am excited for the opportunity to bring this work to the next level with UniCare.

Thank you for including me, and I look forward to hearing the news of award with you.

Sincerely,


Jarrell R. Martin, II, DDS



ATTACHMENT 5: MANDATORY REQUIREMENTS

MANDATORY REQUIREMENTS

- MD001** The Vendor must comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, State, or federal laws and regulations, waiver amendments, or State Plan amendments.

UniCare Health Plan of West Virginia, Inc. (UniCare) will comply with all applicable requirements outlined in this procurement, as well as the SPA and any modifications pursuant to changes to State policy, State, or federal laws, and regulations, waiver amendments, or State Plan amendments pertaining to West Virginia Medicaid, as well as populations enrolled in West Virginia Children's Health Insurance Program (WVCHIP), effective July 1, 2020.

- MD002** The Vendor must comply with all Service Level Agreements (SLAs), as indicated in the Service Provider Agreement (SPA).

UniCare will continue to comply with all Service Level Agreements as required in the Service Provider Agreement. We maintain a rigorous and thorough compliance program, as detailed in Attachment 3, Section 4 of this proposal.

- MD003** The Vendor must accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health and behavioral health services.

UniCare will accept the per member per month premium rate established by DHHR for managed care physical health and behavioral health services, and we understand the Department will continue to apply the normal rate setting process for developing actuarially sound rates.

- MD004** The Vendor must establish a physical health and behavioral health provider network that provides adequate access, as defined by the Service Provider Agreement (SPA), and serves all counties in the State.

Already available to West Virginia Medicaid members is UniCare's well-established, comprehensive network of more than 14,100 unique Medicaid-enrolled physical health (PH) and behavioral health (BH) providers and facilities. Our network currently complies with availability and access standard requirements in the SPA for establishing a PH and BH provider network with adequate access in all

counties in West Virginia (with the exception of specialty services in rural areas where there is no or limited availability of providers within the mileage standards). We detail our provider network and network development strategies, as well as how we monitor and address identified gaps as we continue assuring all covered services are available and accessible to West Virginia Medicaid members in our response to Attachment 6, ND001.

MD005 The Vendor must submit its provider contract templates and addenda to the Department for approval.

UniCare will submit its provider contract templates, addenda, and any revisions that warrant State filing to DHHR for approval upon notification of award. We will also provide evidence of efforts to contract with all Medicaid-enrolled providers.

MD006 The Vendor must submit an initial Value-Based Payment (VBP) plan to the Department and annually thereafter.

UniCare will continue to submit its Value-Based Payment (VBP) plan to DHHR annually. Our most recent submittal was August 2019. Our Chief Financial Officer, Kevin Dean, oversees our VBP plan.

Together with our affiliate health plans, we are a leader in the use of Alternative Payment Models (APMs) that result in improvements to quality, access, and evidence-based clinical performance while containing costs. In West Virginia, we have used provider incentives and rewards to drive improvements in quality and access since 2015. Currently, 35% of our members and 35% of our medical spending in West Virginia is with providers who participate in our Provider Quality Incentive Program.

We currently offer/are proposing 13 innovative APMs that align with the Health Care Payment Learning and Action Network (HCP-LAN) APM framework, including Category 2 Fee-for-Service programs linked to quality, Category 3 shared savings/risk programs, and Category 4 population-based payment programs. These are detailed in our response to Attachment 6, PS007.

MD007 The Vendor must be accredited by the National Committee for Quality Assurance (NCQA) no later than nine (9) months from its operational start date in the State.

UniCare has held NCQA accreditation since 2006. Our most recent renewal was in 2018 and it is valid until September 2021. Our accreditation level is currently Commendable. In 2017, UniCare additionally received NCQA's Multicultural Health Care Distinction, and we are the only West Virginia Managed Care Organization (MCO) with that distinction. Our accreditation is detailed in Attachment 3, Mandatory Qualifications table.

MD008 The Vendor must provide all requested supporting documentation as specified by the Request for Proposal (RFP), and according to the requirements described in Section 3: General Terms and Conditions, as well as Appendix 4: List of Requested Documents.

UniCare will provide all requested supporting documentation as specified by the RFP.

MD009 The Vendor must provide twenty-four-hour access seven (7) calendar days a week to a provider or service in emergency situations.

UniCare will continue to provide 24-hour access to a provider or service in emergency situations. For example:

- **Provider Access.** All UniCare participating PCPs are required to be accessible 24/7, either personally, or through covered arrangements with designated network PCPs. We further detail our processes for assuring members have timely access to care in our response to Attachment 6, ND014.
- **Emergency Service Access.** Our 24/7 Nurse Line and our BH Hotline are available with live 24/7 assistance for members with urgent or emergent needs. These services provide assessment of physical symptoms, education, and referrals, including referrals in a BH-related crisis situation. Our 24/7 Nurse Line and BH Hotline provide members with evidence-based service recommendations that may prevent an unnecessary emergency room visit. Call records are shared with the Care Management team who coordinate follow-up with the member, their caregiver (if applicable), and their providers as appropriate. Members can access our 24/7 Nurse Line or our BH Hotline directly by calling the number on their member ID card, or by calling our Enrollee (Member) Call Center. We provide further details related to our Member Call Center, in our response to Attachment 6, MS018.
- **Nurse Line.** Our Nurse Line Nurses assess symptoms and severity and address many non-emergent conditions and their treatment using sophisticated decision tree software to support their clinical judgment. Nurse Line Nurses also assess each caller's needs, suggest self-care for non-emergency conditions, recommend next steps for treatment of common ailments, such as upper respiratory infections, and urinary tract infections, and direct the member to the most appropriate point of care.
- **BH Hotline.** Our BH Hotline Representatives engage with members to address emergent issues, suggest referrals for treatment, provide education on BH services, direct members to emergent care, and coordinate with local crisis response resources.

Upon notification or identification of a member experiencing a potentially life-threatening event, our 24/7 Nurse Line or BH Hotline staff collect information by telephone to assess the status of the crisis and the services required. Depending on the member's acuity, the response will include contacting emergency services.

MD010 The Vendor must monitor Primary Care Provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) and West Virginia Children's Health Insurance Program (WVCHIP) limits of members assigned per PCP.

UniCare's Network Development team, with oversight by our Network Development Director, monitors, and will continue to monitor, PCP panels for compliance with the Bureau for Medical Services (BMS) limits of Medicaid members assigned per PCP, for applicable populations, including for compliance with the WVCHIP limits. We maintain a robust selection of in-network PCPs to assure members have an adequate choice of physicians with open panels. Our Network Development team reviews the panel roster list to assure the ratio of PCPs to members meets or exceeds the required ratio of one (1) PCP for every five hundred (500) adult members who is accepting new patients and one (1) age appropriate PCP for every two hundred fifty (250) pediatric members under twenty-one (21) who is accepting new patients as outlined in the RFP.

In accordance with the SPA, should BMS notify our Network Development team that a PCP's panel exceeds 2,000 total Medicaid members, we close the PCP's panel in our provider data management system. Once the PCP panel size has reached the capacity limit, we deem the panel closed and no additional member can be assigned to the PCP unless the PCP requests such, or consents to an exception at the request of the member. The request must also comply with DHHR's valid exception criteria. For example, in the instance of continuity of medically necessary care, such as a new member who is an existing patient of the PCP; assignment of a member to the same PCP as other members of a family unit;

availability of mid-level clinicians in the practice; or inadequate numbers of providers in the geographic area. In these cases, we will submit an exception request to DHHR for approval.

For scenarios where members are assigned to a PCP group or PCP team, the panel size is set based on the number of PCPs in the practice multiplied by the established capacity limit per individual PCP.

Our Network Relations Consultants, at the direction of the Network Relations Manager, are responsible for monitoring practices with closed panels to identify opportunities for re-opening.

MD011 The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).

UniCare currently complies with DHHR reporting requirements for submission of network standards documentation and geographic mapping reports. We will continue to submit network standards documentation and geographic mapping reports to DHHR related to our compliance with Provider Network Standards and MCO Reporting Requirements.

MD012 The Vendor must establish screening processes (per applicable federal and State requirements, as defined by the Department) designed to ensure that the Vendor does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs.

UniCare has established screening processes (per applicable federal and State requirements, as defined by DHHR) into our provider credentialing, recredentialing, and single case agreement processes. We have similar screening processes for subcontractors and vendors (per applicable federal and State requirements, as defined by DHHR) to make certain we do not contract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal health care programs.

MD013 The Vendor must participate in public meetings and other events at the request of the Department.

UniCare will continue to participate in public meetings and other events at the request of DHHR and of our own initiative through the life of the contract. We use public meetings as opportunities to connect and efficiently collaborate with community organizations, and UniCare has conducted 7,735 community

events since January 2015. Groups and events we have met with at DHHR's request, include Medicaid provider workshops, at which UniCare's Provider Relations team members present updated information on topics critical to continued success for West Virginia's sponsored health care programs.

Participating in public meetings helps us enhance care delivery by addressing issues, sharing updates about the program, gaining input on how to improve and strengthen relationships, and establish partnerships. Through active participation, we have built extensive experience adapting our training and messaging to a variety of audiences and also responding to new information from the meetings.

As an example of our participation in public meetings and our responsiveness to their input, UniCare attended the Kinship Caregiver Forum hosted by the Children's Home Society in the fall of 2017. During this meeting, we learned of the Healthy Grandfamilies grant at West Virginia State University, and subsequently reached out to this organization to identify ways we could partner to support their mission. We have provided support for a number of their training sessions, have offered our expertise in teaching the health literacy section of their curriculum, and have provided them with a \$25,000 grant to support their statewide expansion.

MD014 The Vendor must comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT), which can be found at the following links:
<http://www.wvdhhr.org/mis/policies.asp>
<https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx>
<http://www.state.wv.us/admin/purchase/privacy/default.html>

We have reviewed and confirmed compliance with the security and privacy policies and procedures for the West Virginia Office of Technology (WVOT) and the Office of Management Information Services of DHHR currently posted on the websites listed in our response to MD014.

MD015 The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.

UniCare's operations are supported by systems compatible with the current versions and standards supported by WVOT. As an incumbent MCO, we have worked with DHHR and WVOT to establish all

required data and system interfaces for the West Virginia Medicaid program and will continue to support all required technology standards and interfaces for these programs, including: eligibility (X12 834 format), payment (X12 820 format), and encounters (X12 837 format). We will also continue to support proprietary file formats, including: the MAXIMUS provider file, immunization data, third-party liability, and maternity kick payment information. UniCare has demonstrated our ability to support DHHR's technical requirements during our 17-year partnership. We will work with DHHR during the planning and implementation phases for inclusion of the CHIP population in the Mountain Health Trust (MHT) program. We will assign a technical lead and form a cross-functional team to support this effort, working together with DHHR, and its agents to design and develop interfaces to support these additional populations. A collaborative approach benefits all of us—especially our members and providers—and results in more consistent operations. Our Technology Services and Implementation teams have supported numerous implementations for 24 Medicaid markets and we are confident our experience combined with our flexible MIS will support rapid development and deployment of new functionality that is required by DHHR for these program changes.

MD016 The Vendor must ensure that the health information system accepts the Medical Assistance Identification (MAID) generated by the Department for all members for data collection and billing purposes.

Our integrated MIS manages member program information and data collection, including that used for billing purposes, using the DHHR generated MAID.

MD017 The Vendor's information management system must have the capability to produce reports in accordance with the State's Medicaid Fraud Control Unit's (MFCU's) standardized reporting template upon request, as referenced in Appendix 5.

UniCare produces reports under the current contract as required by the Medicaid Fraud Control Unit's standard templates using the broad capabilities of our MIS and support teams. We will continue to produce reports at DHHR's request.

MD018 The Vendor must adhere to all State-defined file formats and templates including, but not limited to, 834 enrollment, and 837 encounter files.

UniCare adheres to all State-defined file formats and templates, including 834 enrollment and 837 encounter files, under the current SPA. We will continue to adhere to file format and template requirements, adjusting ongoing processes as required to meet any requested changes.

MD019 The Vendor must obtain approval from the Department for all key staff hired under the contract and all personnel assigned to this contract. In all circumstances, key staff must be replaced only with persons of equal or greater experience and qualifications.

UniCare will obtain DHHR's approval for all key staff hired under the contract and all personnel assigned to administer this contract. As an MCO already serving Medicaid members in West Virginia, we are accustomed to obtaining approval from DHHR and will continue to comply with this requirement. When we must replace key staff, we do so with candidates who have the same (or greater) experience and qualifications to ensure we are always providing a high level of care.

MD020 The Vendor must employ Key Staff, defined as those responsible for providing leadership and creating the standards and processes required for the successful implementation, operation, and maintenance of the program, assigned to the project on a full-time basis. Each Key Staff role must be a full-time position, to be filled by one staff member only, unless otherwise approved by the Department. All Key Staff members must enter the project within thirty (30) calendar days of the contract award.

UniCare employs all designated key staff on a full-time basis to serve West Virginia Medicaid program members. Each key staff position will be filled by one staff member, unless otherwise approved by DHHR. With 17 years of experience serving West Virginia, we already have a full team of key personnel, and our efforts are underway so that we fill open key positions within 30 calendar days of the contract award.

MD021 The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with the Vendor on the project.

UniCare accepts financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting UniCare or working with us on the MHT program.

- MD022 The Vendor must provide a drug-free workplace for employees and all applicable agents including, but not limited to, subcontractors. All agents of the Vendor must not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol, or a controlled substance during the performance of the contract.

UniCare provides an alcohol and drug-free workplace for employees and all applicable agents, including but not limited to subcontractors, as demonstrated through our compliance with the Drug-Free Workplace Act of 1988. We will continue to comply with this requirement and will prohibit employees, temporary employees, agents, and subcontractors from the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol, or a controlled substance during the performance of this contract or while representing UniCare at any time.

- MD023 The Vendor must be responsible for all expenses required to obtain and maintain access to the Department systems. Such expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs.

UniCare will continue to be responsible for all expenses required to obtain and maintain access to DHHR systems as we have done under our current and previous contracts with the State. We understand and agree that such expenses include, but are not limited to, access to State hardware, software, network infrastructure, and any licensing costs.

- MD024 The Vendor must be responsible for costs associated with reports requested and any action that involves the work of the State fiscal agent due to mock request or mock failure to meet State standards, as applicable.

UniCare will continue to bear costs associated with reports requested and with any applicable action involving the work of the State fiscal agent. ***We have an excellent reporting track record with DHHR, with a regulatory reporting timeliness of 100% and 0% of reports returned for quality issues from 2018-2019.*** We anticipate continuing our outstanding reporting record in the renewed contract.

- MD025 The Vendor must make available to the Department the results of any third-party audit conducted including, but not limited to, the Service Organization Control (SOC) 2, on the Vendor's organization.

UniCare will make available to DHHR the results of any third-party audit conducted including, but not limited to, the Service Organization Control (SOC) 2, on our organization.

MD026 The Vendor must provide authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts to the Vendor's performance under the proposed contract.

UniCare provides authorization from our parent company and subcontractor, Anthem, Inc., for the State to have access to its records if such a relationship exists that impacts UniCare's performance under the proposed SPA. The authorization extends to any Anthem, Inc. affiliated or subsidiary entity, which may provide services under the contract.

MD027 The Purchasing Director reserves the right to require any Vendor that files a protest of an award to submit a litigation bond in the amount equal to one percent of the lowest bid submitted or \$5,000, whichever is greater. The entire amount of the bond shall be forfeited if the hearing officer determines that the protest was filed for frivolous or improper purpose, including, but not limited to, the purpose of harassing, causing unnecessary delay, or needless expense for the Agency. All litigation bonds shall be made payable to the Purchasing Division. In lieu of a bond, the protester may submit a cashier's check or certified check payable to the Purchasing Division. Cashier's or certified checks will be deposited with and held by the State Treasurer's office. If it is determined that the protest has not been filed for frivolous or improper purpose, the bond, or deposit shall be returned in its entirety.

UniCare acknowledges and accepts the right of the Purchasing Director to require submission of a litigation bond from any Vendor that files a protest of an award pursuant to the requirements as outlined in MD027.

MD028 The Vendor must have all requirements operational, as agreed upon with the Department, by July 1, 2020.

UniCare will have all requirements operational by July 1, 2020, as agreed upon with DHHR. We began preparing for implementation during proposal development and are prepared to successfully implement by July 1, 2020.

MD029 The Vendor must maintain a primary workplace in the State of West Virginia.

UniCare's primary workplace is located in Charleston. To support our staff working in the field, we plan to open a satellite office in Morgantown. Details regarding our plans for our Morgantown office are located in Attachment 4: Project Organization and Staffing Approach, Section 1: Initial Staffing Plan.



Vendor's Responses to Mandatory Requirements

Instructions for Completion of Attachment 5 - Mandatory Requirements

1. Using *Tab 3 - Mandatory Req & Responses*, the Vendor must provide the **Section**, and **Page Number(s)** where its detailed narrative response or acknowledgement for each mandatory requirement resides.
2. The Vendor must ensure that each mandatory requirement is addressed.
3. It is up to the Vendor to update the **Section** and **Page Number(s)** columns accordingly if the Vendor should respond to a mandatory requirement.



Vendor's Responses to Mandatory Requirements

Tabs in this Spreadsheet:		
1. Worksheet Instructions	Contains instructions for completion of this RFP supplement.	
2. Worksheet Information	Contains information about the contents of this workbook.	
3. Mandatory Req Responses	Contains the mandatory requirements and all related data.	
Columns on the Mandatory Requirements & Responses Tab		
Section	Column	Description
Mandatory Requirements	Req ID #	The unique ID of the mandatory requirement.
	Requirement Text	The text of the mandatory requirement.
Vendor Response Area	Section and Page Reference	Vendor is expected to provide a reference to its RFP response by Section and Page Number where more detailed information about the mandatory requirement can be found.

Mandatory Requirements		Vendor Response	
Req ID #	Requirement Text	Section	Page #
MD001	The vendor must comply with all applicable requirements outlined in this procurement, as well as the Service Provider Agreement (SPA) and any modifications pursuant to changes to State policy, State or federal laws and regulations, waiver amendments, or State Plan amendments.	Attachment 5: Mandatory Requirements	1
MD002	The Vendor must comply with all Service Level Agreements (SLAs), as indicated in the Service Provider Agreement (SPA).	Attachment 5: Mandatory Requirements	1
MD003	The Vendor must accept the rate established by the State on a per member per month (PMPM) basis for managed care physical health and behavioral health services.	Attachment 5: Mandatory Requirements	1
MD004	The Vendor must establish a physical health and behavioral health provider network that provides adequate access, as defined by the Service Provider Agreement (SPA), and serves all counties in the State.	Attachment 5: Mandatory Requirements	1
MD005	The Vendor must submit its provider contract templates and addenda to the Department for approval.	Attachment 5: Mandatory Requirements	2
MD006	The Vendor must submit an initial Value-Based Payment (VBP) plan to the Department and annually thereafter.	Attachment 5: Mandatory Requirements; Attachment 6: Detailed Specification Approach, 8. Provider Services, PS007	2 30
MD007	The Vendor must be accredited by the National Committee for Quality Assurance (NCQA) no later than nine (9) months from its operational start date in the State.	Attachment 5: Mandatory Requirements	3
MD008	The Vendor must provide all requested supporting documentation as specified by the Request for Proposal (RFP), and according to the requirements described in Section 3: General Terms and Conditions, as well as Appendix 4: List of Requested Documents.	Attachment 5: Mandatory Requirements	3
MD009	The Vendor must provide twenty-four-hour access seven (7) calendar days a week to a provider or service in emergency situations.	Attachment 5: Mandatory Requirements; Attachment 6: Detailed Specification Approach, 8. Provider Services, PS001	3 8
MD010	The Vendor must monitor Primary Care Provider (PCP) panels for compliance with the Bureau for Medical Services (BMS) and West Virginia Children's Health Insurance Program (WVCHIP) limits of members assigned per PCP.	Attachment 5: Mandatory Requirements	4
MD011	The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).	Attachment 5: Mandatory Requirements	5
MD012	The Vendor must establish screening processes (per applicable federal and State requirements, as defined by the Department) designed to ensure that the Vendor does not subcontract with entities that are prohibited, suspended, or excluded from participating in Medicare, Medicaid, or other federal healthcare programs.	Attachment 5: Mandatory Requirements; Attachment 4: Project Organization and Staffing Approach, 1. Initial Staffing Plan	5 22

MD013	The Vendor must participate in public meetings and other events at the request of the Department.	Attachment 5: Mandatory Requirements	5
MD014	The Vendor must comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT), which can be found at the following links: http://www.wvdhhr.org/mis/policies.asp https://technology.wv.gov/security/Pages/policies-issued-by-the-cto.aspx http://www.state.wv.us/admin/purchase/privacy/default.html	Attachment 5: Mandatory Requirements	6
MD015	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.	Attachment 5: Mandatory Requirements	6
MD016	The Vendor must ensure that the health information system accepts the Medical Assistance Identification (MAID) generated by the Department for all members for data collection and billing purposes.	Attachment 5: Mandatory Requirements	7
MD017	The Vendor's information management system must have the capability to produce reports in accordance with the State's Medicaid Fraud Control Unit's (MFCU's) standardized reporting template upon request, as referenced in Appendix 5.	Attachment 5: Mandatory Requirements	7
MD018	The Vendor must adhere to all State-defined file formats and templates including, but not limited to, 834 enrollment and 837 encounter files.	Attachment 5: Mandatory Requirements	8
MD019	The Vendor must obtain approval from the Department for all key staff hired under the contract and all personnel assigned to this contract. In all circumstances, key staff must be replaced only with persons of equal or greater experience and qualifications.	Attachment 5: Mandatory Requirements	8
MD020	The Vendor must employ Key Staff, defined as those responsible for providing leadership and creating the standards and processes required for the successful implementation, operation, and maintenance of the program, assigned to the project on a full-time basis. Each Key Staff role must be a full-time position, to be filled by one staff member only, unless otherwise approved by the Department. All Key Staff members must enter the project within thirty (30) calendar days of the contract award.	Attachment 5: Mandatory Requirements	8
MD021	The Vendor must accept financial, legal, ethical, and all other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities supporting the Vendor or working with the Vendor on the project.	Attachment 5: Mandatory Requirements	8
MD022	The Vendor must provide a drug-free workplace for employees and all applicable agents including, but not limited to, subcontractors. All agents of the Vendor must not engage in the unlawful manufacture, distribution, dispensation, possession, abuse, or use of alcohol or a controlled substance during the performance of the contract.	Attachment 5: Mandatory Requirements	9
MD023	The Vendor must be responsible for all expenses required to obtain and maintain access to the Department systems. Such expenses include, but are not limited to, hardware, software, network infrastructure, and any licensing costs.	Attachment 5: Mandatory Requirements	9
MD024	The Vendor must be responsible for costs associated with reports requested and any action that involves the work of the State fiscal agent due to mock request or mock failure to meet State standards, as applicable.	Attachment 5: Mandatory Requirements	9
MD025	The Vendor must make available to the Department the results of any third-party audit conducted including, but not limited to, the Service Organization Control (SOC) 2, on the Vendor's organization.	Attachment 5: Mandatory Requirements	9
MD026	The Vendor must provide authorization from a parent, affiliate, or subsidiary organization for the State to have access to its records if such a relationship exists that impacts to the Vendor's performance under the proposed contract.	Attachment 5: Mandatory Requirements	10

MD027	The Purchasing Director reserves the right to require any Vendor that files a protest of an award to submit a litigation bond in the amount equal to one percent of the lowest bid submitted or \$5,000, whichever is greater. The entire amount of the bond shall be forfeited if the hearing officer determines that the protest was filed for frivolous or improper purpose, including, but not limited to, the purpose of harassing, causing unnecessary delay, or needless expense for the Agency. All litigation bonds shall be made payable to the Purchasing Division. In lieu of a bond, the protester may submit a cashier's check or certified check payable to the Purchasing Division. Cashier's or certified checks will be deposited with and held by the State Treasurer's office. If it is determined that the protest has not been filed for frivolous or improper purpose, the bond or deposit shall be returned in its entirety.	Attachment 5: Mandatory Requirements	10
MD028	The Vendor must have all requirements operational, as agreed upon with the Department, by July 1, 2020.	Attachment 5: Mandatory Requirements	10
MD029	The Vendor must maintain a primary workplace in the State of West Virginia.	Attachment 5: Mandatory Requirements	10

ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH

1. General

- GE001 1 The Vendor should adhere to page limits, as defined within Section 5 of the Request for Proposal (RFP), and provide responses in 12-point font, single-sided, double-spaced, and with page numbers.

UniCare Health Plan of West Virginia, Inc. has adhered to page limits, as defined within Section 5 of the Request for Proposal (RFP), and has provided responses in 12-point font, double-spaced, and with page numbers. Per the Q&A released by DHHR our response is double-sided.

- GE002 1 The Vendor should adhere to templates as indicated within the Request for Proposal (RFP) for the provision of all requested information in Attachment 3: Vendor Qualifications & Experience.

UniCare Health Plan of West Virginia, Inc. has adhered to templates as indicated within the Request for Proposal (RFP) for the provision of all requested information in Attachment 3: Vendor Qualifications & Experience.

2. Benefit Administration

- | | | |
|-------|---|--|
| BA001 | 1 | The Vendor should provide its plan to impose, monitor, and track member co-pays and quarterly household maximums for including, but not limited to, the following: |
| BA002 | 2 | Medical Services (includes Physical, Behavioral Health, Dental, and Vision) |
| BA003 | 2 | Pharmacy Services |

UniCare Health Plan of West Virginia, Inc. (UniCare) has successfully administered Mountain Health Trust (MHT) benefits in West Virginia for 17 years. Benefit Administration involves coordination across virtually all departments to manage co-pays, utilization and service authorizations, referrals, information-sharing and coordination of care across providers, and other critical operations that assure members are receiving the ***right care, at the right time, in the right place.*** Tadd Haynes, UniCare's Chief Executive Officer (CEO), is responsible for assuring these processes run seamlessly.

Experience Matters

Tadd Haynes, MPH
Chief Executive Officer



A native West Virginian, Tadd is an experienced Medicaid leader who drives UniCare initiatives to improve quality and outcomes.

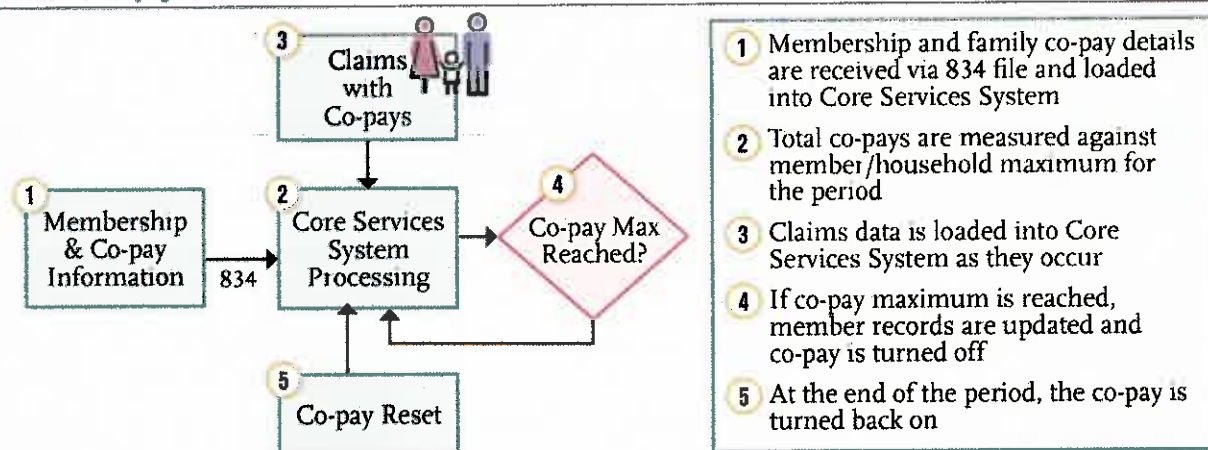
Managing Co-pays and Quarterly Household Maximums (BA001–BA003)

UniCare effectively administers co-pays in accordance with our contract and regulation (Service Provider Agreement [SPA], Article III, Section 3.9). Administering co-pays involves cross functional coordination among departments, including member enrollment, claims processing, member and provider communication, Enrollee (Member) Call Center, and our Provider Phone Line. Figure 6.2-1 summarizes our process for imposing, monitoring, and tracking member co-pays.

Imposing Member Co-pays

Figure 6.2-1. Member Co-pay Process

Member Co-pay Process



UniCare has systems and processes that establish multiple co-pay groupings for members based in part on their MHT tier, and we will establish co-pay groups for West Virginia Children's Health Insurance Program (WVCHIP) members based on their plan type (Gold, Blue, or Premium) and number of children in the household. This will assure appropriate co-pay amounts, maximums, and exemptions will be applied according to State requirements. We recognize the co-pay rules will be different for WVCHIP members and will configure accordingly. For example, current MHT members under age 21 years are exempt from co-pays (SPA Section 3.9), whereas most current WVCHIP members in this age group are subject to co-pays according to type of service, household size, and plan type. We do not impose co-pays for Value-Added Services (VAS).

During the monthly process to upload the 834 membership files, we load (or modify if information has changed) the member into the appropriate group for their co-pay rules and periodic maximum in our Core Services System. We will establish new groups and use similar load processes for WVCHIP members. If the member is part of an exempt population, they are put into a group configured as “no co-pay required.” Our Core Services System will make this co-pay information immediately available to providers via our

provider portal and Provider Phone Line. Members are charged co-pays by the provider at the time of service; UniCare does not bill members. Our payments to providers are reduced by the amount of the co-pay. If the pharmacy benefit were carved in, the pharmacy claims payments would be administered by IngenioRx, our Pharmacy Benefit Partner. As part of the claims adjudication process, IngenioRx would consistently verify member eligibility as well as collection of the proper co-pays based on information in the online claims processing system. When a member claim is received, the system would apply the member's plan and co-pay parameters to the claim, taking into account all co-pays that have already been charged against member maximum. The system would apply up to 500 edits within seconds, helping to assure accurate pricing of the claim, and transmit the member's co-pay amount to the pharmacy. Our Core Services System would accumulate pharmacy co-pays with medical co-pays. UniCare's accumulator would be updated in real time as claims are processed.

Core Services System

The Core Services System serves as the system of record for all provider, member (enrollment and eligibility), claims, and authorization data.

Monitoring Claims Processing of Co-pays

Our Core Services System maintains accumulators for monitoring member co-pays. As claims are processed, member co-pays on the claim record are added to the accumulator. Our system identifies and links co-pays of family members who are enrolled with UniCare, whose co-pays should be combined in consideration of the quarterly household maximum. If a member provides receipts of co-pays by a household member enrolled in another Managed Care Organization (MCO), we incorporate that amount toward the household maximum.

Tracking Co-pay Maximums



Our Core Services System automated accumulator process “turns off” co-pays for members who have met the household co-pay maximum for the member’s co-pay period. This update is immediately available to the Member Call Center, Provider Phone Line, and provider portal. Our system will also generate a letter to the member informing them they have met their co-pay limit and will not be charged a co-pay for the remainder of the period. When a provider verifies the member’s eligibility on our provider portal, they will see co-pays should not be charged. Members will also be able to take the letter to their providers to indicate they should not be charged co-pays for the remainder of the period. When the household maximum is reached, our system will process claims to pay providers accordingly (that is, without reducing the payment). At the end of each co-pay period, our system automatically returns the non-exempt members to a “co-pay required” status and resets the co-pay accumulators. Table 6.2-1 shows the number of households that reached quarterly maximums in 2019. Finally, we require that Medicaid is the payer of last resort and identify Third Party Liability and adjust provider payments when applicable.

Table 6.2-1. Households that Reached Quarterly Maximums and Had Co-pays Turned Off in 2019

	Q1 2019	Q2 2019	Q3 2019	Q4 2019
Number of Households	267	327	340	213

- BA004 1 The Vendor should describe its process for development and revision of Utilization Management (UM) guidelines, as indicated in the Service Provider Agreement (SPA).

UniCare’s Utilization Management Promise (BA004)

UniCare’s coordinated utilization management (UM) approach, part of our Whole-Person Health model, promises members receive timely, appropriate clinical care through individualized programs and coordination of services and community resources. We design and administer our NCQA- and Managed

Experience Matters

Angela Hobbs, RN-BSN
Medical Management Director



Angela has over 12 years of utilization management, case management, prior authorization and medical necessity review.

Behavioral Healthcare Organization (MBHO)-accredited UM programs with the goals of facilitating access to high-quality care, minimizing over- and under-utilization of services, and reducing administrative work for our providers (summarized in Figure 6.2-2). UniCare's service authorization and UM management policies and procedures follow SPA

Article III, Sections 5.4 and 5.6, and applicable State and federal regulations.

Developing and Revising Utilization Management Guidelines

Our UM promise promotes right care, at the right time, and the

right place. Guided by West

Virginia-specific and nationally

recognized medical policy and

industry standards, we have

developed a rules-based system for

determining medical necessity of

proposed care based on member-

specific considerations and clinical appropriateness. ***In consultation with local, network providers, we***

develop our UM guidelines following a hierarchy of established, evidence-based medical necessity

criteria for initial authorization and continuation of services. Our current UniCare UM guidelines are:

- West Virginia State and federal guidelines, standard bulletins, and coverage manuals
- UniCare Medical Policies and Clinical Practice Guidelines
- MCG Care Guidelines® (including levels of care for residential services, and supplemented with clinically sound, peer reviewed, and reputable clinical practice guidelines developed by organizations

Figure 6.2-2. The UniCare UM Approach Improves Outcomes



such as the Substance Abuse and Mental Health Services Administration [SAMHSA], American Heart Association, American College of Obstetricians and Gynecologists, and the American Academy of Pediatrics)

- AIM Specialty Health clinical appropriateness guidelines
- American Society of Addiction Medicine (ASAM[®]) criteria for substance use disorder (SUD) services, supplemented with CMS standards and guidelines as stated in the Special Terms and Conditions of the West Virginia approved 1115 SUD Waiver
- State and federal standards for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)
- IngenioRx criteria

UniCare also uses West Virginia policies and guidelines, including Community Psychiatric Supportive Treatment UM Guidelines for Chapter 503 Licensed Behavioral Health Center Services, to direct our utilization practices for crisis stabilization services.

We work collaboratively with MCG Health to customize our guidelines for our members by integrating MCG guidelines with UniCare's medical policies and other evidence-based criteria. Today, we have over 20 customized guidelines in areas such as general recovery care guidelines, behavioral health (BH) guidelines, and inpatient and surgical care. Each guideline undergoes external review by clinically active experts (board-certified specialist physicians who affirm no financial conflicts of interest) to confirm the relevancy and clinical appropriateness of each guideline in accordance with the selected evidence and real-world clinical practice. Our Medical Policy and Technology Assessment Committee (MPTAC) alongside our Medical Advisory Committee (MAC) reviews and approves all customizations to MCG Care Guidelines, and reviews new MCG editions. Our UM medical necessity criteria are reviewed annually and posted on our UniCare website and are available upon request by members or providers.

UniCare's West Virginia-based MAC and Quality Management

Local Providers Are Key to Our MAC

Dr. Jessica McColley, a member of our MAC, has been instrumental in coordinating Long-Acting Reversible Contraception services through an alliance between Kanawha County Health Department and Cabin Creek Health Systems.

Committee (QMC), described further in Section QU001-QU004, assure local accountability and consideration of regional practice variations in our UM guidelines. *The MAC, comprising local West Virginia licensed practitioners, is responsible for the annual review and adoption of the UM criteria, program description, work plans, evaluation, policies, and procedures.* In their advisory capacity, West Virginia providers such as Dr. Ahmed Faheem have shared critical perspectives about the challenges in meeting HEDIS® measures such as seven-day follow-up after BH inpatient hospitalization, metabolic screenings for those on antipsychotics, sharing information/coordinating care with medical counterparts, and monitoring of individuals taking medications for ADHD. The MAC meets with our Medical Directors and UM, care management, and quality management (QM) teams quarterly to review UM reporting and trends, proposed modifications to the UM criteria or services requiring prior authorization (PA), and provider complaints and recommendations. The MAC also annually reviews provider satisfaction survey results and may recommend modifications based on feedback on our UM process. Along with our Medical Directors, the MAC reports quarterly activity to the QMC, which will also review and annually approve the UM program description.

UniCare evaluates and modifies UM guidelines to comply with new State or federal policies. For example, we adjusted our criteria, and continue to assure compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and 42 CFR Part 438 Subpart K. Our Parity Governance Committee reports to the Medical Compliance and other clinical committees, providing oversight and guidance for sustaining compliance, as UniCare provides parity training to all clinical staff.

UniCare's ongoing analysis of the UM program allows us to update criteria and assure ease of access to care, promoting stability and continuity for our members. UniCare also adopts nationally recognized clinical



practice guidelines (CPGs, described in Section BA015) that support our PA requirements by keeping us and providers informed about scientific advances, supporting consistent delivery of care, and positively impacting health outcomes. Using guideline best practices, utilization, and health outcomes data, we modify our authorization processes and benefit limits if we determine it will advance member health outcomes. For example, beginning in 2016, we were the first and only West Virginia Medicaid plan to remove the benefit limit for tobacco cessation support from providers — a recognized best practice from the American Heart and Stroke Association— thereby allowing members to access unlimited coaching to quit smoking. ***UniCare’s policy change yielded an eight-fold increase in utilization of smoking cessation counseling between 2016 and 2019.*** Our CAHPS® scores affirm more members are receiving advice from their providers about how to quit smoking.

Application of the Utilization Management Guidelines

UniCare’s UM guidelines are objective and provide a rules-based system for authorizing proposed care; however, ***we make sure our application of criteria and guidelines are flexible enough for our UM Clinicians to consider special circumstances, such as psychosocial situations, treatment progression, physical and BH, social determinants of health (SDOH) and cultural needs, as well as the availability of services in the local delivery system.*** Our UM team looks beyond clinical factors and closely collaborates with network providers and other departments, including care management, QM, and pharmacy to meet members’ whole-person needs. Our criteria’s comprehensive range of level-of-care alternatives is sensitive to the differing needs of adults, adolescents, and children. The criteria and guidelines help us consistently match medical services to member needs across the continuum of care — prospectively, concurrently, and retrospectively.



The PA and continued stay review processes are key components of our overall application of UM guidelines and processes. ***Emergency services do not require PA.*** Most routine outpatient services, like

visits with a PCP, screening and evaluations for EPSDT, or well-child visits, do not require PA, so members have easy access to routine and evaluation-based services. To minimize administrative burden on providers, we focus our PA efforts on inpatient admissions, outpatient surgeries and procedures, out-of-network services, home care, durable medical equipment, rehabilitation services, select medications, and diagnostic procedures. We disseminate changes in authorization requirements by sending out provider notices at least 30 days in advance of the change, posting changes at the provider portal and member website, and updating member and provider handbooks.

We designed our workflow, policies, and processes for timely utilization decisions that consider the clinical urgency and necessity of any situation. To accommodate providers' preferences, we accept authorization requests from multiple sources: telephone, fax, and our provider portal. ***Our UM clinical staff are available to assist providers with urgent or emergent requests.*** Through the online portal, providers can receive immediate approvals by answering clinical questions for over 40 different case types. PA determinations are provided in a timely manner and in accordance with the SPA and House Bill 2351 regarding electronic PA request submissions. In 2019, our average physical health turnaround time for urgent care authorization requests was less than 24 hours, exceeding State requirements.

UM Clinicians review authorization requests, capturing all submitted clinical information. When the information provided in the request meets the appropriate medical necessity guidelines and is confirmed a West Virginia covered benefit, the UM Clinician enters the approval into the system and providers receive notice of determination. ***We minimize PA denials by proactively reaching out to providers if insufficient information has been provided to authorize service.*** For example, for electronic requests we communicate all deficiencies to providers within two business days from the day we receive the request (according to HB2351).

If a member does not meet criteria for a service, such as an in-lab sleep study, our UM Clinicians will reach out to the ordering provider and make them aware of other options – in this case, a home sleep study. Similarly, many surgical procedures can be performed safely in the outpatient setting, reducing the risk of hospital acquired infections and complications. Our UM Clinicians make every effort to offer

Health Insight

UniCare's integrated care management platform, Health Insight, provides a holistic view of the member's whole-person needs — supporting our staff with the tools and functionality to support the delivery of high-quality care and coordination of covered services. This allows for direct care of physical, behavioral, and social services and supports timely communication between all Care Management team members, as well as providers and the members.

alternative, appropriate, available and safe settings before a case is routed to a Medical Director for review. When all the information provided for services meets medical necessity, we complete and document the authorization in our Health Insight platform. If an alternative service or level of care is recommended, the UM Clinician works with the provider and care management team to arrange for the alternative service and secures PA, if applicable.

Should the UM Clinician be unable to obtain sufficient information to determine medical necessity, we route the request to our West Virginia licensed Medical Director, who makes the final determination. Only a licensed physician can issue a denial. Providers can request a peer-to-peer consultation to discuss the request and potential treatment or service alternatives. During the peer-to-peer process, our physicians or psychologists discuss service options with the treating provider, without dictating care to the provider or member. For example, we may discuss evidence-based guidelines indicating that a member with a certain condition may be adequately managed in observation rather than inpatient admission.

In the instance of adverse or partial adverse determination, we advise the provider verbally and the member and provider in writing. *Each denial is written individually and outlines the reasons that specific services requested did not meet criteria, factors considered, and additional information or actions available to the member or provider.* As part of our appeal procedures, we include information

regarding grievance and appeal processes that allow the member, their provider, or agent a reasonable opportunity to present evidence and allegations of fact or law orally (informal) and in writing (formal).

Monitoring Adherence to Utilization Management Guidelines

We conduct annual inter-rater reliability (IRR) evaluations in accordance with NCQA standards, showing 94% consistency in 2019. UniCare also performs monthly IRR evaluation and peer audits to assess consistency and accuracy in applying Bureau for Medical Services (BMS)-approved policies and medical necessity criteria. Each month, UniCare sends an IRR question to our UM Clinicians through a survey, and we assess and discuss response consistency at weekly staff meetings and provide training when indicated. A dashboard helps us monitor and evaluate the quality of reviews and identify performance issues that need to be further examined and addressed. We conduct ongoing training based on the results of IRR testing.

Our multi-faceted Performance Improvement and Enhancement (PIE) program continually evaluates our UM program using monthly clinical and non-clinical audits, including call reviews, outcomes reporting, and process validation for compliance with UM policies. Opportunities for improvement are identified and addressed by individual action plans. Since implementation of the PIE program, we have seen consistent staff adherence to process and UM criteria, as demonstrated by our 100% compliance with NCQA standards in our recent 2019 Accreditation Survey.

Strong UM 'PIE' Audits

In West Virginia, UniCare achieved an average score of greater than 99% on all UM Performance Improvement and Enhancement audits throughout all of 2019.

We also conduct daily integrated rounds with our interdisciplinary team comprising of UM, care management, and physician clinical and support staff. Together, we identify trends in service requests and opportunities to improve review processes and maintain consistency in application of UM criteria and determinations. Leveraging the experience and expertise of the entire staff, UM Clinicians bring complex cases to rounds for discussion of alternative levels of care, clinical clarification, resources, or discharge

challenges. We retrain UM Clinicians annually on the application of guidelines and provide training on new and updated criteria and guidelines as they are approved.

- BA005 1 The Vendor should provide its training curriculum for Utilization Management (UM) and clinical staff.

Utilization Management and Clinical Staff Training (BA005)

With nearly 17 years of experience serving diverse populations with complex needs in West Virginia, we have developed comprehensive initial and ongoing staff training through our UniCare Training Academy (Academy). Training incorporates national best practices and West Virginia-specific coverage and issues including BMS-required courses, resources, and information. Understanding that health care is local, we train UM and clinical staff to manage the health of members with an understanding of local care delivery, resources, and challenges. During orientation, UM and clinical staff spend 4 to 6 weeks of initial training, and then spend an average of six months working with a mentor and preceptor honing their skills. This training is a combination of virtual classroom and self-directed material. We assess UM Clinicians' knowledge and use of UM tools using competency-based evaluations. Clinical leadership collaborates with our trainers to assure we address any changes to our plan or any gaps in training.

Our UM and clinical staff trainings focus on reviewing, assessing, and addressing member needs from a whole-person perspective, including physical and BH, dental, pharmacy, and SDOH factors that may impact their access to care and services. ***We are the only MCO in West Virginia that trains member-facing clinical staff in Person Centered Thinking®***



skills, policies, and practices developed through an exclusive multi-year arrangement with Michael Smull, a national leader and co-developer of person-centered curricula. We are also working to identify a partner to introduce the trauma-informed Growing Great Kids curriculum to our EPSDT team. Growing

Great Kids offers a tailored, enriching experience for children who have been exposed to Adverse Childhood Experiences and are living in a highly stressed home environment.

West Virginia Focus. In addition to our core training, our staff are educated on State and local challenges as well as MHT processes and procedures, timelines, requirements, and benefits. We have supplemented our trainings with comprehensive reviews to our entire clinical team on new services as they have been implemented, including BH services in 2015, expansion membership and SUD, and 1115 waiver programs. We will provide similar comprehensive trainings on West Virginia's WVCHIP benefits, requirements, and policies as part of readiness and implementation. We also leverage our UniCare clinicians or community experts to offer monthly trainings on topics especially relevant to West Virginia (Figure 6.2-3). For example, in 2018, we partnered with Dr. Lauri Andress and Dr. Tiffany Sparks from West Virginia University to provide clinical trainings and continuing education hours on Structural Competency and High-Risk Populations, Behavioral and Mental Health Care in Appalachia, and SDOH; we also utilize BMS online trainings (bolded in Figure 6.2-4). In addition, we have trainings supported by Anthem that are available to all clinical staff to promote best clinical practices for trending behavioral and physical health issues. We have leveraged these additional trainings to support staff development and expand condition-specific skills.

Figure 6.2-3. West Virginia Trainings by UniCare Medical Leaders and Community Partners

West Virginia Monthly In-Service Trainings by UniCare Medical Leaders and Community Partners		
This list is not inclusive, but a sample of the types of additional trainings/sessions.		
▪ BH Geriatric Depression and Dementia	▪ BH Adverse Childhood Experiences	▪ Hospice
▪ Women and Substance Use Disorder	▪ Opioid Issues Specific to West Virginia	▪ Immunizations
▪ Hepatitis C	▪ Issues Facing Today's Teens	▪ Diabetes
	▪ Readmission Management	▪ Eating Disorders
		▪ Domestic Minor Sex Trafficking
		▪ Chronic Pain and Nutrition

Comprehensive Training. We provide comprehensive trainings for all clinical staff upon hire, as well as competency-based orientation curricula tailored to care management, UM, and Medical Directors,

respectively. All staff receive refresher trainings annually and have access to courses when needed on demand, including when a manager observes that someone needs additional training. We train clinical staff on clinical policies and procedures, use of our Health Insight platform and other systems, NCQA standards, documentation requirements, clinical best practices, decision-making tools, provider interactions, and cultural competency and diversity. Our UM and clinical staff training curricula are identified in Figure 6.2-4.

Figure 6.2-4. Utilization Management and Clinical Staff Training Curriculum

Utilization Management and Clinical Staff Training Curriculum		
Clinical Trainings — All staff — CM, MD, UM		
West Virginia Medicaid Covered Services and Benefits	Children and Youth and Enteral Care Needs	MCG Care Guidelines® and Review
West Virginia Medicaid Requirements and Procedures	Clinical Systems and Note Documentation	Medicaid Marketing Integrity Program
BMS Online Trainings — Guide to Medicaid	CM Roles and Responsibilities Overview	Navigating Protected Health Information and HIPAA
BMS Online Trainings — Aged and Disabled Waiver (ADW) Program Resources	Cultural Competency	NCQA Requirements — Timelines of Decisions
BMS Online Trainings — Personal Care Services	EPSDT Services and Requirements	Out-of-network providers
BMS Online Trainings — Home Remodeling Resources for People with Disabilities	Ethics and Compliance	Pharmacy Coordination of Care
BMS Online Trainings — BH and Long-term Services	Fraud, Waste, and Abuse: Detection and Reporting	PIE Audit Processes
West Virginia Community-based Programs/SDOH concerns	Harassment-free Workplace: Crafting a Culture of Respect for Employees	Quality Management and Compliance Measures
West Virginia Regional Nuances and Cultural Dialects	Hypertension HIV Renal Self-study Module	The Neuroscience of Bias: From Acceptance to Mitigation
West Virginia Substance Use Disorder (SUD) Waiver: An ASAM Criteria-based Approach	Identify Members for Referral to Case Management	The Opioid Overdose Crisis: Tips, Tools, and Resources to Help You or a Loved One
Appeals and Grievances	Legal Requirements and Ethical Issues	UM Roles and Responsibilities Overview
Building Resiliency After Trauma	Managed Care, Medicaid, and Medicare Overview	
Supported by MCG training in topics such as: Recovery Facility Care, Level of Care Transitions, Inpatient and Surgical Care, and Discharge Planning		
Case Management Medicaid Clinical New Hire Training	Utilization Management Clinician New Hire Training	Medical Director New Hire Training
Care Coordination	Prior Authorization Processes	Accessing Census Reports
Children and Youth with Enteral Therapy Needs	Initial, Concurrent, Retro Review Processes	Administrative Denials Outpatient Authorizations
Care Management — Time Management	Inpatient Daily Census reports	Flesch-Kincaid Denial Rationales
Complex Care Management Workflow	Integration: Treating the Whole Person	Medicaid Clinical Hierarchy
EPSDT — Growing Great Kids	Medicaid Clinical Hierarchy	Medical Director Review: Peer-to-peer and Reconsiderations
Integrated Care Management	Medical Policies and UM Clinical Guidelines	Medical Policies and UM Clinical Guidelines
Introduction to Complex Care Management	Outpatient Authorization Reporting	Over- and Under-utilization Management Overview
Motivational Interviewing	Rounds and Case Staffing	
Person-centered Thinking	Routing Cases for Medical Director Review	
Pharmacy for Care Management	UM Time Management	
Post Discharge Management		
Treatment Planning and Goal Setting		

All clinical staff are cross trained, meaning they regularly participate in a “day in the life” and shadowing experiences with other clinical departments so they are able to understand the cross functional nature of our processes and operations. We have invited subject matter experts to train staff. For example, a representative from Tandem Diabetes presented an overview of continuous glucose monitoring and insulin pump therapy, and a wound care specialist from our parent company presented best practices for managing wounds in the home care setting. Members of our UM staff are active in interdepartmental committees, including QMC and trend management workgroups, to maintain deeper knowledge of health plan operations and functions. As part of our career progression pathway, UM Clinicians are encouraged to obtain certification from the American Association of Managed Care Nurses.

In West Virginia, we perform ongoing quality audits, with additional training for either individuals or entire teams when gaps are identified. Medical Directors and UM leadership provide “Articles of Interest” for areas that impact the plan. In addition to online resources, UM staff have access to local and national Medical Directors and trainers to respond to their questions. Care management-specific trainings are addressed in Figure 6.2-4 and in CM023.

- | | | |
|-------|---|---|
| BA006 | 1 | The Vendor should describe its Utilization Management (UM) monitoring guidelines that operate in conjunction with fraud and abuse detection activities, including, but not limited to, the following: |
| BA007 | 2 | Ongoing monitoring of Emergency Room (ER) utilization |
| BA008 | 2 | Ongoing monitoring of potential abuse or inappropriate utilization of controlled prescription medications |
| BA009 | 2 | Reports and other tools that will be used to monitor and manage service utilization |

Utilization Management Guidelines and Fraud, Waste, and Abuse

(BA006, BA007, BA008, BA009)

UniCare’s UM approach is designed not only to assure compliance with best practices and clinical guidelines, but also to serve as an integral component of our prevention, detection, and response to fraud,

waste, and abuse (FWA) among providers and members. Our plan-wide UM approach to FWA includes UM Clinicians, Medical Directors, QM, our Compliance Officer, UniCare's Contract Liaison/MHT Administrator, Network Development, and the Special Investigations Unit (SIU), detailed in Section PI002. Our analytical tools and monitoring include predictive modeling, overutilization reporting, member trending, provider alignment with utilization trends, quality oversight, and data analysis of ER use and rapid hospital readmissions.

UM staff are trained upon initial hire and annually to identify occurrences or trends related to the potential misuses or fraudulent use of services as they come to their attention. We are committed to simplifying health care and serving as good stewards of State and federal Medicaid dollars, and comply with SPA Article III, Section 8 (8.1, 8.2, and 8.3) FWA requirements. We continually evaluate which services should require review and focus UM efforts on services that have a high potential for overutilization or FWA. For example:

- **Urine drug screens.** As part of our UM oversight and reporting, we evaluated use of presumptive versus definitive drug screens. As a result, we have implemented appropriate UM processes, such as PA for definitive screens, to decrease the likelihood of excessive testing.
- **Breathalyzer testing.** Our analyses identified some providers were billing for breathalyzer testing at every visit. After raising this issue, other MCOs reported they were experiencing similar trends. We approached the State and the code is no longer covered in West Virginia.

Our broad UM program reviews both primary care utilization and provider billing in the context of local, regional, and national benchmarks to identify providers or members with atypical utilization patterns. When utilization patterns suggest the need to reach out to members (for example, going to multiple providers for the same service, or using the emergency room (ER) for non-emergency issues), our interdisciplinary team collaborates to determine an appropriate strategy. We leverage our care

management, provider solutions, Population Health, and Community Engagement staff where appropriate to perform outreach efforts to intervene and remedy the situation. When indicated, we may seek additional quality of care guidance and identification of potential FWA. If fraud or abuse is suspected, it is referred to UniCare's SIU for further review and determination. SIU referral processes support confidential reporting via a toll-free hotline, secure email, and website. FWA action steps for members and providers are described in greater detail in our responses to PI001–PI009.

Monitoring and Addressing Emergency Room Utilization (BA007)

Potentially preventable emergency room (ER) utilization for conditions that could be managed in physician offices, clinics, or urgent care centers is a major source of overuse or waste. Our UM strategies, robust Health Insight platform reporting capabilities, and data-informed enhanced care management model are designed to detect and reduce potentially preventable ER visits, admissions, and readmissions.

Using Information to Prevent, Identify, and Intervene on ER Usage. Our processes for monitoring and addressing ER overutilization begins with sophisticated tools. *Our proprietary predictive modeling includes several tools that quantify the likelihood of future ER utilization and identify members at risk for*

PreManage Data-sharing Solution

Implemented by hospitals and MCOs across West Virginia, PreManage provides near real-time notification of ER visits, which helps UniCare identify frequent usage and aberrant patterns and promote communication across facilities and outreach.

high ER utilization, enabling our team to identify and stratify members for timely interventions. Access to Health Insight, our care management platform, provides clinical staff a comprehensive view of member utilization, interactions, authorizations, claims, clinical history, assessments, and care plans as well as the ER risk scores generated through

predictive modeling. PreManage, a data sharing solution implemented by hospitals and MCOs across West Virginia, provides near real-time notification of ER visits, which assists care delivery partners in identifying frequent usage and aberrant patterns, and promotes communication across facilities and outreach. *In West*

Virginia, we have developed over 13 different cohort reporting alerts within PreManage that have allowed us to intervene when a member has been to the ER and engage the member in appropriate follow-up to avoid a future crisis. Figure 6.2-5 summarizes our broad array of tools and resources that prevent, identify, and intervene to reduce ER utilization, while our Care Management team engages members with education and supportive relationships.

UniCare Customizes PreManage Cohort Alerts

UniCare's PreManage cohort reporting alerts include:

- 4 ER Visits in 12 Months, ER Admission 40 days Post Inpatient Admission
- Health Home ER/Inpatient Encounters
- Pediatric Asthma ER Encounters

Addressing ER Utilization Through Clinical Leadership. Our interdisciplinary clinical leadership team meets monthly in the Clinical Operations Workgroup, which includes care management staff across our overall organization, to review key medical trends (including ER trends), and to identify potential hot spots for program development or quality of care improvement opportunities. We have leveraged this workgroup to enhance alternatives to the ER, including expanded primary care access, programs targeting super-utilizers, and programs addressing comorbid mental health and SUD issues. *Our local Clinical Operations Workgroup developed ER Diversion best practices* with focused education across our clinical organization to make sure that members receive emergency care when they need it, while assuring care is received in the appropriate setting. Best practices include:

- Providing initial and ongoing education on how to appropriately access care in a crisis
- Assisting with coordination of services and social supports to address issues that led to ER use
- Following up on ER visits to make sure crisis plans and follow-up appointments are in place
- Focusing specifically on making sure that members with high ER utilization patterns have medical homes and PCPs and are considered for care management

Figure 6.2-5. Addressing Inappropriate ER Utilization Through Analytics and Member Engagement

Tools and Strategies to Monitor and Address ER Utilization		
✓ PREVENTION	✓ IDENTIFICATION	✓ INTERVENTION
Proactive member education, identification of potential utilization, and specialty programs • Member education upon enrollment regarding Healthy Rewards incentive program, services, supports, and resources available • Proactive member incentives regarding proper use of the ER and using alternative services available as appropriate • Low-intensity ER predictive modeling predicts the likelihood of a member having an ER visit in the next three months for low-intensity conditions such as colds, the flu, skin conditions, medication refills, and minor injuries • Chronic condition management for chronic conditions such as asthma, diabetes, HIV/AIDS, coronary artery disease, chronic obstructive pulmonary disease, and substance use disorder (SUD) • Provider-focused Initiatives Value-Based Payment (VBP) programs offer providers participation in shared savings for reduced non-emergent and preventable emergent ER visits	Processes and tools to identify potential and actual ER utilization • Predictive modeling synthesizes member and claims data to identify and stratify member risk such as the likelihood of ER use • CI³ calculates a risk score for each member • LIER predicts the likelihood of an ER visit in the next three months for low-intensity conditions • ER Triage predicts the likelihood of ER visits for ambulatory care sensitive conditions • Integrated, person-centered screening, assessment, and care coordination processes support the identification of Children with high-risk/high-needs and Special Health Care Needs (CSHCN) • 834 enrollment file review and claims analysis to identify CSHCN, preventable events, and high utilization • Utilization trend management	Outreach and interventions for members with preventable events, complex needs, and high utilization • Integrated care coordination for CSHCN, pregnant women with SUD, members with Intellectual/Developmentally Disabled diagnosis, or other priority populations • Post-discharge follow-up by community based care management team upon notification of an ER visit or a hospitalization to support post-stabilization planning such as locating local food banks and housing • Specialized pharmacy management addresses the impact improper medication prescribing or adherence can have on use of the ER • Onsite care management at key facilities for discharge planning and interventions • CAMC – Charleston Area Medical Center – Memorial • CAMC – Charleston Area Medical Center – General • WVU Ruby (West Virginia University) • Beckley Appalachian Regional Hospital BARH • Chestnut Ridge Hospital (part of WVU) • The Behavioral Health Pavilion of the Virginias • Fairmont Regional Hospital • Mildred Mitchell Bateman Hospital (IMD) • Highland Hospital Crisis Stabilization Unit (CSU)

In addition, our local MAC and QMC and HEDIS workgroups help to monitor and evaluate the effectiveness of our ER strategies on an ongoing basis by reviewing ER visits and other key utilization and quality metrics.

Preventing Avoidable ER Utilization Through Clinical Interventions. As members at risk for high use of the ER are identified, UniCare deploys care management staff to use targeted evidence-based interventions and educational materials to reduce avoidable ER visits. Often we find members who are using the ER most frequently have unmanaged conditions, lack of access to primary care, and unmet SDOH needs. Our interventions include referrals to intensive care management, care coordination delivered through our community-based care management staff, identification and support of SDOH barriers, education about the appropriate use of primary care and connecting the member to a PCP, and ER alternatives including our 24/7 Nurse and BH Crisis Lines. In addition, to our care management interventions like HOPE (high-outreach to promote engagement) program, our on-site Care Managers at key facilities assist in discharge planning and follow-up post-discharge, helping to avoid the need for ER visits.

Steady Declines in ER Utilization

As a result of UniCare's comprehensive ER prevention strategies, ER utilization declined 4.7% in 2018 and 4.8% in 2019.

Monitoring Controlled Substances (BA008)

Pharmaceutical misuse and abuse are significant challenges in West Virginia and across the U.S. UniCare's broad UM approach includes numerous strategies to monitor prescribing patterns and identify and address potential abuse and inappropriate use of controlled prescription medications. UniCare will also continue to work with the State on the pharmacy restriction/lock-in programs, and will remain an active participant with the Substance Abuse Prevention Sub-Committee.

Health Insight Platform. We incorporate the member and pharmacy details from monthly BMS pharmacy reporting into our Health Insight platform. This allows for UM reviewers and the Care Management team to discuss medications as part of their interactions with providers and members. Health Insight also allows us to review medications prescribed during episodes of treatment and discuss any issues or concerns with our Medical Directors. Care Managers educate members on appropriate pharmacy utilization, risks identified in their pattern of medication use, and the importance of regular medication

renewal for chronic care management, maximizing member safety and compliance and discouraging inappropriate use of medications. Today, our QM team reviews the pharmacy reporting and identifies utilization patterns for members and prescribers regarding Suboxone and ADHD medication. If we identify aberrant patterns of prescribing or use, the team will reach out to the prescribing provider and review records. Our QM team works collaboratively with the provider to educate on best practices and treatment.

PreManage Alerts and Clinical Incident Reporting. Leveraging both real-time PreManage alerts and our proprietary clinical incident reporting, we are able to provide focused outreach to members who have presented to the ER with an overdose diagnosis. This enables us to communicate with the ER on a member's treatment needs, collaborate on treatment recommendations, and connect members with a provider for treatment. In 2019, we developed tools to load pharmacy information into member risk profile reports from our clinical data and analytics system to identify members at risk for alcohol and opioid dependence and monitor provider prescribing practice. We will be deploying care management interventions and outreach for potential abuse or inappropriate utilization of controlled prescription medications in 2020.

Controlled Substance Utilization Monitoring (CSUM) Drug Utilization Review. We will begin implementing our Pharmacy Benefit Partner's (IngenioRx's) CSUM program on July 1, 2020. CSUM is a retrospective drug utilization review that notifies prescribers of members who have filled 10 or more prescriptions for controlled substances (excluding diagnoses of cancer, palliative/hospice care, sickle cell, burns, or multiple sclerosis) in a three-month period based on pharmacy data received by the State. By law, initial opioid prescriptions are limited to seven days. CSUM is designed to decrease controlled substance over-utilization by identifying members receiving multiple controlled substance medications, including opioids, from multiple providers filled at multiple pharmacies, or combinations of controlled

substances that may indicate risk. IngenioRx's CSUM program reduces FWA by identifying and addressing drug-seeking behavior and doctor or pharmacy shopping.

Opioid Management. We will also begin implementing IngenioRx's Opioid Management program at the start of the contract, which reduces opportunities for misuse of opioid treatment by helping members gain access to more clinically appropriate treatment. Leveraging pharmacy data received by the State, IngenioRx will assess a member's risk of opioid misuse and a pharmacist will telephone prescribing physicians with members identified as "at risk" or "high risk" to discuss concerns and develop an action plan to reduce potential opioid abuse or misuse. An Opioid Prescribing Summary report will detail providers' opioid prescribing patterns against evidence-based quality standards and peer comparisons.

Reports and Tools to Monitor Utilization and FWA (BA009)

Our utilization reports and trend monitoring not only helps assure members get the care they need where they need it, but also helps us identify inconsistencies in care delivery that may identify quality concerns and FWA. In addition to the tools for monitoring utilization described in BA006 and BA007, UniCare leverages our Quality Assessment and Performance Improvement (QAPI) program (detailed in Section QU001) including tracking of HEDIS measures to identify over- and under-utilization and potential FWA. Continual data mining and review and analysis of our claims and encounter data generate reports that identify outliers and member subgroups at risk for high utilization of services, and opportunities for intervention. QM and Provider Relations information is integrated into trend management reports as part of our Value-Based Payment programs (Section PS007) and quality improvement activities. High-risk populations for which we have developed specific UM and FWA reporting include:

- Infants less than four weeks old with high-risk perinatal conditions
- Children under six years old with BH concerns, like ADHD
- Members with SUD

- | | |
|---|---|
| <ul style="list-style-type: none"> ■ High-frequency ER users or with a history of rapid readmission ■ Pregnant women with prior preterm delivery ■ Members with chronic pain | <ul style="list-style-type: none"> ■ Members of any age with specialized health care needs ■ Members with high predictive modeling scores |
|---|---|

By analyzing overall utilization trending we are able to determine whether high service use is related to true needs, gaps in supports, or FWA. For example, a clinical utilization report identifies members with high utilization to assure they are engaged with care management and they are receiving the right care in the right place at the right time. Our Critical Incident Reporting and Opioid prescription monitoring also reflect our monitoring of monthly claims to identify patterns or incidents to address.

UniCare will continue to notify BMS of all suspected Medicaid FWA. We submit monthly reports related to FWA to BMS, in accordance with SPA, Article III, Section 8.1.4, documenting Program Integrity Activities, with related outcomes, referrals to BMS and the Medicaid Fraud Control Unit (MFCU), overpayments identified and recovered; and Suspension and Adverse Enrollment Action report, with in-network suspensions, termination for cause, and provider credentialing.

In addition to our reporting, our daily rounds are a key tool for identifying and managing potential utilization risks. We assemble our UM and care management teams to meet with our Medical Directors and our West Virginia licensed addictionologist, Dr. Jorge Cortina, to discuss members who are not progressing optimally, such as those with long lengths of stay or complex discharge plans. In integrated rounds, we can identify barriers that may interfere in discharge planning, opportunities for intervention, and strategies for positive wellness outcomes.

- BA010 1** The Vendor should describe its process for preventing and detecting fraud and abuse related to all administered services including Pharmacy, if applicable.

Managing Fraud, Waste, and Abuse in Benefit Administration (BA010)

Our responses to BA006-BA009 describe UniCare's large array of UM-related processes and tools for preventing and detecting FWA related to administered services. We leverage our broad UM approach and technologies to identify concerning trends and combat FWA, improve placement stability, and reduce avoidable hospital stays, length of admissions, and readmissions. Upon hire and annually, all employees receive training on how FWA is defined, strategies to be diligent in monitoring FWA, and actions to take if FWA is identified or suspected.

Experience Matters

Richard Chapman
Compliance Officer



Richard has 20 years of experience overseeing West Virginia health care Compliance and Program Integrity.

We take a multi-pronged approach to manage FWA of all Medicaid services including concurrent and retrospective claims reviews, ongoing targeted interventions, and investigations. When we observe utilization patterns that suggest the need to outreach to members, our interdisciplinary team collaborates to determine an appropriate strategy. We leverage our care management, provider engagement, quality, and health education teams, where appropriate, to perform outreach efforts to intervene and remedy the situation. When indicated, we may consult with our quality department for guidance and identification of potential quality of care concern or FWA, leveraging our SIU. The SIU team of investigators performs daily monitoring of claims for potential fraudulent or abusive behavior, maintaining close relationships with law enforcement agents to quickly identify potentially illegal conduct (detailed in Program Integrity, PI001–PI013).

Experience Matters

Rick Levock
Program Integrity Lead



Rick has over 20 years of West Virginia Medicaid Program Integrity experience.

Pharmacy-related FWA. As discussed in BA008, pharmacy-related misuse and abuse is a West Virginia and national concern. We will begin implementing our Pharmacy Benefit Partner's CSUM and Opioid management programs on July 1, 2020 including the Opioid Prescriber Report (BA008 and CM015) to help detect provider FWA. If pharmacy were carved in, we would work with IngenioRx and BMS to address pharmacy-related FWA. For example, IngenioRx can conduct pharmacy audits, POS edits, and pharmacy lock-in, and could partner with the SIU on identified cases. We would also welcome collaboration with BMS on pharmacy-focused SIU initiatives such as:

- Reviewing internal SUD reporting to identify members utilizing a high number of prescribers and pharmacies to obtain controlled substances
- Evaluating both pharmacy and medical data during review, looking for excessive diagnosis of pain, injury, and ER visits
- Targeting cases of potential “doctor shopping” or drug diversion and refer them to BMS, MFCU, and/or law enforcement
- Reviewing internal SUD reports to identify prescribers who appear to have a large population of member narcotic users
- Referring prescribers to the BMS, MFCU, and/or law enforcement by SIU when further investigation is warranted

- BA011 1 The Vendor should describe its process for modifying its standard Utilization Management (UM) protocols when reviewing referral and treatment requests for members with special health care needs including, but not limited to, the following:
- BA012 2 Standing referrals
- BA013 2 Expedited utilization review processes

Utilization Management Referral and Treatment Requests: Modifications for Members with Special Health Care Needs (BA011)

For members who have been identified as having special health care needs (SHCN) either through assessment or enrollment details, we build upon and refine established UM and care management policies, procedures, and strategies to help us deliver and coordinate the full range of services required. When reviewing referral and treatment requests for medical necessity for all members, but especially for those with SHCN, we consider the member's current clinical needs, psychosocial influences, and the characteristics of the local delivery system. We understand that there cannot be a one-size-fits-all approach; our UM process is designed to be flexible and agile, and to consider the specific circumstances facing each member with SHCN on a case-by-case basis. We make sure members with SHCN, including those with disabilities (or at risk of developing a disabling condition) or a chronic or complex medical or BH condition, are identified, screened, and referred to specialty providers for assessment and appropriate treatment.

UM processes are adapted to assure coordination as all members, including those with SHCN, transition between levels of care. Our UM and care management teams coordinate with a member's providers on discharge planning to prevent disruption of services, or if there is a need for additional services requiring referrals or extended authorizations.

We have policies and processes in place to continually monitor our membership and refer children for inclusion in the Children with Special Health Care Needs (CSHCN) program, when appropriate. For CSHCN who require medical foods, we have developed a single point-of-contact from our UM team, care

management team, and CSHCN liaison to assure continuity and avoid disruption in service for medical foods. We use systematic processes to assess needs and monitor care plans of members enrolled in supplemental security income (SSI) or CSHCN plans, and we use UM and care management to provide direct access to experienced specialists within our network.

For all members, but especially for those with complex or comorbid conditions and multiple admissions, we consider the member's home situation and authorize more days based upon clinical need to assure safety and support for the member. When we receive requests for BH inpatient services, we consider suicidal risk or danger to others, presence of acute psychotic symptoms, level of functional impairment, self-injury, or uncontrolled risk-taking behaviors, and we leverage our integrated care management and UM

programs. For example, if a member who is a child goes to the ER experiencing a BH crisis, the UM Manager contacts care management to confer on the case as soon as UM is notified. If the facility uses PreManage, we have developed alerts that notify us of the ER visit. A Care Manager is assigned to the child according to the presenting issue, contacts the hospital representative to identify the best placement option, and contacts the caregiver to assist in transitioning the child to the best care setting. We discuss condition-specific protocols, standards, and care management for members with SHCN in BA014, BA015, and CM013.

Real Stories



Kevin is a fifteen-year-old member with profound deafness. He wears a cochlear implant that allows him to hear. Before joining UniCare, Kevin's implant charger broke. UniCare authorized disposable batteries to allow him to continue using his device. Recently, the battery supplier alerted Kevin's caregiver that they would no longer carry the batteries. Kevin's existing battery supply was extremely low, and in two days, he would be on his way back to the West Virginia School for the Deaf and Blind, where he resides during the week. If he did not have the batteries or a charger for his device, he would not be able to hear at school. Getting him back to school with an operational device was vital. His Care Manager, Brianne, facilitated a prior authorization with Cochlear Americas in order to get him a new charger for his implant. She worked with them to coordinate a speedy delivery in time for him to return to school. Kevin and his caregiver were exceedingly grateful for Brianne's timely intervention and for UniCare's dedicated service.

UM Approach to Standing Referrals for Members with SHCN (BA012)

UniCare has established policies and procedures to grant a standing referral to a specialist for members with SHCN, including conditions involving BH services for members with a history of trauma, Adverse Childhood Experiences (ACEs), or complex medical conditions requiring specialized care over a prolonged period for a life-threatening, degenerative, or disabling conditions. ***Our current standing referral processes are flexible and do not limit duration or a maximum number of visits allowed, already accommodating members with SHCN; therefore, modification is not necessary.***

Our policy grants members direct access through a standing referral made by the member's PCP to all in-network specialists without requiring PA. In this capacity, the specialists may treat as well as authorize referrals, procedures, tests, and other medical services for the member. Members may continue to see in-network specialists without a pre-service authorization, as long as the specialist deems the visits medically necessary to facilitate ongoing treatment or regular care monitoring.

In special circumstances, and when deemed to be in the best medical interest of the member, we will approve referral requests for out-of-network (OON) providers. The PCP must request a pre-service authorization from UniCare, and the request is reviewed by UM and authorized based on medical necessity. Further detail about our process to facilitate continuing relationships with non-network providers is provided in our response to Sections BA020-BA024.

Approach to Expedited Utilization Review for Members with SHCN (BA013)

UniCare has established protocols to assure expedited authorization for services when the provider indicates the standard timeframe could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function. In order to facilitate discharge

Exceeding Standards for Expedited Authorizations

In 2019, our average physical health turn around time for urgent care authorization requests was less than 24 hours.

planning, we treat all requests when a member is currently hospitalized as expedited requests and comply with HB 2351. In addition, to facilitate transition home after an inpatient hospital stay, UM allows a home



health visit for evaluation of post-discharge needs. We make the expedited authorization decision and provide notice to the provider (and to the member if a denial) as expeditiously as their health condition requires, but no later than two business days or

three calendar days of the receipt of request (whichever is the least from request receipt date). This timeframe may be extended up to 48 hours for expedited pre-service authorizations and up to 72 hours for expedited concurrent reviews upon request of the member or if we justify to Department of Health and Human Resources (DHHR) in advance and in writing a need for additional information and that the member will benefit from the extension.

- BA014 1 The Vendor should describe its process for any condition-specific protocols or standards that will be used to manage members with special health care needs, defined as individuals with complex or serious medical conditions.

Condition-specific Guidelines for Complex, Serious, and Special Health Care Needs (BA014)

Serving Members with SHCN

In West Virginia, UniCare serves the following populations with SHCN:

- Over 16,000 members who are aged, blind, and disabled
- Over 21,000 members with co-occurring physical and BH conditions
- Over 14,000 members with a BH or SUD condition
- 6,885 members with SUD
- 1,964 members with SED
- 8,632 members with SMI

UniCare promotes the use of a comprehensive portfolio of evidence-based preventive health and CPGs that span more than 43 conditions and diseases meeting the diverse needs of the members we serve. CPGs are not a substitute for the professional judgment of health professionals, and we do not use them for medical necessity reviews. We base our UniCare condition-specific, complex care, and disease

management program standards and protocols on current evidence-based guidelines referred to as CPGs.

UniCare adopts these guidelines from evidence-based recognized sources and uses board-certified physicians in the review and adoption process.

Using Condition-specific, Evidence-based Protocols and Clinical Guidelines

UniCare adopts our condition-specific standards and protocols as nationally recognized CPGs from organizations such as the American Academy of Family Physicians, the American Academy of Pediatrics (AAP), American Academy of Child and Adolescent Psychiatry, SAMHSA, and the United States Preventive Services Task Force. CPGs are resources to assist providers and members in the management of chronic medical conditions for adult health, pediatric and adolescent health, infectious disease, substance use, and women's health conditions and disease-specific protocols. These guidelines keep us and providers informed about scientific advances, support consistent delivery of care, and positively impact health outcomes. Our CPGs comprise the strongest evidentiary practice passing through grade two and grade three evaluations to bring strong clinical practice recommendations to our providers. Leveraging these guidelines, we built condition-specific programming for our care management outreach, complex care management, and disease management designed to bring evidence-based practices to guide our programs and processes for members. CPGs support our PA requirements and serve as a resource to help providers identify where to send patients who are positively screened and need additional clinical intervention. These guidelines help providers identify supports and services offered in the community and benefit the members they serve.

Figure 6.2-6. Disease Management Clinical Conditions

Evidence-based Clinical Guideline Conditions
Our current comprehensive portfolio of evidence-based clinical guidelines spans more than 43 conditions and diseases including:
▪ Autism ▪ Hypertension in adults, children, and adolescents ▪ Celiac disease ▪ Obesity ▪ ADHD ▪ Depression ▪ Substance use disorder ▪ Coronary artery disease (CAD) ▪ Chronic kidney disease (CKD) ▪ Diabetes ▪ Smoking cessation during pregnancy

We develop staff training materials and program content — whether directed toward members or practitioners — in accordance with adopted guidelines, professional clinical and technical literature,

government research sources, and recommendations of professional societies and relevant foundations. Providers may receive additional information about patients enrolled in disease management programs and performance, including those listed in Figure 6.2-6, relative to established benchmarks, guidelines, or disease-specific standards of care from their Care Manager and are available on the provider portal and our UniCare website.

We are proud to have 11 disease management programs, including nine with NCQA Patient and Practitioner Oriented accreditation, for conditions like diabetes, asthma, and child and adolescent depression to help members and their caregivers. *Our disease management programs are accredited through 2021 and we are working with NCQA to transition to the Population Health Program (PHP) accreditation, scheduled for review in 2020*, making us one of the first organizations to commit to seeking PHP accreditation and one of the first to go through the review process. UniCare developed protocols, standards, and materials as part of these accredited programs and are informed by NCQA's model that includes keeping members healthy, managing members with emerging risk, maintaining member safety including outcomes across settings, and managing members' multiple chronic illnesses

As we described in our response to BA004, our evidence-based and informed criteria and guidelines undergo a rigorous review process to assure appropriateness in administering West Virginia MHT biopsychosocial, covered benefits that are available to members. We allow for flexible protocols and application to support the utilization and care management of members with complex and serious medical conditions, and SHCN.

Our Standards to Support Members with Special Health Care Needs

Our multi-faceted standards to support members with SHCN focus on the unique needs of the individual from preventive to complex care, as is evidenced by our investment in population programming and capacity building to support the communities in which members live. For example, for members who are



CSHCNs, we have a dedicated Care Manager supporting this population to coordinate care needs including accessing necessary resources. Our UM team works directly with this Care Manager to assure coordination of care and to incorporate any unique circumstances from the member's treatment plan into the service authorization. We identify individuals with

complex or serious medical conditions for our disease management programs, or other condition-specific community-based program, using the following:

- Provider, member, and caregiver referrals
- Data mining
- UM activities
- Monthly sweeps of claims data to identify members with SHCN based on diagnosis codes

In CM001, we describe our processes for identifying and stratifying members into levels of care management who have complex or biopsychosocial needs, one or more chronic conditions, or who have other SHCN. Our UM and care management teams identify care opportunities based on the unique characteristics of these members including child, adolescent, and young adult. Our focus is to improve the health and quality of life for members by providing optimal care management services and supports to reduce treatment variation, enhance access to care, and improve health outcomes. Our care management team has experience in a wide variety of specialties and we match SHCN members with a Care Manager who has specialized skills to meet the individualized needs of the member such as pediatric nursing, BH

clinical licensure, or a specialization in SUD. *Care Managers provide condition-specific education, offering individualized instruction, informative materials, and tools to help members and their caregivers learn about condition management.*

By applying person-centered thinking and trauma-informed care principles, we support each member to establish personal goals and desired outcomes, not based on a prescribed set of metrics or programs, but by tailoring supports and services to best meet the members' direct needs. As part of all levels of care management, the Care Manager contacts the member on an ongoing basis depending on their identified risk and invites members to call with any questions. If at any time the Care Managers determines the member needs additional and more intensive support, they may refer the member, with the member's agreement, for community-based care management with our Community Paramedics (CPs), Community Health Workers (CHWs) and Peer Support Specialists. Throughout our care management engagement, Care Managers monitor members' chronic conditions, coaching them on managing symptoms and what to do in the event of exacerbation of conditions, promoting use of lower levels of care as appropriate. Care Managers schedule follow-up calls on an individual basis based on the nurse's clinical judgment, identified member needs, and the severity of the member's condition according to the stratification level guidelines. In Table 6.2-2 we describe a few examples of our programs to support members with SHCN.

Table 6.2-2. Managing Members with Special Health Care Needs Through Our UniCare Programs

Program	Description
Kanawha County Emergency Ambulance Authority (KCEAA)	Launched in 2018, this paramedicine outreach visitation initiative supports our community-based care management model through engagement of hard-to-reach, high-cost Medicaid members. Using our analytics, we identify members who may benefit from care management, but have been non-responsive to outreach. CPs complete feet-on-the-street outreach, conducting an assessments and connecting members to available community resources, health education, and immediate care needs. They may also conduct safety checks of the member's home. <i>Since implementation, 40% of members we contacted agreed to complete the assessment, and 74% of those members completed the care management program.</i>
Camp Catch Your Breath & Camp Kno Koma	Our UniCare sponsorships provide kids diagnosed with asthma or diabetes the chance to attend a camp specifically designed to help them manage these conditions. In combination with physical activities, children learn how to better

Program	Description
	manage their conditions by sharing their experiences and feelings in a safe and healthy environment.
Shine Light on Depression	Shine Light on Depression is a new school-based initiative that is collaboration of organizations committed to raising awareness of depression and suicide prevention among young people including American School Health Association, Anthem, Inc., Erika's Lighthouse, JetBlue Airways Corporation, and the National Parent Teachers Association.
Shatterproof	West Virginia and UniCare are partnering with the Addiction Treatment Facility Survey (ATLAS) through Shatterproof. This is to pilot an addiction treatment quality measurement system to help providers track quality relative to their peers and learn best practices to support members, states, and health plans to make data-driven decisions when evaluating and selecting addiction treatment facilities.
Neonatal Abstinence Syndrome (NAS) Program	Our NAS/Neonatal Opioid Withdrawal Syndrome (NOWS) program is an episodic care management program that incorporates evidence-based approaches that seek to avoid child welfare engagement through early identification and resolution of the mother's and baby's needs.

- BA015 1 The Vendor should describe its process for how condition-specific protocols and conditions will be updated and shared with primary and specialty care providers.

Updating and Sharing Condition-specific Protocols and Conditions (BA015)

We partner with providers to improve access to care, ease provider administrative burden, provide holistic care, and promote healthy lifestyles for members. Our strategy includes giving providers the tools, resources, and support to succeed while advancing clinical quality outcomes and driving improvement in quality performance measures using our UniCare condition-specific protocols and guidelines. We offer provider education about our condition-specific protocols and conditions — including those for complex members with SHCN — which we share with providers through our Health Insight care management platform, on our website and provider portal, in our provider manuals, newsletters, and blogs, and through our committees. Our provider protocols or guidelines include preventive health, chronic conditions, and CPGs. UniCare uses our dedicated, national-level Clinical Practice and Preventive Health Guidelines (CPG/PHG) workgroup composed of Medical Directors, including our BH Medical Directors, disease

management program owners, and clinical program development managers to support the development, monitoring, and annual update of our guidelines. We distribute CPGs and notice of changes to providers through our provider handbook, newsletters, website, fax blast, and special mailings. ***We disseminate new or revised guidelines to Medicaid practitioners and providers within 60 days of revision and adoption by the health plan's quality committee or MAC, or sooner based on state specific guidelines.*** We also continually modify and update our care management protocols to guide additional levels of supports to make sure we deliver the full range of services members with SHCN may require. We make these documents available to DHHR, Bureau for Public Health (BPH), and other system of care providers such as community-based organizations or stakeholders to access when needed and to assist when addressing a member's care needs and services. We build upon these established protocols to meet the comprehensive needs of members we serve through West Virginia MHT. UniCare reviews, adopts, revises, and shares protocols or CPGs relevant to the needs of members to:

- Assist providers and members in making decisions about acute and chronic medical care, including BH care services
- Assure UniCare's perinatal and high-risk population management programs incorporate current, evidence-based CPGs from recognized sources
- Meet NCQA regulatory and contractual requirements

We update CPGs at least every two years or when there are changes to national guidelines. Through our UniCare Training Academy, we provide education to providers initially and ongoing for specific populations and our protocols or guidelines related to these, such as members with chronic or serious medical conditions. We help providers adopt our standards and protocols by offering training around topics such as local and national best practices, evidence-based practices, strategies to be flexible and adaptable to varying member needs, key quality measures, and identifying and addressing members'

needs. Our Network Relations Consultants provide training and support as needed for providers related to our UniCare guidelines routinely and as needed to address any questions from providers or their staff.

To encourage adherence to clinical CPGs, our Clinical Quality Program Consultants help providers interpret quality data, provide education in person or telephonically about the expectations for each CPG, and review medical record keeping requirements to make sure there is accurate documentation and evidence of compliance. The support we offer providers to improve outcomes through CPG compliance drives positive results in HEDIS scores and other quality-related initiatives.

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| BA016 | 1 | The Vendor should describe its process to honor authorization approvals from previous coverage during the transition period, defined as the period in which members are moving from one Managed Care Organization (MCO) to another or from Fee-for-Service (FFS) to an MCO, or private insurance to an MCO. These processes should include, but are not limited to, the following: |
| BA017 | 2 | Medical Services (includes Physical, Behavioral Health, Dental, and Vision) |
| BA018 | 2 | Pharmacy |

Assuring Continuity of Care for Members in Transition (BA016)

UniCare promotes continuity of care during transitions so members can continue to have access to covered services without any disruption or lapse of service and avoid any adverse impact to the member's health. We recognize members' needs change frequently and providing support during critical transitions is an important care management function, in particular for members with complex or specialized health care needs. In instances of transition of care such as between MCOs, from Fee-for-Service (FFS) to UniCare, or from private insurance to UniCare, we minimize disruption through our established transition of care and continuity policies and procedures to actively assist members. Through these processes, we reduce the risk of fragmentation and support member voice and choice. Because members can change



MCOs monthly, their care can become disjointed. To curtail this disruption, we created the position of a **UniCare Transition Coordinator** to address any disruption of services, potential communication opportunities, or fragmentation when the member transitions to

another MCO or to UniCare from another MCO, FFS, or a private insurance. Our Transition Coordinator will collaborate with other MCO or FFS UM staff and Care Managers, to verify the member's current treatment. The Transition Coordinator will help members prepare for MCO transitions before they occur, if we are made aware prior to the transitions, by compiling and providing a packet of information on continuity of care, coordination of care, and accessing supports from the new MCO. Our Transition Coordinator will have access to the state system that allows them to check back and determine where the member's new MCO was identified and reach out to the MCO for all members who are enrolled in care management to prevent disruption in services and care. We intend to partner with DHHR and other MCOs to develop an automated file transfer process to streamline the sharing of documents when a member changes MCOs. This data could include any active authorizations, approved units, most recent assessments, care plans, and pertinent dollar amounts related to benefit maximums. We understand transitions to managed care can be a significant change and we communicate collaboratively to make sure the transition is as smooth as possible. With appropriate member permission, we collaborate with other MCOs which includes sharing care plans to support the member.

Our Enrollee (Member) Services department outreaches to all new members as part of our welcome call — including those transitioning from a previous MCO, FFS, or a private insurance — to better understand the member's physical, BH, SDOH, ancillary, or pharmacy needs. If identified during this call, or if the member has an existing care plan, we engage our Care Managers to complete a comprehensive assessment to determine the member's current needs and if their current services are still appropriate.

Honoring Prior Authorization Approvals for Medical Services (BA017)

During the time when a member is in transition from one MCO to another including from a different MCO, FFS, or private insurance to UniCare, we approve authorized medical services, including physical and BH, dental, and vision through continued authorization of those services for the same amount, duration,

and scope until the end of the current authorization period as granted by either another MCO or FFS for up to 90 days, as required by the SPA and HB2351. If a provider is OON, and the Care Manager is unable to locate a comparable in-network provider, we may determine the authorization for the OON provider will continue. We make every effort to bring OON providers into our network; if we are unable to do so then we may offer a single-case agreement (SCA) during this transition period. Our Transition Coordinator will review the DHHR report for any transitioning members enrolled in our care management programs and prepare a packet of information to send to the member's PCP and new MCO, once identified.

During our new member welcome calls, we can identify members who are transitioning to UniCare from another MCO, FFS, or from private insurance and through our initial health assessment (initial screening). We determine what type of outreach or services members may need based on previous care management supports received or initial biopsychosocial needs identified. During the outreach call, we can learn from the member or their caregiver about any existing providers or benefits they were using or will need in the future. Our Enrollee (Member) Services Representative communicates this information through Health Insight, our care management platform, and notifies our Transition Coordinator if the member is transitioning to UniCare from another MCO, FFS, or a private insurance and needing care management support. If a member is new to UniCare, we may receive additional details about the prior services they were receiving and their previous MCO coverage. We communicate this information to our Transition Coordinator to assist in gathering the needed detail to continue services. Our Care Managers can assist during a new member transitional period to determine if the member is in an active course of treatment, if any existing providers are in our network, and to determine any changes in needs such as prioritizing urgent needs and service authorization. Upon receipt of the PA documents from a member or provider of the existence of a service authorization, we will assure members continue to receive services

from another MCO or FFS. When a member changes MCOs, we typically receive a call from the member's provider requesting authorization for services.

Honoring Prior Authorization Approvals for Pharmacy (BA018)

UniCare works with the State's pharmacy program to coordinate pharmacy services. Continuity of care and member access to necessary medications are primary objectives of our pharmacy program.

Breakdown in drug therapy can lead to reduced medication adherence and increase the risk of adverse outcomes. During our discharge planning process, we work with the member's treating providers to

assure the member can receive PA, if needed, for medications prior to discharge. We may reach out to

DHHR's pharmacy Vendor to assist the member if there are additional barriers or issues regarding

previously approved medication. If pharmacy services are carved in, our Pharmacy

Benefit Partner IngenioRx's transition policy will help make sure new members who

transition to UniCare can take the same medications. Member eligibility files will be sent

to our Pharmacy Benefit Partner with a transition effective date. New transitioning members with pre-

existing drug regimens will receive up to a 90-day supply of their existing medications to promote

continuity of care. This policy will help meet the member's urgent needs and give us time to collaborate

with the prescribing provider.



Members who receive a supply of any drug based on this transition policy will receive a letter in the mail from our Pharmacy Benefit Partner which the provider will also receive. The letter will inform the member of the temporary supply of the drug and will include instructions to work with their prescribing provider to find another drug on the formulary. Our Pharmacy Benefit Partner will send the letter within 10 business days of dispensing the temporary supply of non-preferred medications.

- BA019 1 The Vendor should describe how providers and/or members will be notified regarding the expiration of medical authorizations, and pharmacy authorizations, if applicable.

Process for Expiration of Authorizations (BA019)

Our aim is to assure that members do not have disrupted or interrupted care. Continuing existing medically necessary services is just as important as initiating new services. We provide written notification to our providers for all approved authorizations that clearly indicates the start date and expiration date of the authorized services. Our Health Insight system generates a letter immediately upon completion of the determination. If pharmacy is carved in, pharmacy approval letters, for PAs will also contain authorization start and end dates. Additionally, for members engaged in care management, the Care Manager will review upcoming authorization expirations (end dates) on the Health Insight platform, contact the member and provider to discuss care plan progress and preferences regarding services, and share this information with the UM Clinicians as necessary to determine ongoing service authorizations. At the time of any adverse determinations, and reduction or termination of previously authorized services, we advise the member and provider in writing, detailing the specific reasons for the determination, the factors considered, and any additional information or actions available to the member or provider.

We conduct ongoing concurrent reviews and request clinical information for all inpatient and residential services on the last covered day to determine if the provider or member indicate that treatment should continue beyond initial authorization. Concurrent review is informed by our daily UM census reports, which contain details on acute and sub-acute services, open and pending cases, anticipated discharge date, authorization dates, previous admission information, assigned Care Manager, and clinical indicators used in our predictive risk model. Through concurrent review, we communicate with a provider prior to authorization expiration, and if additional services are indicated (such as new equipment or supply needs, or pharmacy authorization), we may arrange for expedited authorization and provision of such

services prior to discharge so there is no disruption of services. Our UM Clinician works alongside the care management team to collaborate and assure a safe discharge.

UM staff monitor reports from the Health Insight platform for facility-based services and those engaged in care management, with priority for members with SHCN. They will notify facilities and members of expiring authorizations via phone call or letter and determine if ongoing services are needed. UM Clinicians will assist providers in obtaining PA when an extension of services is needed and refer members to care management or a Transition Coordinator as appropriate.

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| BA020 | 1 | The Vendor should describe its process for authorizing out-of-network access including, but not limited to, the following: |
| BA021 | 2 | Emergency Services, including transportation |
| BA022 | 2 | Medically Necessary Travel, for the West Virginia Children's Health Insurance Program (WVCHIP) |
| BA023 | 2 | Medical Necessity |
| BA024 | 2 | Out-of-State Providers (for example, members who are students, live in proximity to State borders, etc.) |

Authorizing Out-of-Network Services (BA020)



UniCare processes and procedures support the authorization of OON providers to facilitate continuity of care and make sure members can access needed care. Regardless of the member's condition or circumstances, OON providers may be a critical part of accessing necessary care. Our authorization processes enable members to access

emergency services, without needing a PA, regardless of whether the member sees an OON provider. Our Provider Network team makes every attempt to bring requested or necessary providers into our UniCare network to see that members have access to their preferred or needed practitioners. UniCare's compliant and comprehensive provider network and clinical management processes include connecting members to necessary care and assuring access to care across West Virginia, including in rural areas and bordering states. Additional information on our network access is in ND001.

Our Comprehensive Provider Network Meets Members' Needs

During 2019, we initiated a single-case agreement only 60 times.

As a current West Virginia MHT MCO, we use existing DHHR-approved policies and procedures when referring members to OON providers for specialty and medically necessary services, based on sources, including NCQA standards and guidelines and the SPA. In the unlikely event that a network provider is unavailable, our procedures foster timely access to OON providers so members can access the full range of needed necessary services. We initiated SCAs for services such as autism, cochlear implants, and treatments received at Children's Hospital in Philadelphia. When a member is referred for OON treatment, UM reviews the request for medical necessity. If the member meets continuity of care criteria outlined in the contract or if there is no comparable network provider available, then the request is approved as medically necessary. We approve members to see OON providers in accordance with continuity of care guidelines when they travel outside of the service area, if the member is enrolled in college, has a lack of available specialists within travel distance, has a lack of appointment availability with a network provider, or when their needs are so complex that seeking care at an OON provider is in their best interest. Prior to approving for medical necessity, the UM Clinician verifies the OON provider does not have any sanctions or exclusions. All OON approval letters are accompanied by a standard SCA, even if we are unable to contract with the provider.

Authorizing Out-of-network Emergency Services and Transportation (BA021)

When a member is experiencing a medical emergency, our top priority is facilitating access to immediate care where and when needed, 24/7. We provide coverage and payment of emergency services — including transportation — without the need for PA, regardless of whether the medical or transportation provider is in- or out-of-network. When members experience an emergency or crisis, our priorities include:

- Assuring the member receives the immediate care needed to address the emergency and to stabilize their health
- Supporting the member and provider in the provision of post-stabilization services needed to maintain the member's health stability

- Assuring members who require admissions are in the most appropriate care setting
- Providing ongoing care management and discharge planning with the member or their caregivers, facility, and treating providers
- Working with the member or their caregivers to address any factors that may have contributed to the emergency to reduce need for future avoidable emergency services
- Addressing SDOH needs, such as assuring the member has transportation resources available and arranging services as needed

UniCare facilitates access to medically appropriate care for members. Members needing emergency services can access them at the nearest available facility. We comply with all applicable emergency services requirements specified in the SPA, and continue to cover the medical screening examination, as defined by the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations at 42 CFR 489.24, applying the prudent layperson definition and other applicable State and federal requirements. We reimburse OON ER services at 100% of the Medicaid rate unless other payment arrangements are mutually agreed upon by UniCare and the provider, and do not limit reimbursement to network providers. We follow the same policy for placement in an Institution for Mental Disease (IMD) for the first 48 hours since it is also considered an emergency service.

Medically Necessary Travel for WVCHIP Members (BA022)

We will leverage our current processes for West Virginia MHT members to work with the State's transportation partner to assure WVCHIP processes and procedures are followed for medically necessary emergent and non-emergent transportation. Emergency transportation does not need a PA. We will also educate and provide additional information to members and their caregivers regarding transportation coverage for members with Hemophilia and those who need organ transplants. We will provide education

about how to access covered services, including assistance to necessary SDOH needs (such as transportation), and we will work with members to identify providers who are close to their residences. We will also leverage telehealth access where applicable and collaborate with school health clinics to help members access routine medical care. As a VAS, WVCHIP members are eligible for our \$100 Gas Card as well. This benefit helps our members access non-emergent transportation such as therapy appointments, extracurricular activities, self-help meetings, educational programs, grocery stores, and more.

Non-emergency, Medically Necessary Situations (BA023)



Each member situation is unique, and we know the therapeutic relationship between provider and member is a key to positive health outcomes. Our extensive network minimizes the need for OON services for most Medicaid covered services; however, if a network provider is not available or accessible to meet a member's non-emergency, medically necessary need, for covered services, we coordinate services with an OON provider. For example, we have relationships with Children's National Medical Center, Nationwide Children's, and Cincinnati Children's Hospital where we *have an ongoing SCA, and extend network privileges*; meaning we do not require a medical necessity review for routine services and they accept our rates. Normal PA requirements apply and providers must submit notification for routine services such as office visits, but they do not have to submit records or wait for a medical records review. This facilitates access to OON or out-of-state specialties, especially for pediatric subspecialties, which are not always available in state.

Authorizing Out-of-State Providers (BA024)



Unicare has more than 3,600 unique PCP and specialist contracts in bordering states to support members seeing providers near their homes, and maintain a strong provider network with specialty types that members may need to see that are not available in West Virginia. We contract with bordering state

providers in Ohio, Pennsylvania, Maryland, Kentucky, and Virginia. We can leverage our affiliates' existing provider relationships in multiple neighboring states to access a depth of provider types. When a member needs out-of-state services with an OON provider, we work with that provider directly to make sure the member's needs are addressed. For example, if a student is attending school out-of-state, we will review for medical necessity and approve the request. When it is clear members' health care needs can best be met by remaining with their current providers, we work with the OON provider to authorize medically necessary services even if the provider chooses not to contract with us.

- BA025 1 The Vendor should describe its process for circumstances under which a member might be granted a standing referral to a specialist provider.

Granting Standing Referrals to Specialist Providers (BA025)

UniCare is committed to providing accessible, high-quality health care services for our members. We consider the PCP the principal coordinator of care when members require medical services from other health care service providers, such as specialists. Standing referrals enabling a member to obtain services from a specialist without having to obtain additional referrals is not needed as UniCare does not require authorization for in-network specialist referrals. UniCare expects the PCP to send and receive written communication with the specialist describing the care rendered and medical history of members who have been referred for specialty care. This type of open standing referral (or "direct access") to specialists for members with specialized health care needs or complex medical conditions is described in Sections BA011-BA012.

In this capacity, the specialist may treat and authorize referrals, procedures, tests, and other medical services for the member. Members may also select the specialist as their PCP if they are receiving specialized care over prolonged periods of time or their condition, such as AIDS, cancer, or kidney disease, is life-threatening, degenerative, disabling, or the member is SSI eligible.

Care provided by the in-network specialist follows our usual PA rules, according to our UM program and guidelines. In special circumstances, detailed in Section BA027, consideration is made for OON providers. Referrals from OON providers require PA, and a request may be authorized based on medical necessity and availability of in-network specialists.

BA026 1 The Vendor should describe the extent to which a specialist provider may refer services.

Specialists Making Referrals (BA026)

UniCare recognizes there are more than 120 specialty and subspecialty branches of medical practice, and specialist referrals may be needed to confirm or rule out medical conditions. UniCare accepts referrals from all sources, employing a “no wrong door” policy. We educate providers, including specialists, on which services require PA and on the process for requesting it (detailed in Section B004) through our provider manual, alerts, training, and tools on the provider website. Providers may also contact us through the Provider Phone Line. Our care management and UM teams encourage providers during their interactions to inform us of member needs or changes in their situation that may require additional coordination. We will collaborate with specialists to identify specialized services to address the identified needs of the member, including assistance in accessing both covered and carved-out services.

Our Health Insight platform facilitates communication among all providers involved in a member’s care. Providers have 24/7 access through the provider portal to request authorizations or access health-related information specific to their attributed member’s personal health record. For members engaged with care management, the Care Manager will work with providers to assure needed services are being rendered and that the PCP and specialists stay informed throughout care assessment and planning.

Our Provider Services and Care Management staff assist providers, including specialists, in identifying other specialists and arranging specialty care. Authorization is not required if referring a member to an in-

network specialist for consultation or a non-surgical course of treatment. If the specialist refers to an OON provider, the specialist submits a PA request; the UM team will work with the specialist to determine if there is an in-network provider available in the service area. If not, the OON request would be approved. Providers, including specialists, are responsible for documenting referrals in the member's chart and requesting provider updates regarding diagnosis and treatment.

- BA027 1 The Vendor should describe its process for out-of-network referrals, including, but not limited to, the following:
- BA028 2 Members and/or providers requesting out-of-network referrals
- BA029 2 Processes in which a member may continue an existing relationship with an out-of-network provider, or a provider that leaves the Vendor's network, if considered to be in the best medical interest of the member
- BA030 2 Durations permitted for members to see out-of-network providers that refuse to contract with the Vendor for ongoing courses of treatment past the first 90 days of enrollment

Out-of-network Referrals Promote Continuity and Access to Appropriate Care (BA027)



UniCare is committed to continuity and coordination of care to provide high-quality health care services for our members. Our approach to connecting members to care optimizes health outcomes by matching members with appropriate providers, including those in and OON. We commit to facilitating access to medically appropriate care for members. We

continually develop and maintain our network with providers that meet distance adequacy and access standards, limiting our members' need for OON services. In the third quarter of 2019, OON authorizations were 9.86% of all requests for physical health care; of these requests, nearly 30% were for pediatric subspecialties. If a network provider is not

Real Stories

Brett was a neonate with severe congenital heart problem who received corrective surgery and developed a postoperative complication that led to more significant medical challenges. During our weekly rounds with an enterprise neonatologist, we noted Brett's lack of progress. We held a Care Conference with the facility to discuss options and a timeline for a transfer to a specialized facility that could meet his medical needs. Our Care Coordinator found a facility that had experience taking care of neonates with this particular heart problem, but was not yet in our network. We collaborated with both the NICU facility and transfer facility to complete the necessary steps to facilitate payment to the "OON" facility.

available or accessible to meet a member's non-emergency, medically necessary need for covered services, we will coordinate services with an OON provider. In ND001 and ND014, we describe in further detail our processes and approach to making sure members have access to providers and to address care needs. To assure continuity of care, our Transition Coordinator will answer any member access questions, responding to requests regarding access or care needs during times of transition; complete proactive outreach; and outreach members who may need additional coordination of care between different populations or organizations, such as CSHCN, foster care, chronic illness, and transitioning to or from another MCO. When a member receives approval for OON care for continuity, but are transitioning to an in-network provider, we refer to our Care Management team for transition assistance. For example, we have completed arrangements to cover services at Cincinnati Children's Hospital — who provides services for pediatric subspecialties such as neurology, ear, nose and throat, hematology-oncology, and neonatology.

Established, Approved Out-of-network Guidelines

We use existing, DHHR-approved policies and procedures for referring members to OON providers for specialty and medically necessary services, based on sources including NCQA standards and guidelines and the SPA. We provide access to services from OON providers in the following situations:

- There is no available network provider with the training, experience, or specialization available for timely medically necessary care.
- To maintain continuity of care with an OON provider for new members — beyond the initial program transition — for the first 90 days of enrollment, or during active course of treatment such as during late-term pregnancy or cancer treatment.
- The member's PCP or other provider determines that clinical services not available within the network are required for a member and, if not received or received separately, would subject them to unnecessary risk.

- DHHR determines that circumstances warrant OON treatment.
- A member receives emergency or crisis services, post-stabilization services, family planning services, or sexually transmitted infection (STI) treatment.

Because we value and respect the relationships new members have with their existing providers, we work to preserve these relationships, including those between members and non-participating providers. We collaborate with providers who are actively caring for new members to assure continuity of care during all transition periods. As part of transitioning, we involve all providers caring for members, including OON providers, in care management processes.

Members or Providers Requesting Out-of-network Referrals (BA028)

Providing needed care to members by a qualified provider is our top priority. We establish processes for providers and members to request OON referrals that are in the best medical interest of the member, particularly for members receiving ongoing treatment. If a member requests services or a provider with whom we lack an agreement, we work directly with that provider and member to determine the reason for services and to negotiate a provider agreement to provide services. When indicated, we work with the member to identify the closest, most appropriate provider to meet their needs and execute a SCA when appropriate. SCAs with OON providers solidify payment terms including protections related to balance billing, authorization requirements, information-sharing, and treatment plans to assure thorough coordination of the member's care.

Members Continuing Care with Out-of-network Providers (BA029, BA030)

We continue to coordinate care for the member with their OON provider until a network provider is available, or as long as the member requires care that cannot otherwise be met by network providers.

If the member needs specialist services that are not available from a participating specialist in West Virginia, we arrange for the provision of services through an OON provider until a participating provider can fulfill that role. Similarly, if no appropriate network provider is available to offer a member a second opinion, we arrange for the member to obtain a second opinion from outside the network.

If a member is engaged in active treatment with an OON provider, either at initial enrollment or as an existing member, we develop a strategy with the member and providers to transition the member to a network provider once stable during the first 90 days of enrollment. Our Care Managers and UM Clinicians monitor member progress from the time of the OON authorization request through visit or service completion. If the member needs to remain with the OON provider, we work directly with the provider to negotiate the willingness and ability for that provider to join our network. For example, members may request an OON provider for the following circumstances: an acute condition, a serious chronic condition, pregnancy and immediate postpartum care, terminal illness, or degenerative and disabling conditions. We review each request for OON services based on the individual member's needs and the availability of care within our network. Understanding the importance of existing relationships with providers for members with SHCN, UniCare may consider extending authorization timeframes for OON providers based on clinical judgment and member needs. For example, to assure members receive the most efficient care to improve health and quality of life, we may extend authorizations for individuals with rare conditions or nearing the completion of treatment regimens.

- BA031 1 The Vendor should its procedures for ensuring that member information from non-network providers is shared with the member's Primary Care Provider (PCP).

Information-sharing Between PCPs and Non-network Providers (BA031)

As part of our overall efforts to assure coordinated care delivery, we have developed processes to promote continuity of care of a member's covered benefits and promote information-sharing between PCPs and OON providers. To promote sharing with OON providers, UniCare's SCAs include language that **requires the OON provider to send medical records within 10 working days of UniCare's request for information, including member information, records, and data must remain available to UniCare and otherwise remain confidential.** As information is updated in the member's clinical record in Health Insight, the treating provider and the PCP will be available for viewing. Care Managers engaged with the member and OON provider can also directly provide this information to the PCP to further assure that the PCP is apprised of the member's treatment and progress. This information-sharing can also occur during care conferences or as part of the member's care plan development.



- BA032 1 The Vendor should describe its process to assist in enrolling and pairing the member with an appropriate in-network provider within 90 days of enrollment.

Enrolling and Pairing the Member with an In-network Provider (BA032)

During the initial member welcome call, if we identify that a member is seeing an OON provider, then we engage our Care Management and Provider Services teams to either invite them in to our network if they would like to continue to see this provider, or to support the member in finding and connecting with an in-network provider. We use the information we receive in the enrollment file, our initial screening,

and stratification to identify if the member is seeing an OON provider. A Care Manager then works with the member or authorized representative to select an appropriate in-network provider, based on the individualized needs of the member — such as a pediatric cardiologist, if needed — and the distance to the member's residence. Our Provider Services team identifies providers who can meet specific language, cultural, or linguistic needs and can pair members with providers who can meet these needs. Our care management staff confirms the provider is still in the service area and can perform services required, and coordinates the referral, documenting progress in the transition care plan. Care management staff, including the Transition Coordinator, assist with scheduling an appointment with the new provider within 90 days of enrollment. They facilitate the transfer of medical records and other information to make sure the new provider is well-prepared to engage with the member. For additional information on the methodology for assigning members to a PCP, including claims history, proximity, and the contractually defined timeframe, please refer to our response to MS003; for more information on our confirmation of a PCP process, please refer to our response to MS038.

BA033 1 The Vendor should describe its process for transferring necessary clinical information to a member's new provider.

Transferring Clinical Information to New Providers (BA033)

There may be instances where a member's circumstances change and the member needs a new treating provider. We work with the member and their caregiver to identify the appropriate provider needed and help them arrange for appointments and services if necessary. Once a provider is identified, our Care Management team works collaboratively with our Provider Services department to assure the member's new provider is familiar with UniCare benefits and Health Insight. Leveraging Health Insight, our care management information-sharing platform, we make clinical information available, on demand, for providers treating members, including new providers. We provide tools to facilitate information-sharing

between providers. For example, the provider can submit information to UniCare, and we incorporate that into the member's personal medical record on Health Insight. Our Care Managers actively work with both the current and the new treating provider to facilitate a smooth transition to providers. We outreach to providers to assure they received the biopsychosocial information for the member and will facilitate the transfer of information if necessary. The member's PCPs or treating providers are responsible for tracking and documenting appointments, clinical findings, treatment plans, and the care received by members referred to specialists or other health care providers. Members changing PCPs have the right to request this information be shared with the new provider. Our contracts require providers to comply with HIPAA medical transfer rules. Members have the right to have their entire medical record transferred to any provider — and the provider must respond to this request within 30 days.

Facilitating Information-sharing with Out-of-network Providers

To promote stability, continuity of care, and positive relationships between members and their providers, UniCare attempts to bring a member's current OON provider into the network. We work with the provider who can best meet the member's needs, regardless of whether they are in-network or OON. The transition process is coordinated by the Care Management team, in collaboration with a UM Clinician, jointly developing a transition care plan that includes transferring clinical information for, at a minimum, the following:

- The non-participating provider's treatment plan for the member's active course of treatment, for which continued access to care or OON referral was requested
- The specific treatment goal to be reached prior to transfer to the UniCare contracting provider and the estimated date the transfer can be safely accomplished

For example, we work with the member or authorized representative to sign a release of information and request a transfer of medical records to the new in-network provider, and input information to the member's record in Health Insight, which is made available to the in-network provider to enhance coordination of care.

BA034 **1** The Vendor should describe its process for member access and coverage of Family Planning services.

Supporting Members in Accessing Family Planning Services (BA034)

Family planning services and education can help reduce the incidence of preventable medical conditions such as maternal death, infant mortality, and premature and low birth weight babies. These services are also important for preventing unintended pregnancies and enabling women to control the timing and spacing of their pregnancies. To address these goals, UniCare partners with the State and community to educate current members and providers on the importance and availability of family planning services. We work to contract with all local family planning clinics and providers throughout West Virginia. Members may access any qualified family planning provider they choose, even if out-of-network. Our member website and member handbook contain information on pregnancy and women's health and available resources for our members on coverage of family planning services and how they can obtain them. Members receive freedom of choice in family planning methods for which they have coverage; no PA is required. If a member is unclear of where to go to access family planning services, they can contact our Member Services department, who will connect the member to a family planning provider near their home. While we encourage members to consider the benefits of an in-network provider to better support care coordination, we work with the member and provider to support coordination regardless of network participation.

To provide prompt payment to providers, we configured our claims processing system to identify and automatically adjudicate claims for family planning services based on the included diagnosis codes to

reduce provider administrative burden so providers can focus on offering members care. We reimburse providers for covered family planning services, regardless of whether they participate in our network. OON family planning providers are reimbursed 100% of the Medicaid fee schedule. No pre- or post-authorization is required for family planning services.

Available family planning services members can receive include:

- Information on unplanned pregnancy and protection from STIs
- Early and ongoing prenatal and postpartum care
- Family planning, education, and counseling
- Medical visits for birth control and contraception
- HPV and cervical cancer screenings
- Pregnancy tests
- Lab tests if medically indicated in the choice of contraceptive methods
- Tests for STIs
- Screening, testing, counseling, and referral for treatment for members at risk for HIV

UniCare encourages all pregnant members and mothers with infants to make postpartum visits for the purpose of voluntary family planning, and we offer members our *Birth Control That Is Right for You* brochure. We have education and referral processes in place so members have convenient access to family planning services. Currently, our Community Engagement team educates members of child-bearing age about their family planning options and resources at the time of enrollment and in ongoing communications. Health education and counseling is necessary to help them make informed choices and understand methods of contraception. Health education materials are in an easy-to-read and understandable format, culturally appropriate, and at the reading level designated by contract.

Family Planning and Beyond

As a part of accessing family planning support, we include supports throughout pregnancy and after the baby is born. *We build upon our current collaboration with Office of Maternal, Child, and Family Health (OMCFH) and more than 200 community-based organizations across West Virginia to encourage and increase the number of families enrolled in the West Virginia Home Visitation program.* We established collaborative relationships with multiple home visitation programs, as outlined in Table 6.2-3, to support members and their families.

Table 6.2-3. Collaborating with Home Visitation Programs

Program	Description
West Virginia Birth to Three	Our 10-year collaboration with this organization provides a system of services and supports for children who have a delay in their development or are at risk for a delay. <i>In 2018 and 2019, UniCare participated in over 250 events including baby showers, health fairs, and other parent engagement activities.</i>
Right from the Start/West Virginia Healthy Start and Helping Appalachian Parents and Infants (HAPI) Project	HAPI — integrated with Right from the Start — works with local agencies that employ Designated Care Coordinators, licensed professional social workers, and registered nurses to provide education, resources, and services to members to reduce infant mortality. UniCare has a long-standing relationship with the HAPI project and has partnered with them on community baby showers and mom and baby events.
Parents as Teachers	This statewide program promotes early development, learning, and the child's health by supporting parents and caregivers. UniCare collaborates with Parents as Teachers to provide health and benefit presentations to parents and caregivers and engagement activities for children, and we sponsored their literacy initiative, Roll & Read.

We leverage our Care Managers' knowledge about these important programs, community resources, and social services, including the West Virginia Home Visitation program, its various program components, and how to access the resource directory. Care Management staff receive training regarding all of the West Virginia Home Visitation programs available, including these services within the care planning process and documenting referrals made with the member's permission. Engagement in the West Virginia Home Visitation program may also be incorporated into the care plan as a goal to help meet health outcomes identified by the member. To further promote and inform members about the program details and how to become involved, we use the following methods:

- Distributing materials and verbally providing information to members during community events and care coordination activities with members and their families
- Producing and distributing printed materials at community-based service locations

Through our community and stakeholder relationships, we use these opportunities to outreach and encourage members to engage directly with the West Virginia Home Visitation programs. We help members connect to this program through our community partners and collaborate directly with these organizations to promote participation.

Increasing Access to Long-Acting Reversible Contraceptives

We promote access to long-acting reversible contraceptives (LARC) — which do not require PAs — to female members of child-bearing age. UniCare is a leader in family planning and educating female members and providers about the availability of LARC to reduce adverse health outcomes associated with unintended pregnancies. We have strong ties with local organizations to promote our common purpose of achieving State goals and fulfilling our responsibilities to provide access to family planning services. *UniCare's former Medical Director, Dr. Tracy Dlott, founded and led the State's LARC workgroup, which is responsible for coordinating access to both immediate postpartum LARC and outpatient LARC services.* Postpartum LARC services are available at all three teaching hospitals in West Virginia, with plans to implement access in the smaller community hospitals through education and support. The workgroup also is facilitating training for PCPs to provide LARC services instead of having to refer their patients to OB/GYN providers to access outpatient LARC services.



We work closely with all providers of family planning services to inform members of child-bearing age about LARC as a safe and highly effective contraceptive alternative whenever they inquire about contraception alternatives and immediately postpartum. Our Care Managers assess members' interest in

family planning through the screening, assessment, and care planning processes. They review the results of the initial screening and assessments, which asks female members of child-bearing age (not just pregnant members) of their interest in LARC. They educate female members about LARC if they express interest in learning about it and help members identify LARC providers if they need assistance accessing services. Care Managers also send female members educational materials with in-depth information about LARC, including educational material specific to teens.

Supporting Mission WV's Project THINK

Since 2018, UniCare has been the proud sponsor of an evidence-based program that supports teen pregnancy prevention, Mission WV: Teaching Health Instead of Nagging Kids (THINK). Project THINK offers an evidence-based holistic approach to educating youth ages 11 to 19 years who live in high-need communities within rural West Virginia Appalachia to foster positive youth development and reduce high-risk behaviors. We provided \$25,000 to expand Project THINK in Putnam County, which served over 600 children. See CS001 for details. For more information on post-partum care, please see CM010 and CM061.

BA035 1 The Vendor should describe its process for accessing crisis stabilization services.

Assuring Timely Access to Community Psychiatric Supported Treatment (Crisis Stabilization) (BA035)

UniCare provides an array of crisis services such as crisis stabilization, mobile crisis response services, assertive community treatment teams, and crisis intervention counseling. We support these services through community behavior health centers (CBHCs) and individual providers who can deliver interventions in the home or in a community-based setting. In addition, *we established contracts with all of the West Virginia comprehensive crisis stabilization units, collaborating with these entities to support West Virginia youth and adults in this community-based alternative to acute care.* In the rare

event crisis stabilization services can only be provided by an OON provider, we work with that provider to develop an SCA and consider the provider for inclusion in our network. Short-term crisis stabilization provides supportive services, such as medication reconciliation and management and motivational interviewing, to engage West Virginia MHT members in understanding and better managing their BH conditions in the most integrated residential environment. ***Crisis stabilization services not involving hospitalization do not require medical necessity reviews for care completed in 72 hours.***

Our primary goal is to support members to achieve the best outcomes in the right settings of care that minimize trauma and disruption, particularly for West Virginia MHT members, their families, and their caregivers. In addition to identifying members with significant needs who are high-risk for crisis, ER usage, and hospitalization through predictive modeling and other data analytics, we focus on proactive planning for crisis, educating members and caregivers on steps to take in a crisis, providing assistance when members reach out during a crisis, and implementing follow-up.

Support for Members During a Crisis Situation 24/7

We encourage members and their caregivers to use our dedicated toll-free BH Hotline to seek assistance at any time, including during a crisis. The toll-free hotline is available to UniCare members and is staffed live by trained personnel 24/7. Members or their caregivers who call the BH Hotline reach staff trained in recognizing members in crisis who screen and triage the situation. If the member's situation is of a non-routine nature or they express they are experiencing a crisis or emergent situation, they are warm-transferred to a BH Clinician who can immediately assess the risk of harm to self or others or to the 24/7 Nurse Line for medical concerns. We may also provide the member information to the West Virginia Crisis Line (Help for Hope) at 1-800-help-4-WV and the opioid lifeline as an additional supplement to our Nurse Line and BH Hotline. If the member needs emergent care, our BH Clinicians will support the member in seeking emergency care, which may include transportation assistance or finding an urgent

care, provider, or emergency service provider that can meet the member's needs. Our BH Clinicians can provide education, support, or connect members with resources such as peer support programs or recovery support groups. All calls coming into the BH Hotline are logged in Health Insight with immediate notification to the Care Managers, so appropriate follow-up can be addressed and adjustments to the care plan can be made to avoid future crises. Additional descriptions on accessing emergency hotline numbers is located in MS020.

We encourage our members and caregivers to use the BH Hotline in times of crisis, but we fully expect that crises may present at any time. Crisis calls from members who contact our 24/7 Nurse Line or our Member Call Center are warm-transferred to BH Clinicians so the member and/or caller can receive the necessary intervention. *There is no wrong way to access crisis care* — such as through our Member Call Center, 24/7 Nurse Line or BH Hotline, through referrals from a provider such as the member's PCP or a BH provider, or during an ER visit.

Identifying Appropriate Crisis Responses to Reduce Emergency Room Use and Hospitalizations

UniCare's priority in responding to crisis calls is first to make sure our members and their caregivers are safe. Once we confirm the risk of self-harm or harm to others, our secondary goal is to make sure the crisis is resolved with an established plan developed by the member, the caregiver, and the UniCare Care Management team.

When crisis situations are deemed to be non-life-threatening, the BH Clinician considers the services and options available to the member and caregiver specific to the situation. The BH Clinician collaborates with the member, caregiver, and Care Managers to connect members to local providers or services to establish a plan to address the identified issue through an immediate solution or referral for follow-up. We

use PreManage to see if a member presents to the ER, and we outreach, if needed, to determine services needed and if the member could be managed in a crisis stabilization unit (CSU). The established and agreed-upon plan is documented in Health Insight, and we make a referral for follow-up to the member's Care Manager. Examples of the potential services available to members and their caregivers as alternatives to trips to the ER or hospital are summarized in Table 6.2-4.

Table 6.2-4. Crisis Alternatives to ER Visits and Hospitalization

Alternative	Description
In-home Clinical Services	• Goal is to de-escalate a BH crisis and stabilize placement • Includes risk assessment and in-home clinical services • Participants include treating provider(s) or the treating provider entity (clinic) with after-hours or crisis response team • Additional providers are recruited to provide this service
Telehealth Support	• Goal is to support immediate interventions in communities that suffer from shortages of BH providers and facilities • We will offer access to Bright Heart Health, which provides Medication Assisted Treatment and addiction services to young adults in provider offices • We will offer access to LiveHealth Online, which provides low-acuity psychiatric and psychological services to members • We will offer access to FasPsych, which provides high-acuity psychiatric and psychological services to all members on demand
Walk-in Crisis Intervention	• Goal to provide immediate access to services in a less intensive and re-traumatizing setting than an ER or hospital • Includes assessment and coordination of follow-up services • Currently, UniCare maintains extensive relationships with Community Mental Health Centers (CMHCs) providing this service
Mobile Crisis Response	• Goal is to provide on-site crisis intervention services to avoid re-traumatizing members with a trip to the ER or hospital • Services can happen in a home, school, or any safe setting • Includes immediate evaluation and crisis assessment; stabilization strategies and safety planning; short-term intensive crisis intervention; clinical consultation; and referral to acute BH services • Currently, UniCare has established referral relationships for mobile crisis services with CMHCs and other entities throughout West Virginia, such as United Summit Center of West Virginia and FMRS Health Systems
Crisis Stabilization Units	• Goal is to offer an alternative to inpatient hospitalization, particularly for members who have experienced trauma • CSUs provide short-term stabilization services (typically three to 10 days) as an alternative to hospitalization • Includes assessment of the need for treatment within a CSU and coordinating arrangements with the CSU, if necessary • Currently, UniCare has established partnerships with CSUs operated by CMHCs throughout West Virginia, such as Valley HealthCare System

Mitigating Crisis and Promoting Stability Through Safety Planning

At UniCare, we believe the best approach to crisis management is to be proactive, whenever possible, and to have a plan for crises if they do happen. A critical component of our crisis management approach is the development of safety plans as part of the care plan. Our Care Managers identify upon enrollment or at any point the need for a safety plan and develop the plan in conjunction with the member, caregivers, family, guardians, and the member's PCP and other providers, as part of the member's holistic care plan. The safety plan is used to identify situations prone to risk and provide immediate guidance to the BH Hotline representatives, Care Managers, and others responding to crises, to support the members, caregivers, and their support systems during difficult situations.

Educating About Alternatives to Prevent a Crisis Situation

Our continuous educational process promotes and reinforces the use of the most appropriate and integrated resources for emergencies and crisis through multiple sources and touchpoints:

- **Welcome calls** that promote the use of our BH Hotline as the preferred point-of-contact for crises
- **Member materials** that contain information about what to do in a medical emergency or BH crisis; this information is on member ID cards, our member website, welcome letters, and our member handbook
- **Individual safety planning** discussions with Care Managers as care plans are developed, offering an individualized way for Care Managers to have robust conversations with members, caregivers, and families about available options to avoid crisis, de-escalate crisis, or seek care in a crisis
- **Health promotion and member materials** tailored to the West Virginia MHT population needs with visuals about what to do in a crisis, including a magnet we give to caregivers, families, and members that provides the BH Hotline number and other information to support crisis management

Preventing Future Crises with Follow-up, Communication, and Planning

Our primary goal and priority following any member BH crisis is to make sure the member receives follow-up care that helps minimize the potential for future crises. Upon call resolution, we complete a referral allowing the Care Manager to follow up with the member and caregiver to make sure the member receives the appropriate person-centered, post-crisis services. This follow-up could include offering appointment assistance, if needed, and assuring a follow-up care plan is in place.

Each member's assigned Care Manager may work with the member, caregiver, or family to learn more about the event that precipitated the crisis and to develop strategies to engage the member in treatment for BH conditions and individual crisis planning to reduce the risk of subsequent emergencies.

Interdisciplinary care teams — made up of the BH Medical Director, Care Managers, BH Clinicians, and other team members — review emergency calls and situations from the previous 24 hours. The team confirms the response was effective in resolving the member's crisis and incorporates it into the member's safety plan contained within their care plan. The Care Manager works collaboratively with the member and caregivers to create safety plans, educate caregivers on BH issues, and implement strategies to prevent crises.

- BA036 1 The Vendor should describe how they will comply with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program requirements, as indicated by the Centers for Medicare & Medicaid Services (CMS) at <https://www.medicaid.gov/medicaid/benefits/epsdt/index.html>, including its process to ensure that children who are receiving primary care from a specialist receive EPSDT services.

Making Sure Children and Youth Receive EPSDT Services (BA036)

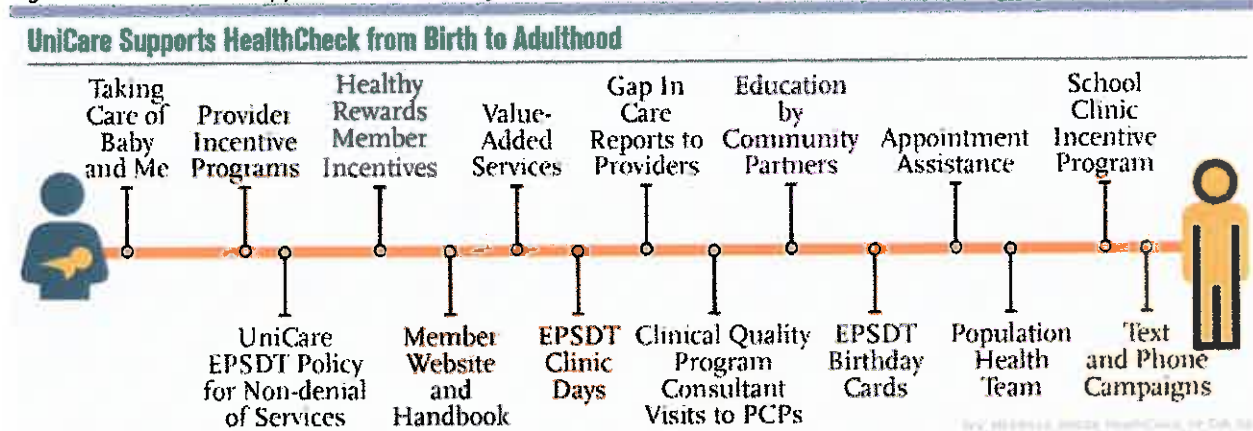
With children and adolescents representing more than half of our members, UniCare will continue to emphasize access to pediatric medical and dental preventive services. We have successfully coordinated and promoted screenings and comprehensive services



for West Virginia's children through the EPSDT program, HealthCheck, since we began operations. ***Our success is evidenced by improvements greater than 14 percentage points in Adolescent Well-Care Visits and Immunizations for Adolescents – Combination 2 between HEDIS 2017 and 2019.*** Our EPSDT program, policies, and tools are designed to make sure our members benefit from the earliest possible health care interventions necessary to identify, correct, and improve physical, dental, and BH conditions. ***We will not deny, reduce, or terminate a service for a child before the service is reviewed in accordance with our EPSDT policy.*** A healthy childhood is the best preparation for lifelong well-being and economic and social stability. UniCare will continue to meet all requirements for EPSDT screenings for members in accordance with SPA Article III, Section 1.2.1 and CMS requirements. We will extend our successful outreach strategies to WVCHIP members to engage them in preventive services and facilitate referrals to the Help Me Grow program to support childhood development.

A dedicated EPSDT Manager monitors EPSDT and HEDIS data monthly, using stratification by age and other analyses to target interventions. We offer an array of programs and strategies to support our members' healthy development from birth, including incentives, VAS, member materials, education, Population Health Team's Community Navigators, and appointment assistance and reminders, illustrated in Figure 6.2-7 and described in the following subsections and throughout this proposal. ***UniCare is the highest scoring plan in West Virginia on Lead Screening in Children, Annual Dental Visit, and Childhood Immunization Status – Combination 3 for HEDIS 2019.***

Figure 6.2-7. UniCare Supports HealthCheck from Birth



Comprehensive Approach to Encourage Timely EPSDT Visits

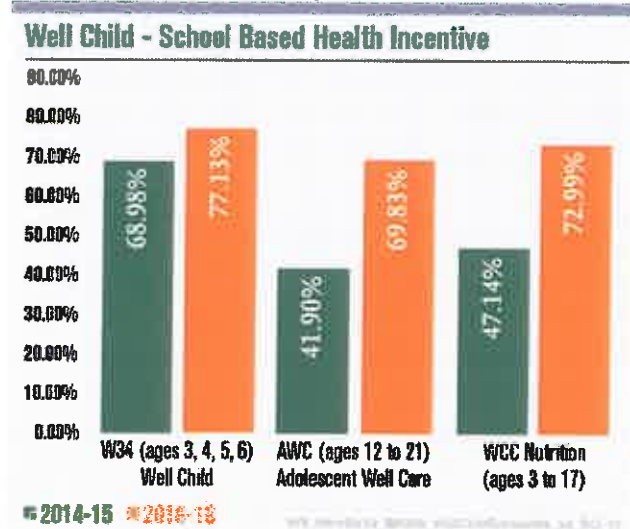
Multi-Faceted Member and Family Education. Recognizing the importance of making members and their families aware of covered EPSDT services and recommended well-child visits, our strategy blends innovative outreach tactics with more traditional member education strategies. Our My Advocate™ program introduces the importance of well-child visits during pregnancy. In addition to a Welcome Call, we mail a welcome packet with comprehensive information about EPSDT services and benefits. We continue to educate members, families, and caregivers about HealthCheck and the periodicity schedule in the member handbook, in Preventive Health Guidelines on our mobile-responsive member website, at community events, and through social media, including Facebook and Twitter. We then engage members and their families with ***annual, age-specific birthday card reminders to schedule needed EPSDT screenings, immunizations, and checkups*** (described further in BA047), as well as other online and printed educational materials, text and phone-based campaigns, and collaboration with providers and community partners.

UniCare also provides reminders and outreach to promote early and regular engagement in dental screens and services as part of HealthCheck. Our efforts have paid off: *UniCare has the highest 2019 HEDIS rate among MCOs for Annual Dental Visit in West Virginia and exceeds the NCQA 75th percentile.*

Member Incentives Promote Compliance. We have found financial incentives offered through our Healthy Rewards Program, a VAS, motivate families to seek care and maintain wellness. Our program platform will be greatly enhanced at the start of this Contract and feature a new \$25 incentive payment for dental visits. This expands upon several incentives currently offered for completing well-child visits and immunizations aligned with EPSDT.

Strong Partnerships with School-Based Health Centers (SBHC). Since 2015, the School-Based Well-Visit Incentive Program (SBWIP) has incentivized participation of SBHCs and members to increase child and adolescent well visits. West Virginia's rural nature made SBHCs an ideal community partner to increase access to high-quality primary care for children and adolescents. After four years, the program demonstrated dramatic improvements in HEDIS measures,

Figure 6.2-8. Improvements from SBWIP



summarized in Figure 6.2-8. Members completed more than 8,000 exams that likely would not have otherwise been completed. Associated HEDIS rates increased more than 11 percentage points.

Assistance and Proactive Outreach to Assure Referrals. We invite members and caregivers to contact us for help accessing EPSDT services. Members may contact our Enrollee (Member) Call Center where Member Services Representatives answer their questions and can assist in finding a provider qualified to provide EPSDT services, setting up appointments, or transportation. Members will also be

able to search for providers who can deliver HealthCheck services in our online provider directory. As part of our Population Health Team, our Community Navigators will help address pressing SDOH factors that may be limiting a family's ability to prioritize health care. For members engaged in care management, the Health Insight platform alerts Care Managers if a member is overdue for a provider visit, and the care management team will contact the family to assist. Using reporting on well-child visits where ICD-10 codes indicate a referral, Care Managers will work proactively with families to make the connection to additional care, with particular attention to CSHCN. For example, this process is followed when routine screening detects a child has an elevated blood lead level.

Supporting and Incentivizing Our Providers. UniCare is enhancing our current training, through the



use of presentation via webinar or in person, for providers. The training will include the schedule for HealthCheck screenings as specified by Bright Futures guidelines, quality measures, the required components of initial and periodic health assessments, information on EPSDT special services, emerging health status issues among members that should be

addressed as part of EPSDT, EPSDT coverage beyond the West Virginia Medicaid State Plan, and services that exceed benefit levels, amounts, frequencies, or duration otherwise allowed.

Our field-based Clinical Quality Program Consultants conduct targeted EPSDT education with PCPs, and regularly audit medical charts of members under 21 years to check that visits include the full array of required HealthCheck components. Our policy is to conduct focused feedback and education with providers when improvement is needed, and develop corrective action plans for any scoring below 80%.

We have designed our UniCare provider Value-Based Payment models to support increased utilization of EPSDT services, with data and information-sharing tools that help providers understand their performance and implement targeted interventions. These include a care opportunity report that lists members overdue for services, Transformation Action Plans that identify opportunities to improve quality, and an easy-to-

navigate Integrated Member Dashboard. We will also offer enhanced reimbursement to key providers who extend their office hours to nights and weekends to provide EPSDT appointments.

New Outreach to Specialists Delivering Primary Care. We understand some children with complex health care needs may receive care most often from a specialist. This year we will begin running reports of youth ages 0-21 years who only have claims from a specialist, so that we can engage with those providers to determine if they are the usual source of the child's care and educate them on our EPSDT program and expectations, as well as connect the member to a certified pediatrician for completion of an EPSDT screening, as needed.

Other Provider and Community Partnerships. UniCare also promotes member access to Clinic Days dedicated to EPSDT services in Federally Qualified Health Centers (FQHCs) and larger clinics, by contacting members who have gaps in care to help them make an appointment and assist them with transportation if needed. In 2019, 243 members were scheduled for well-child visits through EPSDT Clinic Days. *Our goal for 2020 is to involve 10 new providers in hosting Clinic Days throughout the State.*

UniCare's community giving also supports the spirit of the EPSDT benefit. We host Healthy Mom Healthy Baby Showers for expectant mothers to offer health education and introduce partners such as Women, Infants, and Children (WIC) and Birth to Three, sponsor the Think Kids' Health and Hunger project, and annually sponsor an immunization summit for providers in Charleston. We are working to identify a partner to introduce the trauma-informed Growing Great Kids curriculum to our EPSDT team. Growing Great Kids offers a tailored, enriching experience for children who have been exposed to ACEs and are living in a highly stressed home environment.

Evaluating, Improving, and Reporting EPSDT Services

Our Quality Director Victoria Warner, supported by an EPSDT Manager, is responsible for the success of the EPSDT program. Our HEDIS/EPSDT Datamart accelerates the retrieval of relevant claims and encounter data for monitoring EPSDT compliance. With this information in hand, we regularly assess our performance against EPSDT standards and conduct systematic QM activities described previously to monitor and improve access to timely newborn physical exams, well-child visits, dental exams, immunizations, and other specialized EPSDT services. We routinely equip Care Managers and providers with current information on members due for HealthCheck visits so that all are coordinated in taking steps to address any gaps in care and assure referrals and additional treatment that result from EPSDT screens.

Highest Scoring Health Plan

In 2019, UniCare was the highest scoring Medicaid health plan in West Virginia for the following measures:

- Annual Dental Visit
- Adolescent Well-care Visits
- Well-child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
- Childhood Immunization Status — Combo 3
- Immunizations for Adolescents — Combo 2



The UniCare QMC monitors and encourages improvement in EPSDT rates and as part of our overarching QAPI program. Our program is designed to comply with federal and State guidance, and we strive to meet the 80% threshold designated by CMS. We recently increased our Participation and Screening Ratios by six points and one point, respectively, from 2017-2018. We are confident in further improvement as we focus on EPSDT in a future Performance Improvement Project. Additionally, our Quality Improvement Committee reviews an annual evaluation of the EPSDT program that reports outreach, interventions, achievements, and opportunities for improvement. Our EPSDT tracking and reporting includes quarterly and annual EPSDT reports submitted to DHHR in the required format.

- BA037 1 The Vendor should describe its policies and procedures for assisting the State or fiscal agent with the pharmacy rebate resolution process including rejected or disputed physician administered drug claims.

UniCare Assists in the West Virginia Pharmacy Rebate Resolution

Process for Physician Administered Drugs (BA037)

UniCare works with DHHR in support of the State's pharmacy rebate resolution process for physician administered drugs. We have policies and procedures in place today to assist the State with their pharmacy rebate resolution process, including rejected or disputed physician administered drug claims.

UniCare Provides Pharmacy Rebate Resolution Resources

As a primary resource in assisting the State with pharmacy rebate resolution coordination, UniCare provides MHT Regulatory Manager Amber Nary as a single point-of-contact. For additional communication, the State's staff may also work with the UniCare encounters team, claims team, and other health plan staff to resolve any issues with paid physician administered drugs. Some team members who assist with rejected or disputed physician administered drug claims have extensive experience in the collection of data related to the rebate process within our affiliated markets and, therefore, have the experience and expertise to assist the State with these issues.

UniCare Uses Front-End Editing to Avoid Rejected or Disputed Claims

UniCare has procedures in place that use front-end editing during claims processing to avoid rejected or disputed physician administered drug charges. This includes a claim validation process supported by technology system business rules and automated alerts during claims processing.

On the last day of each month, UniCare checks the BMS website for any updates to the BMS Drug Code List. We use the National Drug Code (NDC) required field from the BMS Drug Code List to determine if a procedure code requires an NDC to be billed for the line charge. This makes certain we are collecting NDC

data as required. NDC accuracy is obtained by loading the monthly WVREFR054_Drug Rebate Detail Report NDC crosswalk provided by BMS within an average of 20 days.

To determine the need for an NDC, the claims system logic first looks at the procedure code billed, then at the NDC. We utilize the front-end edits reflected in the following table to validate if the service is subject to rebate and eligible for payment. If an NDC is billed without a procedure code, the line is denied to obtain the correct procedure code for the NDC. The front-end edits in place are shown in Table 6.2-5.

Table 6.2-5. Front-end Edits in Place to Make Sure the Correct Information Is Being Captured Based on State NDC Resources

Front-End Edits to Avoid Rejected or Disputed Physician Administered Drug Claims

Procedure code requires an NDC be billed but NDC is missing
Procedure code and NDC combination is valid but the line is missing the NDC unit of measure
Procedure code and NDC combination is valid but the line contains a qualifier that is missing or invalid
NDC/procedure code combination is not valid
Procedure code requires an NDC but the NDC billed was terminated before date of service from the claim
NDC is billed an outpatient claim with a revenue code only with the provider not billing a procedure code
Procedure code requires an NDC but the NDC billed has a rebate indicator = N
Procedure code does not require an NDC but an NDC was billed

When these edits are triggered during claims processing, the system generates a denial message for the provider advising them of the issue. We offer the provider the opportunity to correct or dispute the claim. We work with the provider and BMS, as needed, to resolve the issue.

As an example of this coordination, providers were not being reimbursed for contraceptives because the NDCs listed on the NDC crosswalk were not valid for the devices used. UniCare was able to obtain a notice from the manufacturer stating they would be retiring the old NDCs and including the new NDCs. We provided this documentation to BMS. This led to the NDC crosswalk being updated and our provider community being paid for the new NDCs. Our outreach not only impacted UniCare's ability to pay for the contraceptive devices but all Medicaid entities in West Virginia. *UniCare will continue to be a partner to the State and BMS in addressing denied or rejected physician administered drugs.*

UniCare Reviews Rejected or Disputed Drug Claims

When the State contacts UniCare's single point-of-contact with a rejected or disputed physician administered drug claim, we first research whether there was a report or data transfer issue. We review the files to determine if the claim line indicated as paid was reported correctly. If the line was not paid and UniCare sent the line as denied, we advise the State the line was not paid and provide a copy of the data sent. If we sent a denied line as paid, UniCare updates the file to reflect the correct information and sends a corrected file to the State.

If the line was paid, UniCare determines if the line was handled correctly based on the BMS Drug List and the WVREFR054_Drug Rebate Detail Report NDC crosswalk information loaded at the time the claim was processed. If we identify an error on our part, we perform a root cause analysis to determine if the line was paid incorrectly due to a system or human error. We work with the providers to process the line as it should have been handled originally. We submit the corrected information to the State and utilize the information from the root cause analysis to improve our processes.

If we receive a request from the State to assist with a manufacturer rebate dispute regarding a physician administered drug, we will use existing processes to research and assist the State with the rebate resolution. We will assist the State in resolving the dispute within 60 days of notification from BMS.

UniCare's Enhanced Process Based on Experience in West Virginia

We are actively working with the State on the NDC encounters rebate remediation project to reconcile disputes from historical encounter data, and will continue to assist and partner with the State on rebate resolutions. In addition, we have enhanced our processes to mitigate disputes and provide the State with the most up-to-date, valid physician administered drug encounter data for the pharmacy rebate program.

UniCare conducts educational meetings with all operations staff on the NDC process to assure

understanding of the rebate program, how claims should be processed, the use of BMS reports to determine NDC accuracy, and how front-end editing assists in fewer rejected claims.

Data Submitted by UniCare for Drug Rebate Collection

In accordance with 5.10.13 of Appendix 3, UniCare supplies the drug utilization data necessary for the collection of drug rebates to BMS via the 837 Claim Encounters files submitted weekly, as well as in the Proprietary Encounters file (known as Blue Box file report) submitted monthly. For each physician administered drug claim, we submit the HCPCS code, NDC number, NDC unit of measure, and NDC quantity for the physician administered medication. We also comply with the time frames to resubmit to BMS any incorrect monthly data file and to resolve encounter data rejections.

UniCare includes 340B modifiers in our claims utilization data submitted to the State for drugs subject to discounts under the 340B program. We require providers to submit a UD modifier for all claims billed for 340B drugs provided to the member. These codes enable the State to identify 340B claims and exclude them from manufacturer rebate invoicing as they are non-rebateable. We will report and validate our 340B drug cost claims data on the standardized template provided by BMS. Also, we will confirm that drug costs for 340B prescribed drugs do not exceed non-340B costs for the same drug, and will provide quarterly attestation that this verification has been completed.

Administering Pharmacy Rebate Programs for Outpatient Drugs

If the pharmacy program is carved in, we will use our Pharmacy Benefit Partner, IngenioRx, an experienced, affiliate Pharmacy Benefit Partner, to administer the pharmacy rebate program for outpatient drugs. IngenioRx manages the Medicaid pharmacy benefit for 17 of our affiliate health plans, and is responsible for assisting in the resolution of drug rebate disputes with manufacturers in those markets. As such, our Pharmacy Benefit Partner regularly assists and has experience in resolving drug rebate disputes

with manufacturers. It utilizes a well-established, experienced Drug Rebate Team that routinely handles rebate issues and knows the usual reasons for manufacturers to dispute drug rebate invoices, including questions about the quantity, formulary status, date of formulary status change, and validity of the submitted NDC.

- BA038 1 The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when medical service limitations are imposed.

Medical Necessity Review Process When Medical Service Limitations are Imposed (BA038)

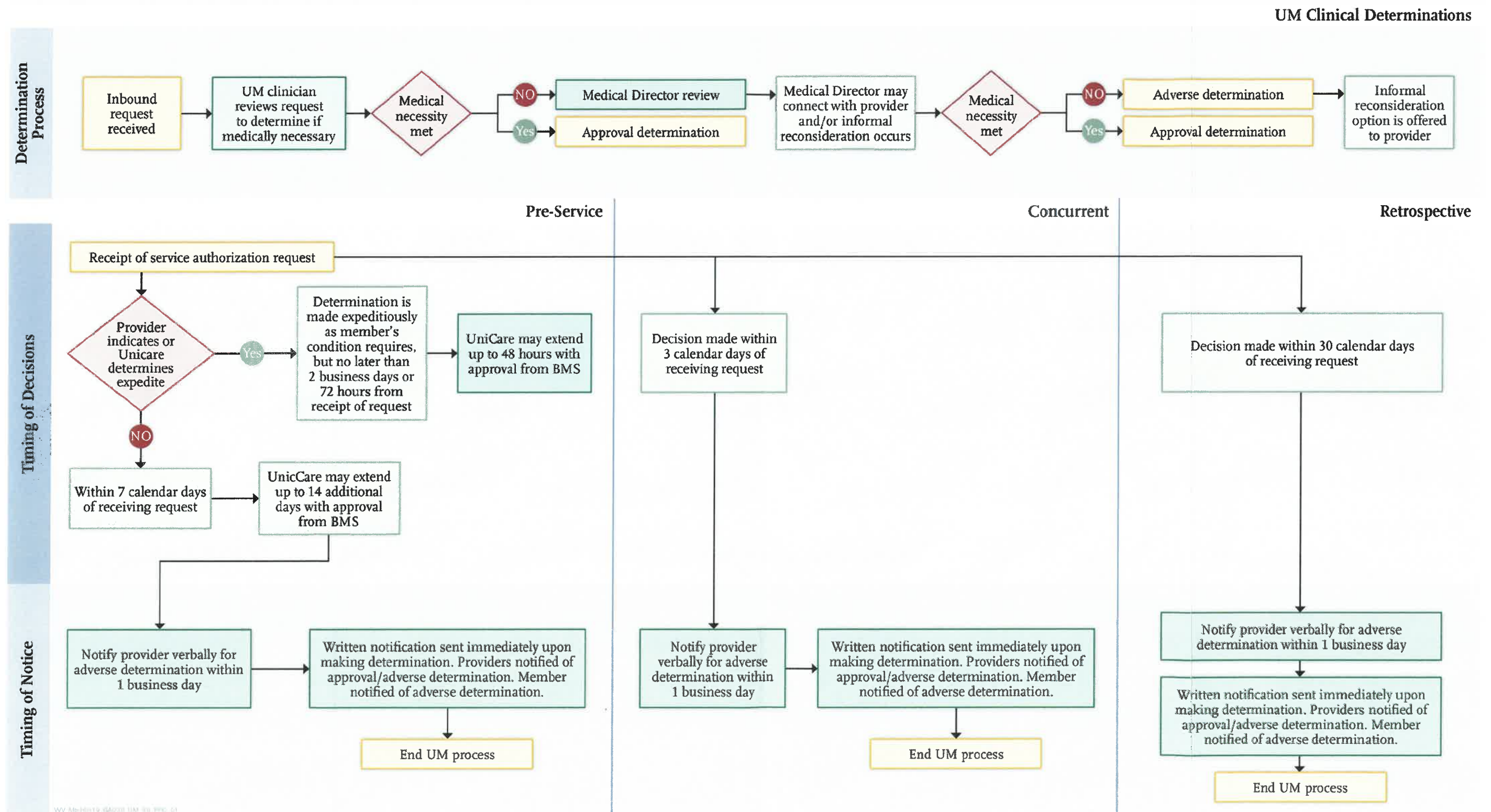
Our goal is to be a clinical resource, not a roadblock to members and providers when accessing medically necessary services and supports. *We do not impose any additional medical service limitations beyond those outlined in the SPA or by DHHR.* Our medical necessity review process assures each request is reviewed on a case-by-case basis, considering the specific needs of each member at the time of the request and in accordance with the FFS Medicaid Provider Manuals, Appendix A, the SPA and House Bill 2351 regarding electronic PA request submissions.

Our dedicated team of UM Clinicians reviews the request in a manner most expedited for the needs of the member, and within the required time frame for the request type – standard or expedited. UM Clinicians check whether the service is a covered benefit or subject to any limitations or exclusions. They work closely with the treating provider and our care management team to obtain minimum necessary clinical information to support quality and informed decision-making, and confirm that decisions consider all member needs and unique circumstances. As UM Clinicians review the request and information, they have access to our decision support system that includes our evidence-based medical necessity criteria. If the requested service is not a covered benefit, or if limitations or exclusions apply, a UM Clinician determines whether there should be a review for medical necessity EPSDT requirements. For example, we

track the service limitations for physical, occupational, speech, or chiropractic care and, using our UM authorizations protocols, we will only authorize services within those limitations. If a member or provider requests services beyond a service authorization limit, our UM Clinician evaluates the request based on medical necessity and the member's current clinical situation. We apply the appropriate guidelines to the services by approving or recommending care that is appropriate to the clinical needs of the members, not based on a service limitation or threshold. We disseminate changes in authorization requirements by immediately sending out provider notices, posting changes at the provider portal and member websites, and updating member and provider handbooks. In Figure 6.2-9, we provide a detailed flow of our clinical authorizations for medical necessity when service limitations are reached. We describe additional processes regarding EPSDT services in BA036.

Figure 6.2-9. Our Processes for Clinical Authorizations After Reaching Medical Service Limitation

UniCare Utilization Management: Clinical Determination and Timing of Service Authorization Decisions



Compliance with the Mental Health Parity and Addiction Equity Act

UniCare brings all our health care resources and experience to Medicaid members with mental health and substance use issues. Our PA processes, medical necessity criteria, network policy, and procedures are in compliance with the federal MHPAEA and 42 CFR Part 438 Subpart K. Criteria for medical necessity determinations for mental health and SUD benefits to any member, potential member, or provider are available on our website and by request, per 42 CFR 438.236(c) and 438.915(a). We adjust services and subcontractor relationships as needed to remain in compliance with parity reviews. We also participate in the Parity Governance Committee, which reports into the Medical Compliance Committee, as well as other clinical committees regarding overall parity compliance. Our ultimate parent company, Anthem, Inc.'s Parity Governance Committee activity supports our individual health plan efforts and gives us oversight and guidance in sustaining full compliance with the MHPAEA.

Our mental health and SUD benefits are comparable and applied on par with other medical and surgical benefits, both in- and out-of-network. We validate compliance with the MHPAEA for any benefits we offer to members beyond those specified by Medicaid in West Virginia. Medical necessity determinations for mental health or SUD benefits are available to any current or potential member on request. If there is ever a reason to deny coverage of mental health or SUD benefits, members are notified in writing of the explanation. Our UM team conducts systematic evaluations to make sure we maintain compliance with all facets of caring for members with mental health or SUD needs. UniCare is dedicated to the principle that mental health and substance use services should be provided at the most integrated level of care while assuring safety, effectiveness, and a focus on recovery and resiliency.

- BA039 1 The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when prescription limits are imposed.

Our Prescription Limited Medical Necessity Case Process (BA039)

In collaboration with our Pharmacy Benefit Partner, IngenioRx, UniCare has policies and procedures in place to allow member access to medically necessary drugs that, per Section 5.4 Service Authorization in Appendix 3, comply with State and federal laws governing authorization of health care services, including, but not limited to, West Virginia Code §33-25A-8s. Cases of medical necessity, including those with prescription (dosage, duration, or frequency) limits imposed, are reviewed on an individual case-by-case basis. No member is denied a medically necessary drug if clinical criteria is met, and there is no compromise to a member's health while awaiting a decision from UniCare.

Our approval process is based on clinical standards for the medication, recommended dosage, and the West Virginia fee schedule. We leverage the BMS Drug Code List and the monthly West Virginia Drug Rebate Detail Report to approve only those medically necessary drugs that are covered benefits. UniCare's goal is to help assure the clinically appropriate use of these physician administered drugs. *In 2019, nearly 2,000 physician administered drug PAs were decided in less than two days on average.*

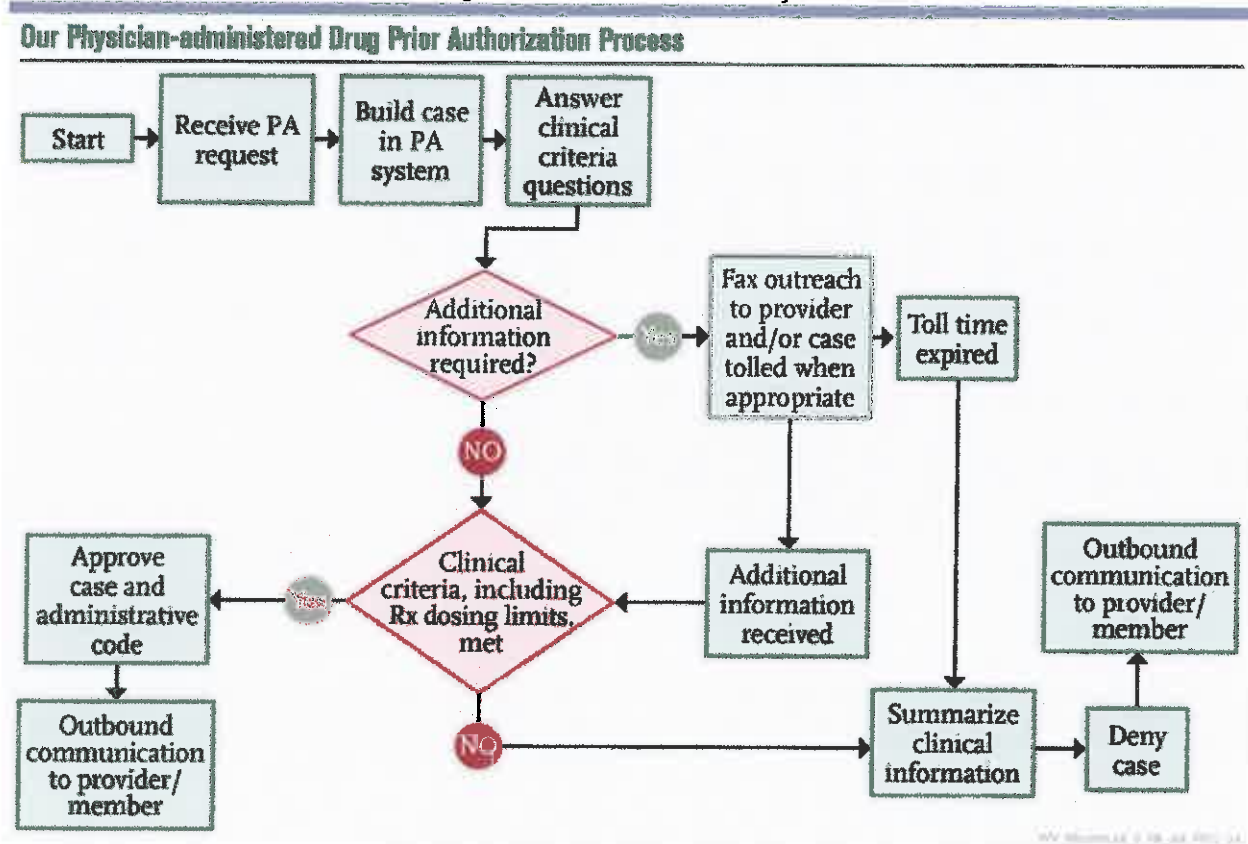
Our Member-focused Prior Authorization Decision Process

When a provider submits a request, IngenioRx's Customer Care Representatives create the case within the PA system and validate the member, physician, and servicing provider as well as the drug selection (including drug name and HCPCS code). Pharmacists conduct the clinical review using clinical policies, FDA indications, and dosing, as well as member-specific clinical information. They also review for any prescription limits based on the West Virginia fee schedule. Every request is reviewed by a pharmacist based on medical necessity for that individual member, using the clinical information submitted, to make sure decisions are clinically appropriate. Criteria for coverage and medical necessity decisions are clearly

documented and regularly updated based on reasonable medical evidence or a consensus of relevant health care professionals.

When the clinical criteria are met and the PA request is approved, the provider will receive an immediate fax, followed by the provider office approval letter. If the PA request is partially or fully denied because criteria or medical necessity is not met, including dosing that is not medically necessary, IngenioRx will contact the provider via fax and mail the official letter to the member and provider. The denial letter includes the specific reason for the denial and information on the peer-to-peer process, appeals procedure, and State Fair Hearing process. Our member-focused physician administered drug PA process is reflected in Figure 6.2-10.

Figure 6.2-10. Physician Administered Drug PA Process That Is Member-focused



To evaluate the PA review process, IngenioRx continuously monitors exceptions and applies IRR, based on nationally recognized criteria, to assess the consistency and accuracy with which clinical reviewers apply medical necessity criteria to PA decision-making.

Our Streamlined Prior Authorization Decision Timeline

IngenioRx provides the required written notices to providers and members within seven calendar days of receiving the request for a PA. When the provider indicates the standard timeframe for a PA decision could seriously jeopardize the member's life, health, or ability to attain, maintain, or regain maximum function, IngenioRx provides an expedited authorization no later than the shorter of two business days or three calendar days after receipt of the request. *In 2019, the average decision time for a physician administered PA was less than two days, with over 51% being decided in one day or less.*

The Importance of Prior Authorization in Continuity of Care

UniCare and IngenioRx understand the care of members should not be disrupted or interrupted, and they comply with continuity of care timeframes in accordance with Appendix 3, Section 5.4.1 Service Authorization Continuity of Care. UniCare also provides notice to providers at least 30 days prior to implementing changes to policies and procedures affecting the PA process.

Our Prior Authorization Process for Outpatient Drugs

If the State carves pharmacy back in, IngenioRx would follow a similar drug authorization process as previously described for outpatient drugs, leveraging the applicable Preferred Drug List (PDL) for any prescription limits and deciding the authorization within the required timeframe set forth by the State. IngenioRx would also implement processes to reduce provider administrative burdens, such as the implementation of autoPAs that use intelligent and automated logic at the point of sale to help bypass the need to submit a PA.

- BA040 1 The Vendor should describe its process for informing Primary Care Providers (PCPs) regarding changes in a member's behavioral health status including, but not limited to, the following:
- BA041 2 What constitutes a change in behavioral health status
- BA042 2 How the member will be assisted to access additional services as a result of a change in behavioral health status

Notifying PCPs of Changes in Member Behavioral Health Status

(BA040)

We communicate changes in the BH status of our members timely and efficiently to those involved in providing care, including the member's PCP, health home, or specialist who is serving as the PCP. We define changes in BH status to include events such as crisis calls, hospitalizations, ER visits, and changes in medication related to BH conditions. Health Insight, our care management system, offers access to member care plans and medical information from UniCare to keep PCPs, other treating providers, and Care Managers aware of changes in BH status that may affect care decisions or require follow-up. Our Care Manager reaches out to members upon discharge to follow up with any barriers and issues with discharge planning. During this discussion, the Care Manager also encourages the member to notify their PCP of the change in their treatment and circumstances. We will also work with members who may be seeing a specialist for BH services to notify the provider of a change.

In the event a member has a change in BH status, the PCP will receive notice through outreach from our UniCare staff. The PCP may also retrieve information from our Health Insight platform or during a care conference. Notifications regarding change of BH status comply with all applicable federal and State privacy laws (WV Code §27-3-1), including 42 CFR Part 2 rules for the Confidentiality of Substance Use Disorder Patient Records, promulgated by SAMHSA. We promote timely notification to PCPs in West Virginia MHT using monitoring of daily census reports by Care Managers, data from pending service



authorizations, pending discharge plans and dates, and alerts from the ER through PreManage — a data sharing solution being implemented by hospitals across West Virginia. Care Managers receive notifications through Health Insight alerts and conduct necessary post-discharge management or post-stabilization outreach needed in coordination with the member's PCP.

To support our goal of providing effective integrated care, we will leverage our Pharmacy Benefit Partner's Pharmacy Director to assist in reviewing overall medication utilization and changes and will report the findings to the member and provider. This role will be responsible for reviewing medication regimens, additions, or adjustments to assess potential drug-to-drug interactions or side effect implications. They will be available to answer questions regarding implications to current care plans.

Changes in Behavioral Health Status (BA041)

Our team uses data and monitoring to timely engage with members and providers in the event there is a change in the member's BH status. If providers use PreManage they may also see alert of a member's admission or change in treatment with proper consents. We actively monitor for the following changes which may constitute as a change in BH status:

- ER presentation resulting in an inpatient admission or initiation of services such as an overdose or suicide attempt
- Crisis call resulting in emergency services contacted
- Increases in level of care or services, such as an inpatient admission
- Change in living situation such as move or involvement (with DHHR approval, as applicable)
- Discharge from services or transfer to another level of care
- Non-adherence with BH medications (if pharmacy is carved in)
- Medical necessity denial for services

UniCare's care management model is supported by predictive analytics, risk stratification, and information-sharing to assure members receive the right level of services and appropriate support. We design our data and assessments to capture our member's whole-person physical health (PH) and BH needs, current and future, while emphasizing the impact of social, economic, and environmental influences on health outcomes. Our model stratifies members to match the appropriate intensity of care management support based on their health status, identified risks and needs, and the use of health care resources.

We recognize a member's health status may be highly fluid and close monitoring, communication, and collaboration are essential to identifying changing needs. Care Managers may also identify member's changing BH status through scheduled and as-needed outreach and completion of key activities, including reassessment and ongoing review of available member-specific information. Our Health Insight platform integrates care plans and claims data, enabling our Care Managers to receive continuous updates on claims activity and service authorizations. This includes:

- Inpatient census and ER reports
- Monthly risk stratification data
- Under- and over-utilization and gaps in care data

Care Managers work across systems and teams to obtain up-to-date information from a variety of sources, including the PCP and specialty providers. They review claims data, service authorizations and denials, call logs, newly completed screenings and assessments, updated care plans, progress summary notes, and other information as it becomes available, to identify any items of concern. Throughout our clinical process, we communicate with all treating providers, maintaining applicable HIPAA and 42 CFR part 2 privacy, to offer regular status updates on the member's stratification level, changes in health status, and contact frequency.

Supporting Members to Access Additional Services During a Change in Behavioral Health Status (BA042)

Care Managers are available to assist members and caregivers whenever their needs change significantly, as identified in BA041, notification of admissions, changes in placement, ER visits, or when the member needs crisis stabilization. Our Care Managers follow up to support any members who have contacted us via the BH Hotline to determine if there is need for additional services. As part of our continued stay review processes during episodes of treatment, we engage our Care Managers to identify any additional needs that the member may have during the change or if there is a transition — for example after an inpatient stay. After assessing the member's needs since the change in BH status, our Care Managers update existing care plans based upon the member's identified needs and selected interventions to address any new issues or concerns. For example, members presenting to the ER as a result of overdose may be offered Peer Support Specialists. Care Managers may also help members to identify community supports and services, helping to clear barriers to help members live their best lives. This is especially important for persons with both medical and behavioral comorbidities and diagnoses, who may be facing additional external factors that limit their access to care. We may use our Community Resource Link to connect the member with necessary SDOH or BH resources or programs in the community. This easy-to-use online tool helps members find locally available supplemental supports and services of which they may not be aware. It includes an internal component that links directly to Health Insight, which enables our teams to track the resources members seek and use most. This helps our Care Managers recommend resources and supports that our members find the most useful, such as supports for housing, utilities, bullying and suicide prevention, back to school resources, drug and alcohol resources, and resources to help members quit vaping or smoking.

Members sometimes have needs that cannot be met through our existing provider network or are not a covered service. To help these members remain in the community, we engage all existing community resources to provide solutions. Because UniCare Care Managers know the local area, they access community supports and actively engage community-based organizations, advocacy groups, faith-based organizations, and other community resources to develop creative solutions for services necessary to promote member independence and achievement of their individualized goals. By increasing awareness of community supports and services, we promote self-management, personal responsibility, and community engagement.

- BA043 1 The Vendor should describe its coordination of care activities between Primary Care Providers (PCPs) and children's dental providers, especially for children with special health care needs (CSHCN).

Coordination of Care Activities with PCPs and Children's Dental

Providers (BA043)



Dental and oral health care are areas of significant health disparities for individuals, in particular for children. These disparities are particularly concerning because individuals who are medically compromised such as CSHCN are at greater risk for oral diseases, which can further jeopardize their health. UniCare understands the importance of providing comprehensive oral health care to improve the overall health need of West Virginia MHT members who are children, aligning with the State's goals. It is with this in mind we have made the decision to bring the key staff role of Dental Director to our health plan. We will not be using a subcontractor to fill this role. Our Dental Director will work closely with our Medical Director and Behavioral Health Medical Director to increase access to comprehensive dental care. We believe adding dental services into this focus gets us even closer to our vision of whole-person care.

We prioritize outreach and collaboration among providers, children's dental providers, adult dental providers, caregivers, members, families, and our UniCare care management and population health teams to optimize health outcomes for our members. We encourage all providers, but particularly our PCPs and specialists designated as PCPs, to play an active role in helping members receive appropriate dental care through data sharing and coordination with our children's dental providers. Through our relationship with SKYGEN, UniCare will continue to meet contract requirements by providing dental services to members including for CSHCN and in accordance with the recommended SPA and EPSDT screening guidelines. SKYGEN established and continues to maintain a broad network of dental providers, with approximately 700 unique providers across the West Virginia MHT networks. While we coordinate dental care needs for members, our subcontractor SKYGEN is responsible for the benefits administration of dental services to members. SKYGEN contracts with local West Virginia dental providers and completes necessary authorizations, provides quality of care oversight, processes dental claims, and conducts all dental network communication and provider education. Our Dental Director will play a critical role in utilization review of dental decisions and the oversight of the clinical algorithms used to determine dental authorizations. SKYGEN offers customized reporting to help dentists and UniCare staff identify members who are at increased risk, have care gaps, and members who may require a more intensive focus on prevention and educational resources. We incorporate dental utilization into Health Insight to incorporate into the member's personal health record and available to treating providers.

Delivering Integrated Care

UniCare supports the delivery of whole-person care by encouraging and educating our medical, behavioral, and dental providers about missed opportunities for collaboration, communication, or coordination.

Engaging and Training Providers to Meet the Dental Needs of Children

To optimize dental care for West Virginia MHT members, our QM, Care Management, and Population Health teams work collaboratively with our Dental Director and SKYGEN to oversee our comprehensive oral health strategy as part of our population health management program. *Our strategy aligns with West*

Virginia's goal to enhance coordinated care across the delivery system through member and community engagement. Using a multidisciplinary, collaborative approach, our care management and population health teams, members, PCPs, specialists, and dental providers — including pediatric dentistry and dental providers who can meet the needs of CSHCN — assure effective coordination of dental care as part of the member's whole-person needs. This will include supporting care management to solve for barriers, such as accessing specialty care and working with DHHR and the WV Dental Association to develop strategies on how to improve cross-system care coordination and support the Oral Health Program goal to promote and improve the oral health of all West Virginians. UniCare meets monthly with SKYGEN during which we review the Performance Indicator report, which provides a comprehensive view of all the metrics in a dashboard format to determine where we meet our goals such as increasing access, closing care gaps, and improving Annual Dental Visit HEDIS rates. We track current progress to goals and identify improvement opportunities based on these metrics and trends. We also review available member complaints and grievances and as we identify concerns or issues, such as lack of information-sharing between providers, we work together with all involved providers to eliminate any barriers.

Informing PCPs of Upcoming or Missed Annual Dental Visits

Our UniCare QM team sends gaps in care reports to PCPs, which includes upcoming dental screenings. Our field-based Patient Centered Care Consultants (PC3s) further support PCPs by walking them through these care opportunities, assisting providers and members in making appointments, or engaging our Care Management staff to work with the PCP to help address any barriers to care for the member such as the need for sedation or transportation. We train PCPs on current wellness and screening schedules, in accordance with EPSDT periodicity schedules, both initially and through ongoing outreach such as through provider-facing interactions with PC3s, in newsletters, and described on our provider portal and website about:

- Providing direct referrals to dentists for babies within six months of their first tooth eruption and no later than 12 months of age
- Encouraging regular, six-month checkups
- Working closely with Care Managers when new members enter West Virginia MHT to identify continuity of care issues or necessary dental care and screenings

Understanding oral health is essential to general health and well-being, UniCare commits to continued partnerships with the State, dental providers, children's dental providers, and PCPs, to improve the oral health of West Virginia MHT members.

Providing Dental Care to Children with Special Health Care Needs

UniCare's Care Managers support the identification of strategies and interventions to support access to and delivery of dental care for CSHCN. Care Managers will collaborate with the member's multidisciplinary care team to develop accommodation strategies such as language assistance, accessible dental chairs, autism or spectrum disorder support, or strategies to reduce anxiety to facilitate access to pediatric dental care. *UniCare has partnered with Family Voices in order to inform our care management strategies to better meet the SHCN of children with disabilities.* Family Voices is a national family-led organization of families and friends of CSHCN and disabilities. We connect a network of family organizations across the United States that provide support to families of CSHCN and promote partnerships with families at all levels of health care — both individual and policy decision-making levels — to improve health care services and policies for children.

In some cases, members and children may have special needs that preclude them from accessing dental services without additional support, such as:

- BH challenges

- Language and communication barriers
- Sensory impairments, such as vision or hearing issues
- Psychosocial issues, such as low oral health literacy, dental anxiety, and past negative dental experiences

Expanding Access to Special Needs Dental Care

We support expanded dental access and education for members with special needs. In 2019, our Anthem Foundation provided support for dental treatment for individuals with disabilities and individuals that are medically fragile by making a national grant to the National Foundation for Dentistry for the Handicapped.

SKYGEN maintains information on whether its dental providers serve members with disabilities or special needs. *Currently, more than*

one-third, 251 out of 667, of SKYGEN's West Virginia providers indicate they can provide services to members with special needs. SKYGEN also has the ability to offer on-site services when UniCare members cannot receive care in a traditional office setting, although the range of services that can be provided may be limited by the equipment that can be transported. In the majority of cases, however, we expect to make arrangements with inpatient and outpatient facilities, as necessary, to accommodate West Virginia MHT members including CSHCN. We support expanding dental access and education for members with special needs.

Coordinating Dental Care for Children

Improved provider to provider communication, system navigation, and collaboration is essential to fully integrate care by addressing cultural or SDOH barriers such as language, health literacy, or transportation.

To optimize dental care for West Virginia MHT members including CSHCN, our interdisciplinary team oversees our comprehensive oral health strategy including working with our Care Management, QM, and Network Development teams, providers, dental providers, and pediatric dental providers.

We seek to identify gaps or needs a child may have related to oral health at the time of enrollment through new member welcome calls and initial screening, because we know access to timely and comprehensive oral health care plays an integral role in helping members achieve overall health and well-being. UniCare

leverages SKYGEN’s clinical expertise and pioneering technology, to provide West Virginia MHT members with access to dental services, including those designed for prevention and for engaging members to take an active role in oral health care. To engage members, we coordinate dental care for children using strategies such as:

Encouraging Annual Dental Visits

To encourage preventive care screenings, we developed a new member incentive — \$25 for children and adolescent members completing an annual dental visit.

- Contacting new members to identify needs, including dental needs, and providing resources and support as needed
- Analyzing gaps in care reports and contacting members in need of dental services through text messages, calls, and mailings and using mobile dentistry to participate and host community events for dental screenings
- Encouraging routine dental care during interactions with children and during face-to-face visits with members by our community-based care management team, including CPs and CHWs, and our Peer Support Specialists, for members with gaps in care or a history of using the ER including for dental needs
- Locating dentists that meet the child’s needs and scheduling appointments or transportation as needed
- Offering outreach and education events throughout West Virginia to encourage appropriate dental hygiene and preventive care

When members do not receive appropriate preventive care, we implement several strategies designed to understand and remediate, if applicable, barriers to care. Care Managers contact members or their caregivers to understand why care has not been accessed. Typical barriers might include lack of transportation, inability to take a member for an appointment because of a caregiver’s work schedule, or lengthy wait times for appointments. Depending on the barrier to dental care, Care Managers, with assistance from Population Health staff, will use different remediation strategies specific to the identified

barrier, such as finding alternative transportation, identifying providers with extended hours, scheduling appointments, or finding alternative providers.

Working with PCPs to Complete Preventive Care Screenings

While our PCPs and dental providers each play roles in initiating and reminding members and caregivers about annual prevention and dental screenings, UniCare and SKYGEN support these efforts with health promotion strategies. We follow the schedule and guidelines for pediatric preventive screenings using the most recent recommendations and established standards of the American Academy of Pediatric Dentistry, Bright Futures, and CMS. UniCare, PCPs, and dental providers are encouraged to initiate and remind members and caregivers about dental screenings. We include additional information about our preventive care in BA046. UniCare and SKYGEN have focused significant attention on prevention of oral disease and screenings. *Our HEDIS scores for dental visits showed a 2.4% overall rate improvement between 2017 and 2019 as a result of focused efforts to improve member participation.*

- BA044 1 The Vendor should describe its mechanisms to remind members of upcoming appointments, including, but not limited to, the following:
- BA045 2 Medical Appointments and Screenings
- BA046 2 Dental Appointments and Screenings, including monitoring utilization and interventions if a member has not had a screening in over one year
- BA047 2 Adherence to the periodicity schedule as dictated by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, as indicated by the Centers for Medicare & Medicaid Services (CMS) at <https://www.medicare.gov/medicaid/benefits/epsdt/index.html>

Mechanisms to Facilitate Appointments and Screenings (BA044)

In partnership with PCPs and dental providers, UniCare helps remind members of medical, dental, and EPSDT-related screenings and appointments. We have instituted specialized outreach tools, such as reminder calls and texts, when permitted, to members or caregivers about upcoming appointments and screenings, as well as assistance with appointment scheduling and transportation. We will also begin sending outreach emails in 2020 with member permission. UniCare resources, such as the Population

Health Team, will assist providers and members through regular reminders, monitoring, and providing supports as needed. This wraparound approach complements appointment reminders that providers send to members, which are supported by our care opportunity reports identifying care gaps. Table 6.2-6 summarizes activities UniCare takes to promote medical, EPSDT (HealthCheck), and dental appointments, in partnership with providers.

Table 6.2-6. Promoting Screenings and Completing Appointments

Responsibility	Care Manager	Population Health Team	QM Team	PCP	Dental Provider
Assist members in selecting medical and dental providers	X	X			
Initiate HealthCheck screening on schedule for babies	X	X		X	
Assist members in scheduling initial appointment or follow-up visit	X	X	X	X	X
Assist members with transportation to checkups	X	X			
Send reminders of HealthCheck screenings and regular checkups	X	X	X	X	X
Reinforce message about regular checkups	X	X	X	X	X
Identify continuity of care needs for new members	X	X		X	

Reminders of Medical Appointments and Screenings (BA045)

Outbound Calls and Texts. UniCare's outbound call campaign targets both adults and caregivers of children who are missing recommended services and appointments, resulting in new appointments and closing of care gaps. We use a text messaging service to send reminders about the need to see a provider for preventive services and the availability of member incentives for some activities. Members can text back to receive further details on transportation, the 24/7 Nurse Line, and other supports.

Care Management. For those engaged in care management, our Health Insight platform will alert Care Managers when a member is due for or has missed preventive screenings and services. A Care Manager conducts outreach and helps the

Successful Outreach Promoting Appointments and Closing Gaps

Our outbound Medicaid Member Call Center team made more than 8,000 live calls to UniCare members in the second half of 2019, focusing on childhood preventive care, asthma medication management, women's health, and diabetes. This outreach generated more than 300 new appointments completed and 560 care gaps closed.

member address barriers – for example, helping to choose an appropriate provider, make the appointment, or arrange transportation. In addition, our Population Health Team, including Community Navigators, can make in-person home visits and telephonic support to assist with PCP appointment scheduling, provide education about needed screenings, and help remove barriers to close gaps in care. We also provide

Reminders to Pregnant Members

My Advocate™ sends pregnant women reminders of prenatal screenings and what to expect at each appointment, and also stresses the importance of oral health for babies.

members with self-management support tools, such as My Advocate™ for pregnant members.

We know members transitioning from hospitals are at increased risk for poor health outcomes. In accordance with the evidence-based Coleman Care Transition model and other best practices, our care management team has specific protocols to monitor and see that follow-up appointments after hospitalizations are scheduled and attended by members. Our on-site, community-based Care Managers have had particular success engaging members in facilities. Our HOPE Program, an intensive, field-based care management program targeting our most vulnerable population, has achieved an 80% engagement rate with Care Managers who meet hospitalized members face-to-face. Such engagement promotes making and keeping post-discharge appointments.

Reminders of Dental Appointments and Screenings (BA046)

UniCare has been effectively facilitating and tracking covered dental services in West Virginia through our dental vendor, SKYGEN. We will continue to promote covered dental screenings, referrals, and treatment to members eligible for EPSDT according to the SPA, Article III, Section 1.2.

UniCare recognizes dental disease as the most common chronic childhood disease and understands the importance of access to dental providers and services. Our QM team works directly with our Dental Director to identify members with care gaps for targeted outreach. We notify members and caregivers prior to their birthdays to schedule their dental visit, and we follow up through a phone call or mailer with those who miss this preventive milestone.



UniCare also helps to meet dental needs in underserved areas through a mobile sealant program in school-based dental clinics, community events, and coordination with Head Start. Our engagement team holds approximately 50 oral health-focused events across West Virginia each year, in addition to providing oral health tips at several community health events.

Our partner SKYGEN has the capability to identify when dental screenings for EPSDT members have been missed – including if the member has not had a screening in over a year. We will work with the Dental Liaison to develop an educational campaign for members with overdue screenings, including reminders and targeted outreach for members with clinical complexity. Our multiple strategies to promote dental screenings and treatment have helped improve our HEDIS and CMS Core Measure scores between HEDIS reporting years 2018 and 2019:

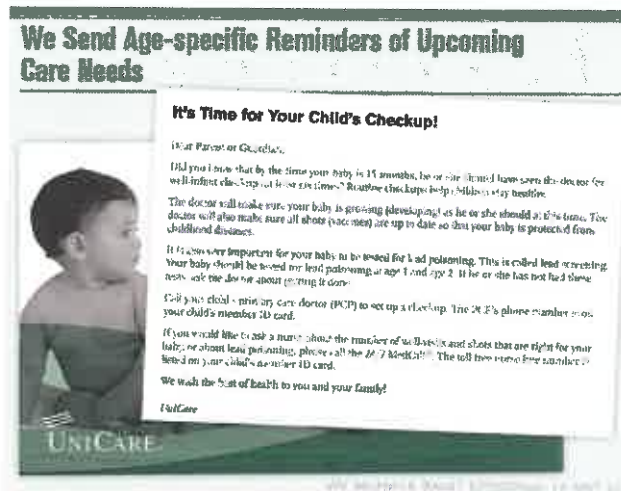
- Percent of eligible members who received dental services increased by 4.7%
- Annual dental visits for two- and three-year-olds increased by 3.3%
- Dental sealants for six- to nine-year-olds increased by 52.9%

Assuring Adherence to EPSDT Schedule (BA047)

UniCare's EPSDT Program is committed to building healthy habits through appropriate screening and preventive care, as detailed in BA036. We follow the schedule and guidelines for pediatric preventive screenings using the most recent recommendations and established standards of the AAP, Bright Futures, and CMS. In addition to the activities described in BA044 and BA045, including calls, texts, emails, and Healthy Rewards Program incentives payments for completing well-child visits, immunizations, and dental visits, the following outreach and supports are targeted to our HealthCheck members and their EPSDT certified providers.

Birthday Reminders. We send EPSDT birthday cards reminding caregivers of upcoming screenings and care needs. An example is provided in Figure 6.2-11. We also use our HealthCrowd text messaging service to send EPSDT service preventive reminders. In 2018, UniCare made more than 84,000 contacts about EPSDT service needs via text to its members. As a complement to our ongoing care coordination outreach for EPSDT, we will make automated IVR calls with the member's or caregiver's option to speak with a live agent to assist with appointment and transportation scheduling.

Figure 6.2-11. We Send Reminders for Upcoming Care Needs



Overdue Reminders to Members and Providers. We send overdue postcard reminders to members who are behind on receiving EPSDT services within 90 days of a missed visit. The postcard reminds the member and caregivers the child is past due for a checkup, and encourages them to schedule an appointment with their EPSDT certified PCP. UniCare also sends a monthly mailing reminding providers of the importance of EPSDT services with a list of members on their panel who are overdue for EPSDT services.

Partnering with Providers. We print and distribute the EPSDT Periodicity Schedule to provider offices, and are developing a new web-based EPSDT training to providers. Our Clinical Quality Program Consultants enhance these education efforts during office visits and other interactions to foster awareness of EPSDT requirements and how the office staff can effectively use our care opportunity reports to contact members to make appointments. For CSHCN receiving primary care from a specialist who is not accustomed to providing or billing for EPSDT services, we will target relevant education to these specialists in 2020 and assist with referrals to assure appropriate screenings are completed.

Monitoring and Improving EPSDT Adherence. Our QM team provides overall management of the EPSDT reminder system processes for members and providers, as well as reporting on EPSDT performance. In 2019, UniCare was the highest scoring Medicaid health plan in West Virginia in the following EPSDT-related measures: Annual Dental Visit; Adolescent Well-Care Visit; Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life; Childhood Immunization Status – Combo 3; Immunizations for Adolescents – Combo 2. We have achieved significant improvements, and plan to initiate an EPSDT Performance Improvement Project at the start of this Contract.

Achieving Improvements in Prevention and Well Care Visits

Measures that improved more than 5% over three years (2016–2019) include:

- Adolescent Well Care Visit (14.98% increase)
- HPV Vaccine for Female Adolescents (14.14% increase)
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents — Activity (11.30%), BMI (8.78%), Nutrition (5.86%)

WV, 2016-2019, EPSDT, Well-Child Visits, Combo 3

3. Care Management

- CM001 1 The Vendor should describe its Care Management program, including, but not limited to, the following:
- CM002 2 Processes to organize its care management department by disease or problem type
- CM003 2 Processes to identify members for participation in the care management program, including screening and timeliness of enrollment, risk levels/tiers, Social Determinants of Health (SDOH)
- CM004 2 Processes and timeframes for assigning members to a care manager
- CM005 2 Processes for identifying candidates for care management, or those receiving high-cost care, who would benefit from care management
- CM006 2 Processes for how care managers will establish relationships with members, including frequency and timeliness standards after the initial health assessment
- CM007 2 Processes to ensure that members who have specialists as Primary Care Providers (PCPs) are receiving primary care services on an ongoing basis, and interventions if adequate services are not being provided
- CM008 2 Processes to ensure continuity and coordination of care
- CM009 2 Processes to identify pregnant women at enrollment and on an ongoing basis
- CM010 2 Processes to promote "early and often" prenatal care for women identified as being pregnant
- CM011 2 Processes for Supplemental Security Income (SSI) members, if different
- CM012 2 Processes for administering care management for both adults and children
- CM013 2 Processes for administering care management for members with special health care needs, defined as individuals with complex or serious medical conditions
- CM014 2 Processes for administering care management for children with special health care needs (CSHCN)

UniCare's Care Management Program (CM001)

UniCare's integrated care management program is an integral part of our population health management approach. We align our team's passion and the State's priorities in supporting our members across the continuum of care and partnering with communities to meet the needs of the population. With UniCare's 17 years of service in West Virginia, we excel at person-centered, evidence-based clinical care management and population health programming. Our care management program is led by our Director Integrated Care Management, Vicky Gallaher, a certified Care Manager and leader with population health experience spanning 19 years serving West Virginia in the care delivery system.

Experience Matters

Vicky Gallaher, RN-BSN
Director Integrated Care Management



Vicky brings almost two decades of experience and is responsible for our integrated care management team which is organized to maximize collaborative efforts between medical, pharmacy, dental, and Population Health Management functional areas.

Vicky will be accountable for strategy and operational excellence for UniCare's care management program and will oversee the Care Management and Utilization Management (UM) teams. She will work in tandem with our Population Health Director to assure we meet the whole-person health needs of our members and the needs of our community.

Interdisciplinary Team Cares for the Whole Person

In 2019, UniCare's Interdisciplinary Care Management teams co-managed 3,282 members presenting with BH and PH conditions and SDOH needs.

Our care management model is fully integrated, including psychosocial, physical, behavioral, social and oral health. Our Care Management team members are interdisciplinary, trained in management of comorbid conditions, and supported by our UM, Quality Management (QM), and community outreach teams, with *staff in every corner of West Virginia*.

Care Management Program Processes

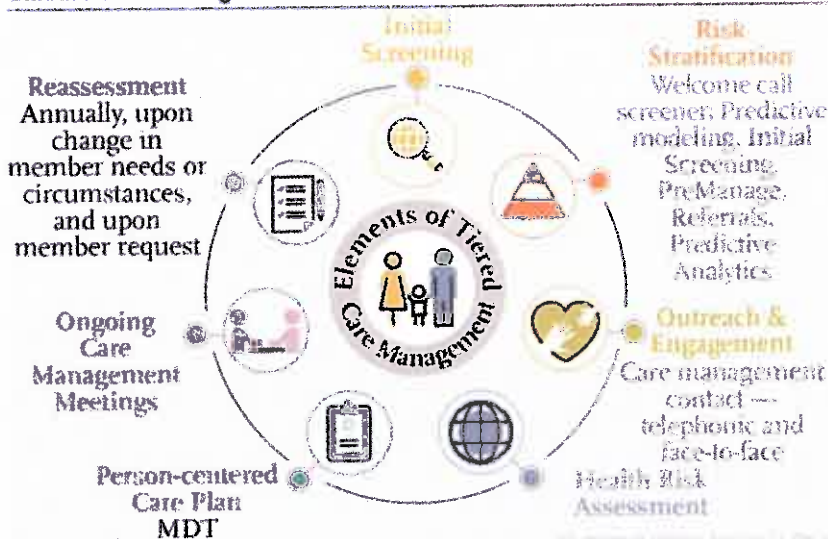
Based on Care Management Society of America (CMSA) standards, UniCare's care management processes, illustrated in Figure 6.3-1, use member screening and assessment results, predictive modeling, and risk stratification to identify the appropriate tiers of intervention for each member's individualized needs. *Elements of the integrated*

care management process are highlighted throughout this section of this proposal, marked by icons that align with Figure 6.3-1.

Using the best practices of trauma-informed care, grounded in recovery and resiliency, and reflecting person-centered principles and cultural

Figure 6.3-1. Our Care Management Processes Are Data-driven

UniCare Care Management Processes



competencies, our Care Management team is positioned to help deliver the right care, in the right place, at the right time. Members are matched to a Care Manager with the training and licensure that best meets their needs and serves as a single point of contact for that member, with access to resources across our care team. *We reduce fragmentation of care with a single, integrated, and person-centered treatment (care) plan for each member enrolled in care management.* Led by an Integrated Care Manager, with support from our interdisciplinary team (IDT) of clinicians across our organization, person-centered care plans are developed and implemented, and monitored with adjustments through ongoing care management meetings and annual reassessments.

Technology Is Central to Our Care Management Processes

Health Insight aggregates and pushes actionable data across UniCare departments, promoting effective, efficient, and collaborative care management – particularly for complex, high-risk individuals with special needs. *Health Insight helps to connect the member's multidisciplinary team — including those external to UniCare — and facilitate information-sharing and collaboration.* Our staff and the member's providers can access a member's history and needs, including

Health Insight

UniCare's integrated care management platform, Health Insight, provides a holistic view of the member's whole-person needs — supporting our staff with the tools and functionality to support the delivery of high-quality care and coordination of covered services. This allows for direct care of physical, behavioral, and social services and supports timely communication between all Care Management team members, as well as providers and the members.

PreManage Helps Identify Members for Care Management

Leveraging current and historical member utilization data available in PreManage, we can quickly identify:

- New members with high-risk factors
- Members with current health care needs
- Members who may be likely to develop chronic conditions

PreManage is used in concert with other UniCare tools.

all physical, behavioral, lab, pharmacy, and identified social needs. Our care management operations are built on evidence-based models and data-driven practices, incorporating medical and non-medical factors into predictive analytics, dashboards and monitoring, care gap identification, UM trending, and addressing potential preventable events (PPEs). *Our team uses PreManage, a data sharing solution, to*

develop customized reporting that affords us a timely and early opportunity to identify members for targeted clinical interventions to help manage conditions and assure appropriate utilization.

UniCare's Care Management Program Works

Our community-based care management program has an exceptionally high member engagement rate, and has improved patient outcomes, reduced costs, and achieved high member satisfaction.

- As of October 2019, our care management engagement success rate with community-based team members is 97%.
- Members with behavioral health needs who are co-managed in our integrated care management program have yielded estimated savings of \$340 per member per month due to improved condition management and appropriate utilization.
- In 2018, 96% of members surveyed indicated their Care Manager knew about their needs, provided essential information, and helped them access needed care.

Care Management Department Organization (CM002)

UniCare offers a multitude of programs within our integrated care management program to address a member's individual needs. Our interventions include wellness and prevention; nine NCQA accredited condition-specific, disease management programs; and our tiered, integrated care management program, which is organized into three risk tiers of intervention supports based on member disease, problem and complexity. Our program focuses on improving member health outcomes with an emphasis on West Virginia health priorities, such as diabetes, cardiovascular disease, maternal health, depression, oral health, and substance use disorder (SUD). Members are identified and linked to the appropriate program supports based on our proprietary predictive analytics and clinical risk stratification.

Our care management program foundation includes a “Community Well” level of supports focused on wellness and prevention, available to all members. These supports are presented in Figure 6.3-2.

Figure 6.3-2. All UniCare Members Receive Wellness and Prevention Supports

Care Management Supports for All UniCare Members	
Community Well: Wellness and Prevention	Supports Provided ▪ Care coordination services, including SDOH navigation and health literacy needs ▪ Assistance in navigating the health care system ▪ Education on available benefits ▪ Online Well-being program ▪ My Wellness Guide ▪ Disease-specific education ▪ UniCare community engagement team events, including Baby Showers and Clinic Days ▪ Social media health information
	▪ On-demand telehealth via a computer, tablet, or smartphone ▪ 24/7 Nurse Line and BH Hotline ▪ Enrollee (Member) Call Center ▪ Healthy Rewards member incentive program ▪ Health Education A-Z ▪ Community Resource Link ▪ Value-Added Services ▪ Electronic health record

The care management department is organized cross-functionally, integrating physical, behavioral, and oral health, and social support services in close collaboration with UM and population health teams.



We employ Integrated Care Managers as well as Specialized Care Managers for members with conditions or circumstances such as Children with Special Healthcare Needs (CSHCN), high-risk OB, and post-discharge. Our disease management program — focused on particular conditions — serves as an adjunct to integrated care management. All Care Managers focus on “whole-person” health and are supported by an IDT of licensed and non-licensed professionals dedicated to meeting the needs of our members. Care Managers conduct daily rounds that include Care Management and UM clinicians, team leads, our Director of Integrated Care Management, Medical Management Director, and Medical Directors. Based on the results of the health risk assessment (HRA), Care Managers work in collaboration with members, their caregivers, and providers to identify the care management risk tier and needed supports, including the frequency of care management meetings and identification of the multidisciplinary team in the development and ongoing review of care plans.

Figure 6.3-3 describes the stratification criteria, including disease or problem, and supports provided to members for each of the three tiers — Low, Medium and High-risk.

Figure 6.3-3. Care Management Risk Stratification Tiers Organized by Complexity, Diseases, and Problem

Disease, Problem, and Stratification Criteria

Tier 3: High Risk	Stratification Criteria	- Children and adults with SHCN, with abuse and/or trauma histories, with significant SDOH needs, or with other complex diagnoses - Individuals with multiple complex, comorbid conditions - Pregnant women with historical/current use of substances or high-risk pregnancy - Infants with NAS and/or in NICU - Adults and adolescents who are experiencing homelessness or have a history of residential instability	- Adults with serious mental illness and children with serious emotional disturbances - Transplant candidates - Individuals with HIV/AIDS, cancer, chronic renal failure, sickle cell disease, and other chronic complex conditions - Individuals transitioning from a nursing facility, a SUD facility, or experiencing other complex transitions
	Supports Provided	- Intensive care management to support clinical care and SDOH needs, including face-to-face support from a community-based Care Manager and/or CHW/Community Paramedic/peer support - Completion of health risk assessment and creation of a person-centered care plan within 30 days - MDT meetings at least monthly (or as required in their care plan) in the member's preferred setting	- Daily, weekly, or monthly integrated care management rounds as needed - Reassessment upon change in enrollee condition or request of the member, or member of MDT - Monthly updates to the care plan
Tier 2: Medium Risk	Stratification Criteria	- Clinically complex members with manageable conditions and high risk of higher than average future medical costs and lower likelihood of imminent inpatient admission - Identified gaps in care	- Historical patterns of inpatient and outpatient utilization and admission - Member identified needs, including SDOH needs - Referrals
	Supports Provided	- Short-term care management to support clinical care and SDOH needs, including face-to-face supports - Completion of health risk assessment and creation of an individualized care plan within 30 days - Monthly MDT meetings, care plan updates, and reassessment as indicated - Monthly care management meetings - Health coaching	- Referrals to community resources and supports, including caregiver supports - Assistance to obtain needed care (such as durable medical equipment or testing strips) - Coordination of services, including VAS, community services, and social supports - Integrated weekly rounds - Pharmacy access and medication adherence supports
Tier 1: Low Risk	Stratification Criteria	- Members with manageable conditions and moderate to low risk of high future medical costs - Members with no clinically manageable conditions evidenced in up to the last 12 months of eligibility with the plan	- Members not accessing preventive care in previous 12 months - Members identified through health education campaigns for targeted outreach
	Supports Provided	- Targeted health education - Preventive service reminders - Taking Care of Baby and Me®	- On-demand health education - Peer and integrated case rounds - Personal health record - Tobacco prevention and cessation

Identifying Members for Care Management (CM003)

The process of identifying members who may benefit from care management begins immediately upon enrollment. Through an electronic notification from our predictive modeling tools or through other means, we identify these members and assign them to a lead Care Manager whose expertise best supports the members' primary condition. We assign an initial risk tier to each member based on our review of enrollment data and results of the initial health assessment (initial screening). This initial risk tier informs our prioritization of outreach. We make a first outreach attempt as soon as possible, within 5 days for members based on initial risk tier of medium (2) and high-risk (3), and within 3 days for members in need of post-transition management. The care management risk tier drives the intensity of care management. As members' needs change, they may move in and out of specific care management risk tiers, but will remain assigned to a single Care Manager while engaged. This helps reduce fragmentation and offers seamless continuity of care.

UniCare uses five key data sources to identify members who may benefit from care management:

- *The State's enrollment file supplemented with real-time member utilization data* from PreManage
- *Initial screening, including SDOH questions*, following identification at initial enrollment
- *Predictive data analytics* using historical member utilization as available
- *UM data mining* for existing authorizations
- *Referrals* from providers and agencies, internal staff, and member self-referral

Initial Screening



Our care management processes include the elements presented in section CM001 and begin with an initial screening. This is one of the first ways we identify and engage members in care management, especially those members with Special Health Care Needs (SHCN). We use multiple strategies to conduct an initial screening of each member's health care needs within 90 calendar days of the effective date of health plan enrollment for all new enrollees, described in our response to question MS006.

Capturing Social Determinants of Health

UniCare leverages SDOH data in our care management and UM processes, gathering information about members' SDOH needs and resources during screening, assessment, and outreach. We capture SDOH data through provider claims, ICD-10 codes, new enrollee welcome calls, initial screenings, and interactions with our community-based team(s). This data include members' educational levels, health literacy, transportation needs, housing security, physical safety, and access to food, utilities, clothing, childcare, phones, and household needs. *We recently updated our initial screening tool to incorporate additional SDOH questions (subject to Department of Health and Human Resources' [DHHR's] approval).* These questions help identify unmet SDOH needs in key areas outlined in Figure 6.3-4. Additionally, the Care Manager incorporates SDOH needs captured through the assessment process into the member's care plan, which includes goals and interventions designed to help meet each member's SDOH needs.

Figure 6.3-4. UniCare's New Initial Screening Tool Identifies Additional Social Determinants of Health Needs

SDOH Factors Addressed in New Initial Screening Tool				
Transportation	Housing Stability	Interpersonal Safety	Food Security	Employment and Education
▪ Lack of transportation for medical appointments ▪ Travel distance to providers	▪ Alternate shelter ▪ Loss of housing ▪ Inability to pay for utilities ▪ Condition of home	▪ Occurrences of physical or mental abuse ▪ Aggression or behavioral problems ▪ Prone to falling	▪ Access to healthy food ▪ Ability to buy food	▪ Level of education ▪ Training programs ▪ Employment status
Health and Personal Outcomes Quality of Life, Psychosocial Outcomes, Behavior Change, Clinical and Health Status, Productivity and Satisfaction				

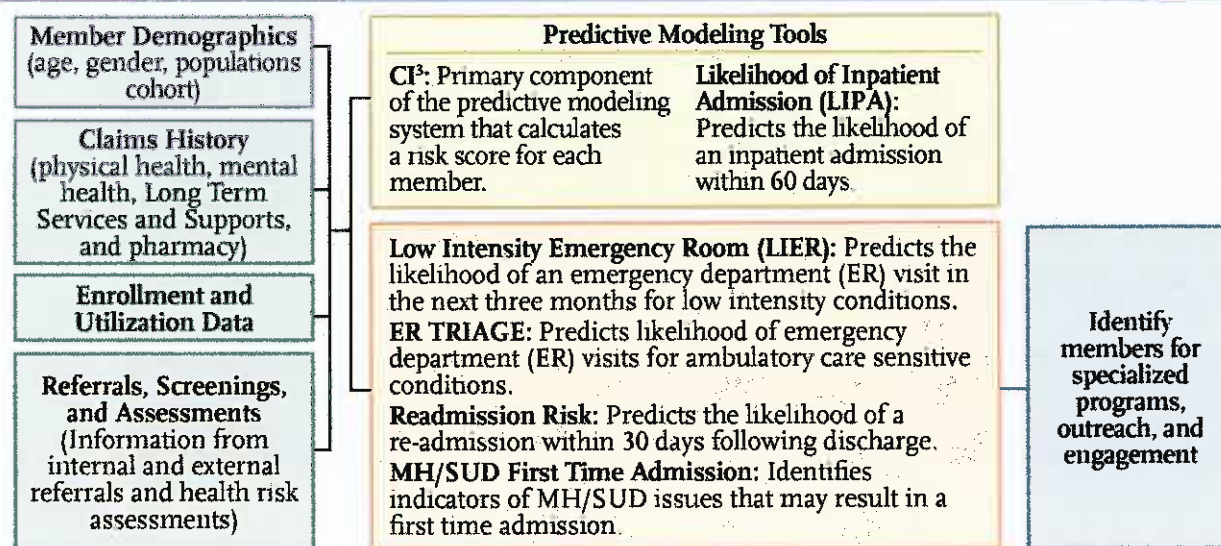
SDOH factors are also identified by providers, incorporated into patient treatment plans, and can be captured via Z-codes in submitted claims. In 2020, we will incentivize providers to conduct SDOH screening and referral as described in our response to question PS007.

Risk Stratification, Tier Assignment, and Prompt Enrollment



Our approach to care management stratification considers multiple factors and is not solely based on clinical indicators. *We apply predictive modeling tools monthly to generate a member-specific risk score and stratification tier.* Member-specific information is refreshed monthly through our Continuous Case Finding process, including updated claims and the results of comprehensive assessments and reassessments. Figure 6.3-5 summarizes how our tools are used to identify risk scores and stratification tier.

Figure 6.3-5. Our Data Analytics and Predictive Modeling Tools Help Identify Members' Risks



Our Proprietary Chronic Illness Intensity Index (CI³) is based upon Johns Hopkins' methodology of Adjusted Clinical Groups and UCSD Chronic Illness and Disability Payment System and is used to identify and predict risk specifically for our Medicaid members. Using claims data aggregated from a 12-month look-back period, members are stratified according to complexity, from low to high risk, and assigned a risk score. Our tools are updated no less than quarterly to align with disease mappings, National Drug Codes, and ICD10. This helps us identify members with frequent emergency room (ER) or inpatient visits or have complex and comorbid needs. Our data analytics and predictive modeling tools continue to grow.

Our Data Analytics and Predictive Modeling Tools Identify Members' Risks

Our Health Care Analytics team has recently developed an additional 30 predictive models based on 65 outpatient surgery categories

Our new Likelihood of Inpatient Admission Score predicts inpatient admission based on disease or comorbid conditions within the next 60 days. We use all available sources of data, such as claims, inpatient and ER utilization data, and available State reporting data to identify known clinical issues, medications, and other relevant health information. Our analytics continuously and systematically assess the complex interactions of physical, behavioral, and social factors in the delivery of health care, aligning

members to the appropriate tier of care management. On a population level, we use these data to inform and refine our care management approaches and targeted interventions.

Connecting Members to Care Management (CM004 and CM005)



UniCare uses a person-centered approach to connect members to care management. *This shifts our Care Managers' orientation from leading care management activities to working with members to establish their own goals and make decisions that improve their overall health and quality of life. We incorporate evidence-based programs into care management training, such as Person-Centered Thinking® by the Learning Community for Person Centered Practices, Trauma-Informed Care, and Mental Health First Aid.*

In our combined response to CM004 and CM005 we introduce our care management process, how we identify members for outreach, and Care Manager assignment. As noted previously, we consider the unique circumstances of each member in consideration of Care Manager assignment, and will adhere to



Mountain Health Trust (MHT) Service Provider Agreement (SPA) outreach timeliness and frequency standards. Our assignment protocols address members' needs holistically in keeping with the State's goal to enhance coordination of care; we do not separate the management of members' physical, behavioral, and biopsychosocial care, instead

offering interventions that promote whole-person health. Our outreach and delivery methods vary based on personal preference of members, their barriers, and cultural needs. Our care management goals are to:

- Provide statewide community-based care management options — UniCare Care Managers, Community Health Workers (CHWs), and Community Paramedics (CPs)
- Enable members by providing information and education for self-management
- Confirm the member’s understanding of their needs and help them identify goals and interventions
- Promote access to appropriate and high-quality health care
- Help members manage and monitor their health conditions and events to improve outcomes

Identification and Timely Assignment to Care Manager

We identify members for care management upon enrollment and continuously through several processes — using our suite of analytic tools, internal and external referrals, and our initial screening process. Once a member is identified and engaged, Care Managers complete our comprehensive HRA and care plan within 30 days.

Assigning Care Managers with Expertise Aligned with Member Needs

We promptly assign members to a Care Manager to begin person-centered outreach within *five days of assignment for high-risk members, and three days for members who need post-discharge management.*

In addition to a member’s level of risk, we consider several other criteria to match members with Care Managers. For example, we assign members with primary physical health (PH) needs to a registered nurse (RN) or with primary behavioral health (BH) needs to a licensed mental health professional. Our Care Managers’ expertise includes, but is not limited to pediatric, NICU, and OB nurses; nurses experienced in critical care, public health, cardiac care, wound care, and transplants; and BH and SUD clinicians licensed as an LCSW, LGSW, or clinical psychologist. Child members in transition and CSHCN in our risk tier 3 are assigned to a dedicated, experienced CSHCN Care Manager. We also cross-train Care Managers under our fully integrated care management model, since members typically have multifaceted needs.

Care Managers have access to our IDT of subject matter experts to help them facilitate coordinated services for members with more complex needs.

The Care Manager supervisor reviews the member's clinical history in Health Insight, and designates a Care Manager, considering the member's location and primary diagnosis. Depending upon the member's risk tier, we offer care management supports designed to meet their needs. This person-centered approach typically follows members with newly diagnosed, non-catastrophic conditions which may be self-managed for two to three months, and longer for members with multiple complex social and health needs. Regardless of the member's risk tier, we always consider primary condition, language, location, and their preference in the assignment process.

Establishing Relationships with Members (CM006)

A Care Manager's chief responsibility is to connect with and develop trusting relationships with members and collaborate to enable access to individualized, holistic care and services. They respect the member's voice, choice, and dignity in the process by adhering to Person-Centered Thinking principals.

Care Management Promotes Person-centered Thinking

Person-centered thinking is a care management philosophy that supports positive control and self-direction of the members' own lives. It emphasizes what is important to each member in order to be satisfied, fulfilled, and happy.

Steps to Establishing a Relationship with the Member

Care Managers partner with members to lead their own care planning — helping them to define their personal goals and interventions. Care Managers explain their role as the member's advocate, reviewing initial screening results, and then discussing immediate care and service needs. They also educate members on the care management process and determine their preferred contact method and frequency. Care Managers use evidence-based motivational interviewing techniques to support and sustain member and caregiver engagement. They help a member identify available resources to meet their needs, including

covered and Value-Added Services (VAS), available Fee-for-Service (FFS) benefits, and resources funded by other agencies, programs, and community resources.

Care Manager Contact Frequency

Our Care Managers understand and respect the many challenges members and caregivers experience, including what may be an overwhelming number of contacts from providers and others involved in member care, and confusion about how to access services. By default, Care Managers arrange for monthly, quarterly, or annual face-to-face contacts with members in our high-risk, medium-risk, or low-



risk tiers, respectively. Although Care Managers will recommend a contact method, frequency, and scheduling, guided by the member's risk tier, the member ultimately determines frequency and means of contact (face-to-face or telephonic). In 2020, we

anticipate the *deployment of video technology for care management staff, giving members and caregivers even more personal access to their Care Managers.*

See Table 6.3-1 for a summary of all our standards for Care Manager outreach by risk tier.

Table 6.3-1. Standards for Care Management Contact with Members and Caregivers

Care Management Risk Tier	Contact Requirements
Tier 3 — High-Risk	• Minimum of one contact monthly in member's preferred setting or telephonically; weekly, bi-weekly, or monthly contact based on member preference • Local community-based care management team support as indicated • Reassessments upon change in condition of member or multidisciplinary team request • Care plan reviewed and updated monthly
Tier 2 — Medium-Risk	• Monthly or quarterly contact based on member preference • Face-to-face or telephonic contact by Care Manager, CHW, Community Paramedic, or peer support based on member preference • Care plan reviewed and updated, and reassessments as indicated
Tier 1 — Low-Risk	• Ongoing predictive risk monitoring • As needed, targeted care management outreach and education
Community Well	• Ongoing care coordination for all members, such as through community engagement, telehealth, social media, Enrollee (Member) Call Center, and incentive programs

Other Care Management Outreach Triggers

Care Managers receive near real-time alerts on member ER use and facility admissions, and contact members, for example, to assist them with in-home services or durable medical equipment (DME) needs, or to confirm satisfactory transition and access to needed services and supports two business days post discharge. A Care Manager may deploy our community-based care management team, such as CPs and CHWs, to make a home visit to check on service delivery and member safety. Care Managers also reach out to identify why members have experienced care gaps or high service use and identify solutions, such as needed services or engagement in special programs like tobacco cessation or chronic disease management. Care Managers will engage members to perform reassessments according to their risk tier and when needed, for example:

- Following a change in the member's needs, risk tier, or care setting
- Following member calls to the BH Hotline, or internal and external referrals

Receiving Ongoing Primary Care from Specialists (CM007)

UniCare recognizes that primary care services for members with highly complex care needs, life-threatening illnesses, or underlying health conditions may best be managed by a specialist who renders the majority of the member's care. Our guidelines for when specialists may serve as a PCP reflect each member's unique circumstances. For example, we may allow an infectious disease specialist to serve as a PCP for members with HIV. In all circumstances of specialists acting as a PCP, must agree to assume all PCP responsibilities to coordinate a member's primary health care services.

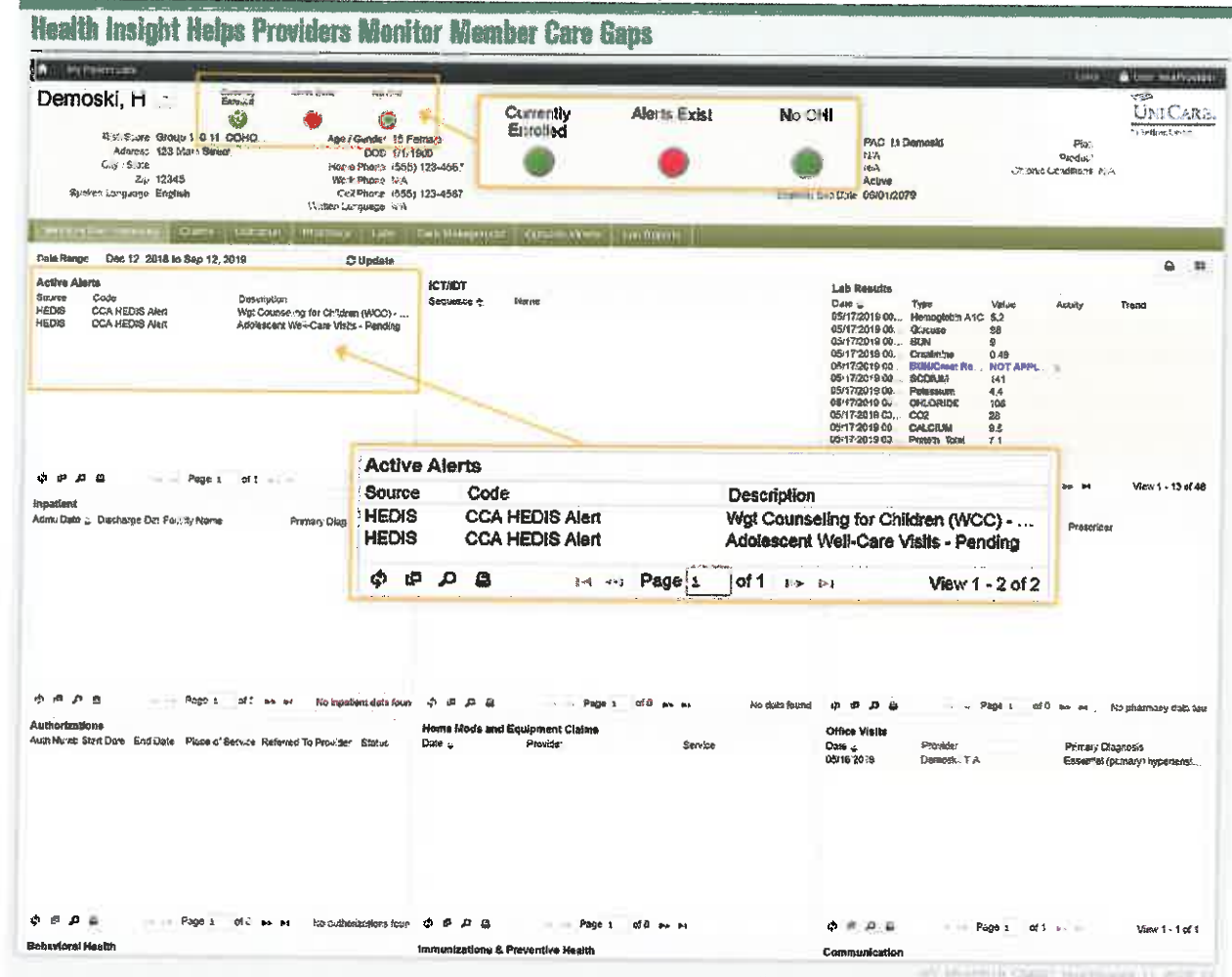
Helping Specialist PCPs Monitor Utilization and Care Opportunities

We support specialists who assume the principal role as PCP with strategic tools to help them monitor primary care opportunities. For example, we show them how to use Health Insight to anticipate or identify

care opportunities, identify real-time health utilization, and to view upcoming or missed services. See Figure 6.3-6 for a sample Health Insight screenshot. Care Managers also review utilization records, claims data, EPSDT Periodicity Schedules, and care opportunities to assure necessary primary care services occur for members under a specialist's care. Care Managers also outreach to these members and caregivers about services they are receiving to identify any barriers to care and whether these have been properly addressed. UniCare supports specialists in a PCP role through our health promotion and targeted health education activities reminding members of upcoming preventive screenings and available resources and tools to support their primary care service needs. Our Network Relations Consultants train these specialists about the EPSDT Periodicity Schedules for Medicaid members under age 21, the care management process, and about PCP contractual obligations such as maintaining 24/7 availability for members who rely on them for primary care.

We will develop a reporting and communication process in 2020 to identify participating specialty providers acting as PCPs for our members in the last 12 months, and engage them to be sure they continue to meet PCP standards, and have the appropriate information and training to perform PCP functions. Our reports will track care opportunities for these specialists with indicators, such as gaps in care and missed screenings or unused referrals, and relay this information back to the specialist.

Figure 6.3-6. Health Insight Helps Providers Monitor Care Gaps



Continuity and Coordination of Care (CM008)

Care coordination and continuity of care are embedded in our care management processes, including UM, initial screening and assessments, and care planning activities. We make sure that each member has access to the appropriate array of treatment and services they might need, when they need it, to support their overall health and well-being. This is most important:

- At times of transition, such as between care settings
- Upon discharge or a change of Medicaid or West Virginia Children's Health Insurance Program (WVCHIP) coverage

- When members are receiving care and services from multiple providers, agencies, community resources, and social services as described in our response to CM043
- For coordinating between PCPs and children's dental providers described in our response to BA043
- When members experience a change in providers

Care Managers directly coordinate member care, managing referrals for medically necessary care, provision of EPSDT, coordination and communication with and between providers, with community supports, and services provided by third parties including agencies or other payers. Information is readily available to participating providers via Health Insight, including members' personal health history, assessments, and care plans. We take seriously the need to coordinate care that may be covered by sources other than UniCare, incorporating provider treatment plans and care plans developed by external agencies or MCOs into our care planning process, such as from family planning providers, Women, Infants, and Children (WIC) program, school-based health centers (SBHCs), and community and social services. In addition, we have well-established processes for preserving continuity of care for members who are new to UniCare as they transition to our plan and to participating providers, including the new WVCHIP population; new members may access out-of-network (OON) providers who are their main source of service for the first 90 days of enrollment. If necessary to preserve OON continuity of care beyond this period, we will review requests for medical necessity as outlined in BA027–BA030.



Supporting Members with a Transition Coordinator

Members who transition to or from health plans, FFS, levels of service, settings, or between providers are at the greatest risk for potentially preventable events and adverse outcomes. As such, ***UniCare will further invest in our Whole Person Health model by employing a Transition Coordinator who will***

work with other entities to facilitate smooth member transitions by sending and obtaining data, and conducting customized outreach with more complex member transitions. Our Transition Coordinator facilitates the transfer and receipt of prior service authorizations (SPA, Article III, Section 5.4), UM data, and clinical information, such as disease and care management, and complex case management notes. They help manage and enhance our processes to identify and assess new members for potential coordination and continuity of care needs to assure all members transition safely, smoothly, and timely. We routinely monitor for and begin care coordination for transitioning members, such as individuals:

- New to UniCare transitioning from West Virginia Medicaid FFS or another Managed Care Organization (MCO)
- With a BH disorder, or at admission or discharge from an Opioid Treatment Program
- Newborns admitted to the NICU
- With unstable housing or who are homeless
- With a high-risk pregnancy in third trimester, or within 30 calendar days of delivery
- In active treatment for cancer, organ transplant, or dialysis
- Hospitalized at the time of plan enrollment

Our Transition Coordinator responds to questions and requests about sharing information during times of member transition, conducting proactive outreach, and early identification of members who may need coordination of care such as CSHCN, SSI, and children in foster care.

Supporting Timely Discharge Planning and Outpatient Connections

Our members' needs change frequently; supporting them during critical transitions between care settings is one of the most crucial care coordination functions. Therefore, our Care Managers are dedicated to facilitating safe and successful member discharge planning. *UniCare's Post Discharge*

Management (PDM) Care Manager or a community-based Care Manager located in the provider's location follow members during inpatient stays, supporting highly coordinated care and minimizing the risk of readmission or placement disruption.

Coordination and Continuity When Providers Leave the Network

To minimize disruptions for members receiving medically necessary care at the time of a provider termination, members in active treatment for chronic or acute medical conditions continue care with their discontinued providers through the lesser of the current period of active treatment or up to 90 days with the successful transition to another participating provider. ***We extend this timeframe if in the best clinical interest of the member, as approved by the Medical Director in consultation with the member's PCP.***

UniCare maintains policies to provide continuity of care when a practitioner, physician group, or hospital leaves the network. Upon identification or notification of a provider termination, we notify members of the impending termination and their right to request continued access to care and transition assistance provided by care management. In accordance with the MHT SPA, Article III, Section 5.3 and State legislation (H.B. 2351), we honor prior authorizations for the duration of the approval or up to 90 days.

Continuing Care Past 90 Days

When medically necessary care is needed beyond 90 days from transition and a participating provider has not been identified, a Care Manager will contact OON providers directly to discuss the members' well-being, health status, treatment and care plans, and discuss the opportunity for the provider to join our network. We expedite credentialing for qualified providers. In rare instances when a provider refuses to join the network for ongoing courses of treatment after 90 days, we reassess, at a minimum of every 90 days thereafter whether:

- The member continues to require the relationship and/or the services provided
- UniCare's network is now able to provide the needed services and we could begin a transition plan

We continue to authorize OON providers when determined to be in the member's best interest, in keeping with our response to BA032.

Early Identification of Pregnant Women (CM009)

We have multiple methods to identify members who are pregnant both at the time of enrollment and as soon as possible thereafter to enroll them into our comprehensive perinatal program. Once we identify members who are pregnant, we quickly assess obstetric (OB) risk and initiate care management including perinatal education to mitigate risks to healthy birth outcomes. All our members who meet our high-risk obstetrics criteria are referred to our OB Care Management program.

UniCare Member Deliveries
UniCare supports on average 3,100 member deliveries per year.

Strategies to Identify Pregnant Women Early



Our comprehensive Taking Care of Baby and Me® (TCOBAM) maternal and child health program helps us identify members who are pregnant as early as possible. The DHHR 834 enrollment file, claims and utilization, and our initial screening are our most reliable sources of data; we use additional sources such as predictive modeling, maternal data mining analytic tools, and referrals from internal staff, community-based partners, and State agencies. In 2019, we identified and outreached to over 1,650 potentially high-risk pregnant women and after assessment confirmed their risk level, successfully engaged over 400 of them in care management.

Solution to Identify Pregnant Women at OB/GYN Registration

In addition to the previously mentioned identification methods, our ultimate parent company has partnered with Availity, an industry-leading health care information technology company, to incorporate our HEDIS® Attestation for Maternity tool into the OB/GYN patient registration process. This tool requires OB/GYN clinics to ask our members of reproductive age about pregnancy status at the time of check-in and to notify us of members who are pregnant in a secure file transfer. Participating clinics

capture and report the estimated delivery, first prenatal visit, and postpartum visit dates. This innovation has led to a substantial improvement in early identification of pregnant members, essential to supporting members and improving maternal and birth outcomes.

Promoting “Early and Often” Prenatal Care (CM010)

Incentivizing Providers to Share Completed PRSI Notices

In July 2020, we will be incentivizing providers who submit to us a completed State Prenatal Risk Screening Instrument (PRSI). PRSI notification will assist us in early identification of high-risk OB members, subject to DHHR approval.

West Virginia has consistently reported some of the highest incidences of low birth weight, preterm birth, and infant mortality across the nation. UniCare is committed to reversing this trend. Early and sustained member engagement in prenatal health is critical to improving birth outcomes. In addition to care management supports for

high-risk prenatal members, UniCare offers a continuum of supports through our TCOBAM program, health education, My Advocate™ (a communications resource), group support with the CenteringPregnancy model of care, Healthy Rewards™, and a tobacco cessation program. *We also assist members to schedule a prenatal care visit within 14 calendar days of the date we learn of a pregnancy.*

Taking Care of Baby and Me

TCOBAM promotes active and passive targeted health outreach to our members who are pregnant, tailored to their risk tier. We encourage them to act as self-advocates in their health and the health of their babies by seeking early and continuous prenatal care. *All pregnant members stratified as high-risk are enrolled in our intensive OB Care Management program; these members are assigned a UniCare OB High-risk Care Manager who contacts them within five calendar days to initiate care planning.*

TCOBAM engages members in prenatal care as early as possible with health education and counseling to help them make informed choices. Members receive individualized services with multiple communications and tools based on their goals, strengths, needs, and preferences, incorporating the risk

factors discovered in our ongoing initial screening and assessment processes. Through TCOBAM we provide educational materials throughout the pregnancy, and link members to community resources to optimize their health before, during, and after the pregnancy.

Maternal Health Member Education

TCOBAM members receive initial and ongoing information on the importance of receiving prenatal care, attending prenatal classes, postnatal care, and newborn health and wellness. Throughout the pregnancy we provide stage-level maternity education and resources designed in accordance with nationally recognized ACOG standards on important clinical topics such as tracking for baby movement, maternal weight gain, tips for a healthy pregnancy, and important information about newborn health.

TCOBAM, along with our engagement platforms MyAdvocate™ and Healthy Rewards, are designed to engage and inform members throughout the perinatal period.

24/7 Nurse Advisors for Pregnant Members

Nurses are available to provide members with pregnancy support 24/7.

My Advocate

To more effectively screen for risk factors and engage all our members during and after pregnancy, UniCare offers My Advocate, a multi-channel communications program that enables women to communicate via IVR, calls, or text. My Advocate provides health education and healthy pregnancy surveys by phone, text message, smartphone app, or online to pregnant members. It is personalized, providing “to-dos” for each stage in the member’s pregnancy. In addition to promoting early and frequent perinatal care, My Advocate specifically:

- Allows members to complete our OB High-risk screener by phone or online to determine their risk tier and need for care management or coordination. In 2019, 1,048 members responded to a UniCare Care Manager OB High-risk screening request

- Continually monitors the health of the member, identifying changes and alerting our OB High-risk Care Managers to reach out to members as risks are identified
- Offer members “click to call” for our 24/7 Nurse Line to ask questions and get a prompt callback from an OB High-risk Care Manager

My Advocate has resulted in higher percentages of high-risk pregnant members engaged in comprehensive OB care management among members screened. Participating markets have also experienced higher rates of pregnant women screened for risk factors within 45 days of identification and enrollment in My Advocate — 41% compared to 28% within non-participating markets.

Group Support for Pregnant Members

We also give members an opportunity to engage early and often in their perinatal care via group support with the Centering Healthcare Institute. We promote and encourage providers to adopt the CenteringPregnancy model of care, which:

- Allows participants to experience prenatal care visits in a comfortable small group setting outside of exam rooms with other members due around the same time. Visits are 90 minutes to two hours long
- Encourages members to educate, motivate, and support each other, creating lasting friendships as they share common experiences of pregnancy, birth, and family care
- Encourages members to actively engage in their own health care and own their health information

CenteringPregnancy nearly eliminates racial disparities in preterm birth. It currently operates in Morgantown and Harper’s Ferry. We continue to seek opportunities to use this evidence-informed model of care in partnership with Bureau for Public Health’s (BPH’s) and our OB providers throughout West Virginia.

Healthy Rewards for Perinatal Care

We will further promote early and continuous engagement through our Healthy Rewards program, offered as one of our VAS. Members who are pregnant can receive a gift card or other reward each time they meet any of the goals in Table 6.3-2.

Table 6.3-2. Healthy Rewards for Members Who Are Pregnant

Prenatal Goals	Healthy Reward
Attending their first prenatal checkup within 42 days of enrollment	\$25
Attending at least six prenatal visits	\$25 and a car seat or portable crib
Attending their postpartum checkup 21-56 days after delivery	\$25
Bringing their infant, up to two weeks of age, to their first well-baby visit	\$25
Attending six well-baby checkups before their child's 15 th month	\$25

Baby & Me Tobacco Free Program

Among our evidence-informed programming we promote early prenatal interventions through Baby & Me Tobacco Free™. This public health initiative, available to all pregnant West Virginians, offers an evidence-based, smoking cessation program for pregnant and postpartum members who want to quit smoking. *We partner with the State's home visitation and targeted case management initiative, Right from the Start (RFTS), to bring Baby & Me Tobacco Free to our members.* RFTS takes this program to expectant moms in RFTS Regions 1, 2, and 3 (regions with the highest smoking rates), to offer tobacco cessation sessions at convenient locations including their home and clinic setting. *Pregnant women who test tobacco free at prenatal sessions qualify for Walmart gift cards up to \$25 per month to cover the cost of diapers and baby wipes for up to 12 months postpartum.*

Unique Care Management Processes for SSI Members (CM011)

UniCare identifies new Supplemental Security Income (SSI) eligible members from the SSI indicator on the DHHR 834 enrollment report. Given the potential for higher risk or care management needs, we make at least five outreach attempts to contact these members for an initial screening to support the State's goal

to deliver access to care, and to connect individuals identified to an assigned Care Manager if needed. Our newly revised initial screening helps us capture additional SDOH influencers which disproportionately affect SSI members. This augments our outreach with SSI members who have social service needs and would benefit from our Life Essentials program, which offers members additional services and supports to meet their SDOH needs in collaboration with community partners. In addition, Care Managers check homeless status of members in the Homeless Management Information System (HMIS) system to link members to housing service providers, described further in response to CM043.

SSI Member Education and Supports

While our SSI members receive the same level of care management supports available to all members, including transitions in care supports described in CM008, we assure they have information about and can easily maintain access to the additional services and resources they may rely upon or need in the future to address their disability-related needs. We also make certain that our community partners who serve the SSI population have our materials and contact information.

Promoting Community Engagement for Members with SSI

We use multiple methods to engage with members on SSI beyond our standard telephonic new member welcome call and initial screening at the time of enrollment through community engagement. We also conduct grassroots outreach and education to community-based organizations, such as West Virginia's Aging & Disability Resource Network (ADRN) through the State's Bureau for Senior Services that supports individuals with disabilities to provide education to members and families. Our partnership with the West Virginia Coalition to End Homelessness supports referral and connection to a wide array of housing services for our SSI members including street outreach, access to Coordinated Entry, Rapid Rehousing, permanent supportive housing, shelter/homelessness prevention, Housing Opportunities for

Persons with AIDS (HOPWA) Housing Program, State Opioid Response Program services, and SSI Outreach, Access, and Recovery (SOAR) services, a national best practice federally funded program to help states increase access to SSI benefits for people who are homeless or at risk of homelessness and who have mental illness or other co-occurring disorder.

Assisting Members to Access SSI Coverage and Transition to Adult Waivers

UniCare Helps Members with the SSI Application Process

Our Care Managers help members with an SSI qualifying condition, informing them about the application process and connecting them to the appropriate Social Security Field Office. We help them complete the SSI application either online or in person, and refer them to legal, advocacy, and community resources such as Social Security Disability Resources in Charleston, Huntington, and Oak Hill.

We also help members monitor their SSI eligibility status, educate them on how to schedule appointments with one of the State's 16 Social Security Field Offices, as appropriate, and assist them with questions about SSI Continuing Disability Reviews and Redeterminations. Care Managers have the member's clinical history, assessments, and care plans, which may be useful to members and their providers during SSI redetermination reviews since clinical evidence is essential for the SSI

evaluation. Even if children qualify as "disabled" under SSI and are therefore eligible for Medicaid, they can still experience significant waiting periods to access adult waiver services. *In 2019, we identified and worked with about 800 Transition Aged Children eligible for SSI to gain access to benefits and services they need.* We work with these members to address access challenges and others as shown in Table 6.3-3.

Table 6.3-3. Transition Challenges and UniCare Interventions

Transition Challenges	UniCare Interventions
Members and families are uninformed about adult waiver options	• Assist members and families to learn about and apply for adult waivers • Build waiver coordinator relationships to assist with applications • Help members and families understand which services they received as children that ought to continue following transition to adulthood
Adult waiver waiting lists	• Identify community supports until Medicaid or waiver benefits are available • Link members ineligible for community waiver programs or not yet enrolled to county-based Community Support Program services, such as support coordination and family respite care
Providers lack time to review the complete medical history of new young adult patients	• Care Manager will make care plan, assessment, and patient history available to new adult providers

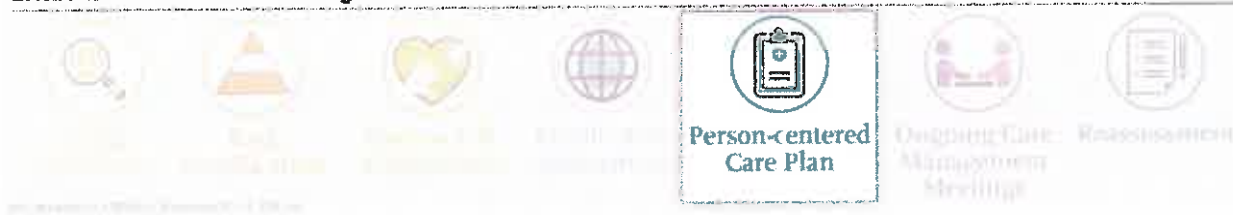
Transition Challenges	UniCare Interventions
Medical transport delays result in cancelled or rescheduled time-sensitive medical appointments	• Care Manager will help members know transport options available for urgent, immediate, or planned transport needs and how to discuss their needs with adult providers to prevent visit cancellations
Adult facilities may lack sedation services for medical tests, which children's hospitals may routinely provide when necessary	• Care Manager will discuss with members the options available and how to discuss with adult providers to plan for these appointments
Pediatric facilities are designed to have space for multiple family members in an exam room; adult outpatient facilities may not have space for wheelchairs or equipment	• Include facility space and accommodations planning questions on the transition form and process with providers and members • Partner with CIL to regularly survey provider practices for accessibility, including provider communication skills

Training Care Managers on SSI Member Care Management Needs

We leverage internal and external subject matter experts with experience serving the SSI population to inform our training plan for the care management team. Beyond standard employee and job-specific training, the member-facing staff are schooled on SSI-related topics. The team receives in-depth and expansive training on topics such as ER and nursing facility diversion; addressing MHT goals for SDOH such as housing; transition care planning; end-of-life care, palliative care, and choices; disability cultural competency; and working with external case managers supporting SSI members.

Care Management Processes for Adults and Children (CM012)

Elements of Tiered Care Management



As a current West Virginia Health Bridge and MHT MCO, we have many years of experience supporting adult and child members under a fully integrated Whole Person Health model. Our model is informed by our experience in the State and the experiences of our affiliates serving Medicaid and WVCHIP members; we apply person-centered, evidence-based,



integrated, collaborative, and community-focused principles to the model. Additionally, it is sensitive to members' experiences; for example, we support and address member diversity, SDOH needs, and individual learning and linguistic needs.

Key Characteristics of Whole-person Health for Care Management

We have numerous essential and unique elements to manage each member's care continuum. Care management initiatives deliver whole-person, comprehensive service coordination, chronic and complex care management, and person-centered care planning. See Table 6.3-4 for a sample of the key characteristics of our care management program that are in place for both adult and child members.

Table 6.3-4. Sample of Key Characteristics of UniCare's Whole Person Health Model for Care Management

Key Characteristic	Purpose
Data-driven	To identify members using referral guidelines, analytics, and predictive models followed by targeted outreach
Telephonic or face-to-face contact	For direct collaboration with the member, their PCP, and other providers or caregivers involved in managing the member's health
Multidisciplinary support team	To include our Medical Directors, BH Directors, and an IngenioRx pharmacist, as needed in care planning
Care Planning	To initiate the member's person-centered care plan with planned interventions by: • Assisting members in navigating the health care system • Including evidence-based, clinical, condition-specific, and preventive service guidelines for adults or children • Arranging for face-to-face coordination with our community-based care management team (CPs and CHWs) • Developing formalized care transition protocols during member transitions in services or coverage • Collaborating with providers on their plan of treatment, and with State agencies or community-based organizations also serving our members • Referring members to community-based or other resources to meet health care or social service needs • Providing comprehensive, holistic, and culturally competent care management

Assessing Members for Care Management Services

In addition to our initial screening tool, UniCare has over 200 assessment and screening tools integrated into Health Insight. Our assessments help us to determine current or escalating risk factors and identify members

who may benefit from care management programs. We use adult and child-specific screening tools and assessments. See MS006 through MS014 for an in-depth description of our assessment processes.

Assessment tools help Care Managers gather PH and BH status and needs, and identify SDOH factors which may have an impact on a member's ability to access needed care and services. Care Managers partner with members to develop a care plan consistent with their goals and objectives. Please refer to CM004 and CM005 for more information about our assessment and Care Manager assignment processes.

Initiating and Coordinating the Member's Care Management Plan

Care Managers assist members and caregivers in identifying providers and community-based services and supports, referring members for medically necessary care, and scheduling appointments. They coordinate the member's care with their clinical and community-based service providers and share information necessary to meet the member's needs as defined in the care plan. For example, Care Managers coordinate care and share information about adult and child members with:

- PCPs coordinating member care, including medical homes or Health Homes
- Specialists, BH providers, and community-based service providers
- Other State programs and systems involved in member care, such as family planning service providers, WIC, and FFS service providers outside scope of plan coverage

Child-focused Care Management Processes

While our care management processes generally apply to both adults and children, we have processes that take into account the unique needs of, and resources available to children.

- **Coordinating with other child-serving entities.** Care Managers for Medicaid and WVCHIP children under age 21 coordinate care plan needs with, for example: SBHCs; the Title V State agency; child protection services; early intervention agencies; community-based programs serving children in

the juvenile justice system; and coordinators serving child members in West Virginia's CSHCN program at specialty clinics and in community-based care.

- **Partnering with authorized representative(s) in care planning and initiation.** We identify each child's caregiver, including parent(s), other family members, legal guardians, providers, Care Coordinators at other agencies, or other authorized representatives, with whom we should engage to develop, initiate, and sustain care planning.

Coordinating Non-medical Community-based Resource Needs

In addition to coordinating the member's clinical care needs, our Care Managers screen members for SDOH needs that may contribute to poor health outcomes as an integral part of our care management process to inform care planning and interventions. They identify, refer members to, and coordinate with appropriate non-medical services and supports using our integrated Community Resource Link, documented in the member's care plan. The Community Resource Link provides Care Managers and members with a network of community-based social services such as non-emergency medical transportation (NEMT) to appointments or special transportation requirements, housing supports, workforce opportunities, food and nutritional needs, drug rehabilitation, and other community supports. Care Managers monitor member use of community-based resources in care planning and multidisciplinary team meetings. See our response to CM043 for how we coordinate care with community resources and social services.

Care Management for Members with SHCN and CSHCN (CM013, CM014)

UniCare takes every effort to identify members with SHCN early, including people with disabilities (or at risk of developing a disabling condition), chronic or complex medical or behavioral conditions, and CSHCN, by screening and immediate referral to our care management program and specialty providers.

Special Provisions for Members with Complex Care Needs

As a part of our Whole Person Health model, UniCare offers additional supports to help all members with complex care needs to access covered services:

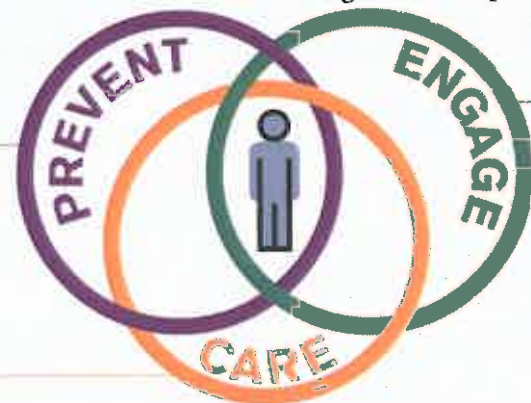
- NEMT referrals and coordination, and special transportation requirements for safe transfer
- Telemedicine solutions for PH, BH, and SUD services, and At Home Preventive Care
- Medication Therapy Management beginning July 2020
- Access to and coordination of respite services and medical food services as appropriate
- Community supports tailored to address the unique clinical and social needs of members with SHCN such as local Aging & Disability Resource Centers, Centers for Independent Living, Easterseals, the Multiple Sclerosis Society, and the West Virginia Autism Training Center

We have extensive experience implementing person-centered clinical programs, including intensive care management, to help adult and child members with SHCN reach optimal wellness. Among our many evidence-based and informed programs are our ASPIRE palliative care and Neonatal Abstinence Syndrome (NAS) programs described next. SHCN and CSHCN members may need an increased frequency of integrated care planning supports, whether daily, weekly, or monthly, and an increased focus on care coordination with external organizations including providers and State agencies.

Whole Person Health

Our Prevention Teams use data analytics and provider outreach to identify care opportunities for members.

Our Population Health team and Community Engagement team understand our West Virginia landscape.



Our Care Management teams meet the member where they are and on their schedule to help treat their individual needs.

We have also built special programs for certain sub-populations, for whom we have identified a need for additional care management services. Through these specialized care management programs, we improve member identification and engagement, and identify opportunities to improve health outcomes and patient safety, such as reducing avoidable admissions, readmissions, and low-acuity ER visits.

ASPIRE: UniCare's Palliative Care Program

ASPIRE is a home-based palliative care service that treats members with an advanced illness (primarily cancer, congestive heart failure, and COPD), estimated to be in their last year of life, and at high-risk for high utilization rates. A team of physicians, nurse practitioners, nurses, social workers, and chaplains help members and their families manage symptoms, coordinate care, and remain comfortable in their homes, aligning with each member's goals and choices. As of January 2020, there were 75 of our members receiving palliative care services.

Special CSHCN Care Management Provisions

Our care management program supports a comprehensive system of care for CSHCN by partnering and coordinating with other programs that serve our child members. Children in multiple systems of care may have case managers outside of UniCare who are managing their needs, and we coordinate with them to minimize duplicate efforts. For example, we coordinate with Title V State agency staff, coordinators in specialty clinics, SBHCs, and other settings, as appropriate.

We also assure CSHCN have access to EPSDT services to maintain their Periodicity Schedules for immunizations and well-child visits, and for Private Duty Nursing (PDN) services following an EPSDT screening and exam, when medically necessary. Our Care Managers monitor child members for significant changes in condition. We know that children and youth may have varying needs and medical

complexities that may require sporadic or longer term access to medically necessary services such as PDN services to avoid further disruption in their lives.

Our Care Managers assure all CSHCN have access to a qualified medical home with team-based, EPSDT certified, provider-led care, which places the member and their family at the core of treatment planning.

We also partner with child-focused community-based organizations to help members better engage in their care. We collaborate with the West Virginia Office of Maternal, Child, and Family Health (OMCFH) care coordinators to share care plans and data on CSHCN, to improve service delivery and outcomes. See our response to BA014 for further information about our condition-specific processes for members with SHCN.

Neonatal Abstinence Syndrome

Under the State's Perinatal Quality Improvement Collaborative NAS Pilot we work in collaboration with eight Community Mental Health Centers (CMHCs) and the NAS project, to provide addiction treatment and other supportive services to pregnant members with alcohol or opioid use disorder (OUD) to help determine the most effective ways to reduce newborn risks. The

NAS project screens for substance use to decrease the neonatal death rate and reduce the short and long-term medical impact of substances on babies' health outcomes. The pilot supports pregnant moms with

Real Stories

One of our members gave birth prematurely to twins. At 18 months old, the twins continued to experience respiratory issues, had several hospitalizations to the PICU on ventilators, and struggled to eat and gain weight. The State's Birth to Three Coordinator for CSHCN referred the case to our CSHCN Care Manager, Sam, to address the twins' unmet needs.

Sam called the twins' guardian, Delia, who shared that she was very overwhelmed — fighting bone cancer and caring for two other children, including an infant. She was having challenges getting authorizations approved for the twins' specialist at Children's National Hospital in Washington, D.C. Additionally, the twins needed cardiology and gastroenterology specialty services at the D.C. hospital, but kept missing appointments due to repeated hospitalizations near their home.

Sam was unable to reach Delia after the initial contact. She realized the needs of the members were too complex to manage by telephone, and referred the case to one of UniCare's community-based Care Managers, Naomi, who successfully reached Delia and held a face-to-face visit. Sam and Naomi collaborated to obtain the necessary authorizations for the twins' follow-up care at Children's National Hospital. Naomi provided extensive education to Delia regarding infection prevention, nutrition, and age-appropriate milestones. She continues to visit Delia and the twins monthly to make sure all of their needs are being met. *Since the members were enrolled in UniCare's care management program and the State's CSHCN program, they have not had any more hospitalizations, have gained weight, and avoided feeding tube placement.*

OUN to reduce the effects on the child with one year of postpartum substance use treatment, parenting, and medical care for mom and infant in their StrongWell program.

UniCare Reduces the Number of Neonatal Abstinence Syndrome (NAS) Cases and Related Expenses

In the first operational year, May 2018–April 2019, our NAS program identified 1,044 pregnant members at risk for SUD. Thereafter, the percentage of babies born with NAS dropped from 19% to 12%, leading to \$0.38 PMPM in savings, or \$384,396 in total annual savings. UniCare saw a similar decrease in the percentage of births with NAS before the program began (19%) and after one year of operations (12%).

UniCare’s NAS program includes interventions to address the impact of substance use before, during, and after pregnancy, such as prioritizing pregnant women for substance use screening, providing wraparound case management services for pregnant women with SUD and increasing familiarity of evidence-based standards of care for newborns with drug-withdrawal syndrome. Our organization’s NAS program was launched by UniCare (the first NAS program by our

national Medicaid plans) in May 2018 and includes:

- Advanced analytics predictive modeling
- A peer support program for female members of reproductive age with an SUD to connect them to care, recovery, and social support services
- Intensive case management for pregnant women with SUD that lasts through six months post-delivery
- An OB practice consultant to conduct outreach to high-volume family practice, OB, and pediatric providers who may care for families at risk for SUD or NAS

The program also includes a NAS Provider Toolkit, a resource to increase PCP’s familiarity with routine Screening, Brief Intervention, and Referral to Treatment (SBIRT) methods and tools; prevention and care of NAS and Neonatal Opioid Withdrawal Syndrome (NOWS); interventions known to decrease severity of symptoms in NAS newborns and reduce costs associated with NAS; local treatment and support resources; and available health plan resources.

- CM015 1 The Vendor should describe strategies to manage members with a history of prescription drug abuse, and processes for monitoring potential abuse or inappropriate utilization of controlled prescription medications.

Supporting Members with a History of Prescription Drug Abuse (CM015)

Decreasing Opioid Overdoses

We realized a 32% decline in opioid overdose in 2019 compared to 2018 and a 53% decline since 2017.

As we described in our response to BA008, we use multiple monitoring and reporting mechanisms, such as our predictive modeling tools, to identify members and providers with a history of and who are at risk for prescription drug and controlled substance misuse or abuse. *We leverage these multifaceted strategies to focus our care management efforts on intervening and coordinating services for members with a history of prescription drug abuse or inappropriate utilization of controlled medications.* These strategies complement our overall approach to improve quality of care and the health of members who are receiving SUD services as part of the 1115 waiver programs and created in accordance with the SPA requirements in 10.11.2. Once a member receives a SUD diagnosis, has evidence of an OUD, prescribed multiple narcotics, or is experiencing pain management issues, we assign the member to a Care Manager specialized in SUD supports. All Care Managers receive opioid lifeline training to best support members with a history of opioid abuse or have evidence of an OUD. Care Managers and Peer Support Specialists work closely with the member, their family or caregiver, providers, and other members of their support team to identify, coordinate, and monitor the member's treatment by providing community referrals and SUD support services. Through our Integrated Opiate Abuse Initiative, we offer enhanced care management to those who:

- Have a documented history of prescription drug abuse
- Meet criteria for our opioid Drug Utilization Review program
- Have providers who express concern about excessive use of opiates

Meeting HEDIS® Benchmarks

UniCare is in the top 90% of Medicaid MCOs for the HEDIS rate for Initiation and Engagement of Alcohol and Other Drug Dependence Treatment.

- Have six or more opiate prescriptions or three or more providers in a one-month period
- Are discharged by a provider from his or her panel because of suspected opiate prescription fraud
- Fill prescriptions for opiates while actively enrolled in a methadone or buprenorphine program

To help assure comprehensive, coordinated care and promote optimal health outcomes, we will continue to work collaboratively with DHHR's pharmacy program. We leverage pharmacy data, incorporated into our Health Insight system, to inform and support member and caregiver education, provider consultations, and integrated care planning with all system partners. Secondary sources of pharmacy and prescription information include member feedback gathered through the HRA, member transition data, State required health assessments, and verbal reports from members, caregivers, or providers. We leverage the support of our Pharmacy Benefit Partner, IngenioRx, to collaborate on programs and resources for members. *To support our goal of providing effective integrated care, we will use our Pharmacy Benefit Partner, IngenioRx's Pharmacy Director to assist in reviewing overall medication utilization and changes and will report the findings to the member and provider.*

Describing our Programs to Identify and Address Prescription Drug Abuse

In collaboration with our Pharmacy Benefit Partner, IngenioRx, we are implementing several programs in the summer of 2020 to support members including our Controlled Substance Utilization Monitoring (CSUM), Opioid Management, Behavioral Health Psychotropic Medication Management, and Safe Choices Programs.

Our **CSUM program** will leverage pharmacy data from the State to identify members receiving multiple controlled substance medications, opioids from multiple providers and those filled at multiple pharmacies, or combinations of controlled substances that may indicate risk of drug misuse. Once identified, our Pharmacy Benefit Partner will relay this information to prescribers so they can engage those members at-risk for adverse events to encourage early intervention and offer education and treatment on the

appropriate use of their prescribed medications. Our Pharmacy Benefit Partner will reach out to prescribers to coordinate care and reduce the risk of controlled substance overutilization, high dose opioid use, doctor and pharmacy shopping, and pharmacy costs. *Our CSUM program includes similar components as our ultimate parent company, Anthem, Inc., Anthem's award-winning Medicare Opioid Overutilization Management program, which received an Excellence Award for Care Management Strategies from the Pharmacy Benefit Management Institute.* As an example of the impact this program can have, Table 6.3-5 provides 2019 outcomes for this program for eligible Medicaid members in our affiliate health plan in Indiana.

Table 6.3-5. Indiana's CSUM Program Decreases Unnecessary Prescription Drug Use

Measure	CSUM Program Results
High Utilization	58% of eligible Medicaid members with 10 or more claims for controlled substances reduced their claims for controlled substances to less than 10 at 180 days post-intervention.
Drug Interaction	100% of eligible members with concurrent claims for opioids, benzodiazepines, and muscle relaxant discontinued at least one drug class with 96% discontinuing both opioids and muscle relaxants and 39% discontinuing both opioids and benzodiazepines.
Overutilization of Pharmacies and Prescribers	53% of eligible members decreased their utilization of multiple opioid claims, multiple prescribers, or multiple pharmacies.

Our *Opioid Management Program* will reduce the opportunities of misuse of opioid treatment, including the development of an OUD, by targeting outlier provider opioid prescribing patterns, and assisting members in gaining access to clinically appropriate treatment. This program will assess physicians' opioid prescribing patterns compared

Demonstrating the Effectiveness of our Opioid Management Program

Comparing the average number of opioid utilizers at greater than 90 morphine equivalent dose per day for calendar year 2016 to January through September of 2019, there was a 51% decrease in the number of opioid utilizers in our affiliate Medicaid health plan in Indiana.

to their peers and evaluated against several utilization metrics such as an overall opioid prescription count, percentage of members newly started on opioids, and an opioid utilization summary of at-risk members. We will offer the information to prescribers as a report card to show their prescribing patterns and offer multimodal support to reduce the opportunities for opioid misuse or abuse. We will assess members' risk of opioid misuse, and a clinical pharmacist will telephonically reach out to the prescriber

of members identified as *at-risk* or *high-risk* to discuss the reason for concern and develop a plan to reduce opportunities for opioid overutilization or misuse.

Our ***Behavioral Health Psychotropic Medication Management*** program will help providers prescribe in a manner consistent with guidelines, reduce polypharmacy, and can identify scenarios where members or their caregivers may be misusing or abusing stimulants and benzodiazepines. Through this program, we will leverage pharmacy data received from the State to monitor and manage the appropriate use of antipsychotic medications. This provider outreach program targets members with multiple prescribers or multiple psychotropic medications and addresses polypharmacy issues and inappropriate prescribing of psychotropic medications for children under the age of six and adults over age 65. We will encourage medication compliance as recommended by evidence-based treatment guidelines and monitor for opportunities to improve care. We will provide physicians with feedback on their prescribing behaviors as compared to accepted standards of clinical practice or evidence-based treatment guidelines. The goals of the program

**Demonstrating the Effectiveness of
Our BH Psychotropic Medication
Management Program**

In our affiliate health plan in Indiana serving Medicaid members, 86% of members who were identified as taking multiple psychotropic medications prescribed by multiple providers discontinued or reduced one or more of the medications.

include reducing polypharmacy, promoting medication adherence and follow-up care, decreasing inappropriate prescribing and use of psychotropic medications in children and older adults, and improving performance on HEDIS measures. Components of this program comply with the SUD Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.

Our ***Safe Choices Program*** will use data from members with multiple ER visits for diagnoses such as SUD or OUD, abuse of drugs, poisoning or overdose by drugs, anxiety, drug dependence, dental pain, and

back or neck pain. It will include members with three or more prescribed controlled substances that include opioids and benzodiazepines or a high usage of opioids from multiple providers.

Our clinical team, facilitated by Dr. Jorge Cortina, will review members identified for potential interventions with the member or provider. Once identified, our Care Manager will provide outreach to the member regarding services available, potential drug treatment options, chronic pain management and prescription alternatives, and provides community supports related to addiction treatment if needed. Our UniCare Medical Directors or Pharmacists may contact the prescribing provider if we identify concerning patterns.

**Board-certified in Addictions,
UniCare's BH Medical Director
Supports West Virginians**

Our BH Medical Director, Dr. Jorge Cortina, continues to treat individuals with SUD through his active practice and supports West Virginians and the State through:

- Collaborating with our Anthem Foundation and WVU to establish Project ECHO
- Serving as a member of the Treatment and Research Subcommittee of the Governors Committee
- Working with Shatterproof as a member of the Office of Drug Control Policy State Advisory Committee
- Serving on panels sponsored by West Virginians for Affordable Health Care

Implementing Interventions to Decrease Prescription Drug Abuse



In addition to our member outreach by our Care Management team and identified pharmacy strategies, UniCare participates alongside our ultimate parent company in an enterprise workgroup. Together our strategy provides focus on monitoring prescription drug abuse, specifically focusing on opioid practices, early identification, treatment and recovery from OUD, and deterrence from fraud and abuse. Our Quality team has a high-volume prescribing list for ADHD medications and buprenorphine – we use this list to identify providers who may need target medical record reviews to monitor the quality of care rendered for those services. UniCare uses a multifaceted, holistic approach to support members in West Virginia with prescription drug abuse and SUDs including interventions such as:

- Encouraging and reimbursing providers for **SBIRT** during annual routine medical exams to help detect SUD
- Enhancing education and access to **Medication-Assisted Treatment (MAT)** providers, like contracting with **Bright Heart Health**, and training through **Project ECHO® (Extension for Community Healthcare Outcomes)**
- Promoting **Quality MAT** providers, by promoting the inclusion of MAT services corresponding to BH therapy services
- Partnering with NICUs to establish **care practices for newborns with NAS**, while encouraging non-pharmacologic treatment, parent involvement, and protocols to decrease the severity of symptoms and improve outcomes
- Partnering with **Coalition to End Homelessness** to offer innovative approaches to recovery including peer recovery support and coaching, street outreach, access to housing and ongoing housing supports, SUD therapy, and MAT services
- Participating on the West Virginia State Advisory Committee for **Shatterproof/WV ATLAS**, to promote quality SUD services
- Provide education such as **What's Up with Opioids?**, a collaboration between Anthem and the National Urban League that offers an online toolkit with a step-by-step guide for hosting a discussion to help prevent opioid misuse and addiction
- Provide support through our SUD Recovery Support Program VAS, which uses predictive relapse analytics and condition-specific content to engage and encourage members providing aid in their recovery from opioid, drug, or alcohol use using a smartphone

Engaging Members in MAT

Sixty percent of UniCare members with OUD are receiving MAT, and we saw a 58% increase in Quality MAT services from 2017 to 2019.

As part of its commitment to increase access to comprehensive MAT, *UniCare brought the Project ECHO model to West Virginia in June 2017*. Through collaborations with three academic medical centers — West Virginia University School of Medicine, Medical University of South Carolina, and Eastern Tennessee State University — our ECHO model uses videoconferencing to conduct virtual clinics, mentoring, and

Increasing Access to MAT Decreases Opioid Overdoses

As a result, from January 2018 to June 2019, we increased the number of members using buprenorphine, and during this same period, claims for opioid overdoses decreased. As the number of members with OUD on MAT increased, rate of claims for opioid overdoses decreased 53% when compared to same period in 2017.

Project ECHO® Educates Members

- 46 one-hour sessions held
- A total of 656 attendees included 124 individuals with an average of 14.3 providers per session
- 38 de-identified case presentations
- Hub members presented 32 didactic presentations
- 40 organizations have participated, including Charleston Area Medical Center, Marshall University, and other providers in and outside of West Virginia

member case presentations between academic medical centers, specialists, and community providers who are MAT certified or interested in becoming MAT certified. Project ECHO's Opioid Addiction Treatment offers providers and primary care teams no-cost training in opioid addiction, supporting all providers in West Virginia. The program offers addiction treatment training including management

of buprenorphine, injectable naltrexone, and access to a virtual learning community for treatment guidelines, tools, and member resources. The ongoing support and knowledge sharing facilitated through the ECHO model supports local PCPs or treating providers to offer complex, specialty care in their communities.

Future Pharmacy Programs, if Carved-in

In the future, should pharmacy be carved-in, we will augment our programs and interventions with the full array of pharmacy management programs offered by our Pharmacy Benefit Partner IngenioRx. IngenioRx, will implement safety edits at point-of-sale to promote compliance with the SUPPORT Act, which includes State-approved maximum daily morphine limitations and edits that monitor concurrent prescribing of opioids and benzodiazepines and of opioids and antipsychotics. IngenioRx's proprietary claims monitoring program will review claims to make sure they adjudicate according to the benefit

design and will use algorithms and leverage analytics that identify outliers to recognize opportunities for better management. This continual monitoring allows for prompt adjustments to the coding and optimizes claims adjudication accuracy. This claims monitoring process produces efficiencies in cost of care by maximizing the cost-effectiveness of benefit delivery. *While reducing the risks and harms associated with inappropriate medication utilization, our affiliate health plan in Indiana recognized multi-million-dollar annual savings as a result of this claims monitoring.* If a member receives prescriptions from multiple prescribers or pharmacies without provider knowledge or is suspected of selling or fraudulently redistributing their medication, IngenioRx can activate a pharmacy lock-in program to promote the member's safety through this coordination of care.

- | | | |
|-------|---|---|
| CM016 | 1 | The Vendor should describe its process for performing screenings or assessments as part of its care management program, including, but not limited to, the following: |
| CM017 | 2 | Members with special health care needs, defined as individuals with complex or serious medical conditions |
| CM018 | 2 | Children with special health care needs (CSHCN) |
| CM019 | 2 | Clinical, social, or other criteria used to determine which members require care management and assignment to care managers |
| CM020 | 2 | Performance of health assessments |
| CM021 | 2 | Implementation of targeted education programs |

Screenings and Assessment Process (CM016–CM018)

UniCare administers standard processes for screenings and assessments to identify member needs and risks under our care management program. We supplement our processes with proven data

UniCare understands the importance of early detection and prevention by engaging evidenced-based strategies.

Carolyn Bruzdinski, PHD, VP,
Regional Cancer Control, American
Cancer Society

analytics, predictive models, and evidence-based strategies to further support the identification and engagement of members who may benefit from care management. Through effective screening and assessment processes, we fully learn about a member with SHCN's current services and unmet service needs. Our Care Managers are trained to assess members identified in the State's priority populations, in

addition to those with a health priority as indicated in our UniCare population health analysis: diabetes, cancer, cardiovascular and heart disease, COPD, asthma, and depression. We also have identified several social determinants of health (SDOH) priority areas, including food insecurity, housing, and transportation.

In addition to our initial screening and HRA, we have over 200 assessment tools with branch tree logic to identify when to use additional assessments. These additional tools help Care Managers uncover care opportunities, enhancing their review of a member's clinical history, service utilization, claims, risk levels, and predictive analytic measures to promptly identify complex or serious medical conditions, and design an person-centered treatment plan (care plan) that meets members' care and service needs. We also describe our assessment methods in the responses to MS006–MS014, BA014, and BA043.

Assessing Adults with SHCN (CM017)



UniCare performs an initial screening with all adults who are new to the plan, which may trigger outreach for an HRA when certain clinical or SDOH indicators are identified. We use a general adult HRA for members who have not presented a primary BH need, and a BH-tailored adult HRA when such needs are identified. As members with SHCN often have comorbid and complex conditions, additional assessments may be indicated based on the member's responses to the HRA, such as questions about the member's mood and functioning, and other specialized, evidence-based assessments for chronic conditions, OB, or activities of daily living. For example, consistent with the West Virginia SPA, Article III, Section 10.11, the evidence-based SBIRT tool is incorporated into our process to identify members who use alcohol and other drugs at risky levels, supporting the State's 1115



SUD waiver. Assessment responses may trigger an additional needs-specific assessment, such as our Special Needs Assessment; it identifies, for example, whether the member has more limited abilities, or needs a prescription diet, special equipment, or DME. Additional examples of other assessments include dementia, adult oncology, the need for palliative care, and caregiver assessments.

We have vastly expanded our assessment processes for all members to reflect the many non-clinical factors that influence health and well-being. In addition to our sophisticated tools to support member stratification into risk tiers High, Medium, or Low-Risk, or Community Well (see our response to CM006 for details), the State's goal to address SDOH has been incorporated into our screening and assessments. Further, we use a trauma-informed approach to gather information to avoid unnecessary reassessments for members who have a known history of, or current trauma, when appropriate. Care Managers may also interview members, families, and caregivers for a family-driven approach.

Care Managers obtain and review existing assessments and screenings from providers, State agencies, and other MCOs and incorporate this information into the assessment and care planning processes, to make sure we have current, accurate, and complete information. They gather and review this information continuously to support ongoing care coordination, prevent service duplication, and reduce fragmentation for the member. *Care Managers also access continuous data analytics of past member utilization via Health Insight to identify new or emerging risk factors that may escalate a potentially preventable event or condition-specific outcomes.*

As detailed in CM005, our assessment process relies upon person-centered principles, individualized by member. We capture information about current member care, services, and supports and the holistic needs of each member. Care Managers embrace and pursue this whole-person view through our extensive suite

of assessment tools, and with evidence-based practices and training to rapidly engage members in the appropriate risk tier.

Assessing CSHCN (CM018)

In addition to our child HRA, Anthem has designed a specific Children and Youth with Special Health Care Needs (CYSHCN) assessment to improve care management practices and member engagement. We developed our assessment process and tool to help address fragmented coordination across system of care partners, providers, and MCOs, as well as non-clinical factors that influence a child's health and well-being. For example, when we obtain and review existing assessments and screenings from providers, State agencies, and other MCOs, we include SBHCs in this outreach to incorporate their information into child assessment and care planning processes. We also incorporate the State's CSHCN Screener and complete our CSHCN Assessment Note within Health Insight to document the child's medical eligibility tier, needs for more medical care than is usual, and functional limitations. The CSHCN Assessment Note captures details specific to their needs, such as whether they need special equipment, or a prescription diet. More than 300 CSHCN are currently assigned to a dedicated CSHCN Care Manager.

Anthem Expands Scope of Care Managers, Improves Member Outcomes with CYSHCN Program

UniCare's Children and Youth with Special Health Care Needs (CYSHCN) program is part of a continuum of care for our Medicaid members under the age of 18 years. The CYSHCN process for identification, screening, and outreach helps Care Managers define interventions on health-related behaviors that can help improve care coordination, provide targeted education, decrease fragmentation of services, and increase access to care. Anthem developed and completed CYSHCN-customized clinical training with clinical care management teams across the country. The training focuses on enteral therapy care, health promotion, care coordination needs, and emergency preparedness for pediatric populations. Anthem also developed a cross-training preceptor tool to broaden the scope of Care Managers who engage with CYSHCN.

The CYSHCN screening tool is designed to improve member identification, engagement, quality, and scope of care management, and member outcomes — decreasing costs related to avoidable admissions, infections, wounds, readmissions, and low-acuity ER visits. *To date, we have achieved the following results nationwide:*

- Improved Anthem's member engagement rate by 44% in the first year of implementation
- Achieved cost savings across affiliate markets of \$8.1 million during the first year, from improved member outcomes and service use

Criteria for Care Management, Assignments (CM019)

Screening and assessments are organized into domains that assist in identifying members' primary conditions and needs. See Table 6.3-6 for a summary of the clinical, social, and other criteria we use to determine care management needs and Care Manager assignment.

Table 6.3-6. Assessment Criteria for Care Management Placement and Care Manager Assignment

Clinical Assessment	Social and Other Considerations
Clinical history: Barriers to care, cognitive status, medications, height and weight, BMI, nutrition, vision, hearing, and immunizations	Demographics and general information
Condition-specific assessments for future use	Cultural and linguistic needs, preferences, limitations
Clinical history: Criteria on adult assessment, and types of physicians involved in child's care, dental history (hx), PH hx, family planning, cognitive status, reading and speech, barriers to care	Life planning activities
Substance use and BH For children over age 10	Activities of daily living, community and caregiver resources
Condition-specific assessments for future use, including pediatric-specific assessments	Environment, housing, and community
Substance use: Historical and current, drug screen score	Social cohesion: Family, children, and friends
Nicotine use and vaping	Legal issues
Hospitalizations and ER visits	Risk of violence, personal safety
Conditions list	Activities of daily living, community and caregiver resources
BH treatment history, current services	Environment, housing, community
Suicide and homicide assessment	Social cohesion: family, children, friends
Mental health screen	

Care Managers capture member responses in the assessment tool, which they document in Health Insight, and partner with members and caregivers to develop the member care plan goals and interventions.

With information from the screening and assessments, supplemented with our predictive analytics and risk stratification, members are initially assigned to a risk stratification tier, as described in CM002. See Figure 6.3-7 for our criteria for determining risk tiers and need for care management.

Figure 6.3-7. UniCare's Care Management Stratification Criteria

Care Management Stratification Criteria	
Tier 3: High Risk	- Children and adults with SHCN, with abuse and/or trauma histories, with significant SDOH needs, or with other complex diagnoses - Individuals with multiple complex chronic conditions, comorbidities, or co-occurring conditions and/or 3 or more ER visits - Pregnant women with a history/current use of substance use or current/historical high-risk pregnancy - Infants in NICU and/or with neonatal abstinence syndrome and parents of NICU infants if they are members - Recently incarcerated members - Adults and adolescents who are experiencing homelessness or have a history of residential instability - Adults with serious mental illness and children with serious emotional disturbances - Transplant candidates - Individuals with HIV/AIDS, cancer, chronic renal failure, sickle cell disease, and other chronic complex conditions - Individuals transitioning from a nursing facility, a SUD facility, or experiencing other complex transitions
Tier 2: Medium Risk	- Clinically complex members with manageable conditions and high risk of higher than average future medical costs and lower likelihood of imminent inpatient admission - Identified gaps in care - Historical patterns of inpatient and outpatient utilization and admission - Member identified needs, including SDOH needs - Referrals
Tier 1: Low Risk	- Members with manageable conditions and moderate to low risk of high future medical costs - Members with no clinically manageable conditions evidenced in up to the last 12 months of eligibility with the plan - Members not accessing preventive care in previous 12 months - Members identified through health education campaigns for targeted outreach

Monitoring the Performance of Health Assessments (CM020)

UniCare actively monitors and evaluates Care Manager performance of assessments. This is an essential step to understand the effectiveness of our tools as well as the success our Care Managers have in determining member clinical and social needs. We use several ongoing, quarterly, and annual monitoring tools to measure performance. We assign CSHCN to a dedicated CSHCN Care Manager, and adults with SHCN to a Care Manager whose expertise supports management based on the member's primary condition. For more information on the Care Manager assignment process for all members, please refer to CM004.

- Monthly reporting of open and closed care management cases, and frequency of engagement

- Quarterly quality audits to review timeliness of member engagement and interventions, completeness of assessments and care plans, consistency between the care plan and treatment plans, and appropriate identification of member opportunities for improvement
- Annual care management program evaluation, including member satisfaction
- Monitoring of member complaints with the care management process or Care Managers
- Achievement of care plan goals, medication adherence, and follow-up activities

Care Management Quality Oversight



UniCare, under the leadership of our Director of Integrated Care Management, continuously monitors quality measures and Care Manager performance. We establish baseline measurements, set measurable goals, use established quantifiable measures, and conduct periodic re-measurements. We monitor care management performance against these goals:

- 95% or greater on the overall Care Manager audit
- 90% or greater on the member satisfaction survey (CAHPS®)
- 95% or greater on Care Manager adherence to each of four medication-related metrics

We also evaluate member experience by analyzing related complaints, and administering a quarterly survey of members actively enrolled in care management. Our Care Manager clinical audits are coordinated to:

- Measure adherence with all West Virginia SPA, NCQA, and Care Management standards, services, operations, and control processes
- Assure Care Managers are uniform and consistent in the practice of care management

UniCare Excels at Care Coordination for Children

In 2019, UniCare met the 90th national percentile of parents or caregivers who reported satisfaction in their child's care coordination by our Care Managers.

- Identify opportunities for improvement
- Identify staff educational needs regarding documentation and other care management processes

Targeted Education Programs (CM021)

We have targeted education programs specifically designed to support members to better understand and self-manage chronic illness(es) and conditions, medications, and wellness, and to connect to UniCare programs and community-based resources. The member's

Care Manager has a significant role in providing education to members and caregivers. Examples of educational programs and materials designed and approved for use include, but are not limited to:

- Taking Care of Baby and Me program materials for pregnant members
- Tobacco cessation for adults or children who screen for tobacco use
- Early and accessible family planning services and education, teen and adult long-acting reversible contraception (LARC) education
- Tools for self-management and on-demand access to care, such as our 24/7 Nurse Line, and Community Resource Link's SDOH resources
- Specialized Toolkits designed for families, such as ADHD and EPSDT
- **Condition-specific education**, offering individualized instructions, materials, and tools to help members learn about condition management, such as *Controlling High Blood Pressure*, *Healing Your Heart*, and *Helping Your Child Manage Asthma*. They also leverage our NCQA accredited disease management program's evidence-based programming and materials that address:

- | | | |
|--------------------|------------|------------------------|
| ○ Asthma | ○ COPD | ○ Adult or Child Major |
| ○ Bipolar Disorder | ○ Diabetes | ○ Depressive Disorder |

UniCare provides more smoking cessation classes and more counseling than any other organization in West Virginia. We appreciate the tobacco cessation efforts by UniCare to better the health of our fellow West Virginians.

Sarah Bolyard, West Virginia
Executive Director, American
Heart Association

- Coronary Artery Disease
- HIV/AIDS
- Schizophrenia
- Congestive Heart Failure
- Hypertension
- Substance Use Disorder

UniCare also partners with community-based organizations to provide targeted education. For example, we have relationships with the American Heart Association (CPR training, Kids Heart Challenge), Beckley Dream Center (Dining with Diabetes initiative), and the United Way of Central West Virginia (substance use recovery supports).

CM022	1	The Vendor should describe its process for creating educational materials and educating members and care management staff.
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Creating Educational Materials (CM022)

UniCare provides robust outreach and education with meaningful, linguistically, and culturally appropriate messages. Focused on wellness, prevention, and self-management of complex conditions, our range of materials support all members, caregivers, and providers. We use educational strategies and materials that help meet our members' learning needs and preferences and adhere to federal and State requirements. UniCare's Care Management team is bolstered by our extensive health education library and tools with materials aimed at members, caregivers, and providers.

Using clinical knowledge and judgement, our Care Managers and Certified Diabetes Educator regularly review and recommend updates to UniCare's health education materials and recommend new materials and topics where appropriate. During IDT meetings, staff discuss members' circumstances and identify tools and resources best suited to support them. *All UniCare staff are oriented to the library of health education tools and materials and have access to them at their fingertips.* For example, Care Managers share or forward pertinent materials with members during encounters in real time simply by clicking on the material in Health Insight.

UniCare's health education materials are designed to promote wellness, improve utilization of preventive services, and reduce health risks by providing education about healthy lifestyle behaviors on a wide variety of topics such as: tobacco cessation, alcohol and drug use, immunizations, prevention of sexually transmitted infections, HIV, family planning, nutrition and weight management, exercise and physical activity, injury prevention, and parenting skills. Our materials also educate members on how to effectively use the managed health care system. We maintain an organized delivery system of health education programs using educational methods appropriate for members that are effective in achieving behavioral change for improved health outcomes.

Process for Creating Educational Materials

Assessing Health Education Needs of Our Membership

We regularly design and update health education materials based on current evidence, member data, community health trends, and stakeholder feedback. A continuous review of changes in evidence-based preventive health and treatment recommendations assures our education materials, programs and initiatives are up-to-date. We use member data to inform our outreach and materials dissemination to drive appropriate service utilization, improve access to preventive care, and encourage risk reduction behaviors. UniCare identifies and responds to health trends and issues in the community. For example, given the recent surge in e-cigarettes and resulting health concerns, we updated our educational materials specifically to address e-vaping. In our development process, we also solicit feedback from UniCare members and other stakeholders. For example, *in February 2020, our Stakeholder Advisory Committee meeting will include identification of new topics for health education material development.*

Developing, Refining, and Endorsing Materials

UniCare works with a Stakeholder Advisory Committee to test new materials and gather feedback around the appropriateness of the topic, content, and presentation of information. This advisory group is made up of members and their caregivers, stakeholders, and other community partners.



We also present member materials at our Member Engagement Committee (MEC) meetings for review; our first meeting of 2020 will occur in February. Members can provide suggestions to improve content and format to make sure materials are informative and easy to understand. With approval of the State, we will also use social media to obtain feedback on materials; we plan to post materials to our Facebook page and solicit input from members, providers, advocacy groups and other followers. Further detail on materials development is described in our response to question MS001.

Member Education

UniCare's health education materials and services are used across multiple departments. We employ a variety of educational strategies and methods to accommodate diverse learning styles such as visual, auditory, social, and solitary. All health education services are available in other languages upon request through our Interpreter Service. **Health education**

Three Key Components of Successful Member Health Education

- Improve health literacy so members can have the knowledge, skills and information to make healthy choices
- Support member navigation of the care delivery system and covered services and benefits
- Be meaningful and responsive to the member's health, wellness, and social needs

modalities include one-on-one education in person or telephonic; health education classes; 24/7 Nurse Line; live and automated outreach calls; targeted mailings to members; provider educational materials; Healthwise A to Z — a web-based resource available to members — and health education brochures available on our website to members and providers.

Care Management Staff Education

In our response to question CM0023, we describe a comprehensive, mandatory training program for newly hired Care Managers that includes orientation to UniCare and Medicaid, care management skills and processes, and systems training. *Orientation and exposure to health programming and member health education materials are woven throughout Care Managers' initial orientation training, peer mentorship and ongoing in-services. Care Manager competencies include accessing and using member education materials.* UniCare provides tuition assistance and awards for our Care Management team's professional development and encourages skill development in state-of-the art approaches to health education, goal setting, action planning, and motivational interviewing.

- CM023 1 The Vendor should describe its staff qualification and training requirements for individuals involved in coordinating care, including, but not limited to, any specialized care managers for certain conditions.

Care Management Team Staff Qualifications (CM023)

UniCare designed a comprehensive approach to support recruitment, hiring, and retention of a highly qualified, experienced, and trained Care Management team that can successfully perform all required Contract functions and provide the best possible services to our members, providers, and DHHR. We require our Care Management team to have the qualifications outlined in Figure 6.3-8.

Figure 6.3-8. UniCare Employs and Develops a Highly Qualified Care Management Team

Care Management Team Staff Qualifications		
Position	Education	Minimum Required Experience
Director of Integrated Care Management	RN and/or LCSW	5 years' experience as Care Manager for Medicaid program; demonstrated member communication skills
Integrated Care Manager or Community-based Care Manager		
Nursing	RN	3 years' clinical experience or equivalent combination of education and experience working in pediatrics, BH, or chronic care
Social Work	BSW	3 years' experience working in a social work agency
Licensed BH Clinician	LCSW, LGSW, LICSW, LPC, or clinical psychologist; or master's degree in SW, counseling, or related BH field or nursing	3 years of BH experience or combined equivalent education or experience
Specialized Care Managers		
CSHCN Care Manager	RN	3 years clinical experience; integrated care management experience working in area of specialization
Post-discharge Care Manager		
High Risk OB Care Manager		
Utilization Managers	RN, clinical psychologists, master's-level licensed clinicians	3 years of recent acute care experience, experience in BH healthcare setting, and/or managed care. Care management and BH experience (SMI, SED, SUD, dual diagnosis)
Other Care Management Team Staff		
Community Health Worker*	High School Diploma or GED	5 years' experience supporting member services
Peer Recovery Specialist	Associate's Degree (BA/BS preferred)	2 years of experience in health services, BH or peer support services; understanding of care coordination concepts or combined equivalent education or experience
Health Coach	BA/BS in health-related field	3 years' experience in health care, care management, discharge planning, or BH
Outreach Care Specialist	High School Diploma or GED	1 year of experience, understanding of Medicaid/managed care or combined equivalent education or experience
Community Paramedic*	EMT-P	Minimum Required Experience: Per Community Partner*

All licensed staff are licensed in the State of West Virginia
 *Community Health Workers and Community Paramedics are employed by communities and serve as part of our local UniCare Care Management teams.

Foundational Curriculum for New Care Managers

UniCare implements a comprehensive competency-based training program for newly hired Care Managers that uses a blended learning solution including the flipped classroom model, virtual instructor led training (vILT), asynchronous self-paced activities, preceptor guided practice sessions, eLearning

using a Learning Management System, POD-casting, and videoconferencing. The following illustrates our three-phase curriculum summary for all Care Managers.

- Phase I: General Orientation to UniCare and Medicaid
 - *All newly hired Care Management staff complete a general company orientation.* Topics include corporate history and structure; mission statement; values; ethics; cultural competency; health disparities; leadership principles; HIPAA; fraud, waste, and abuse; basic safety and security principles; sexual harassment policies; benefits; and performance evaluation process.
- Phase II: Care Management Skills and Processes
 - *This training is designed to give new Care Managers focused training on their role.* Major topics include: Introduction to the Care Management Program; HIPAA, CPSUI, and other regulatory topics; member identification, screening, and grouping; engagement and motivational interviewing techniques; assessment(s), including problem identification; stratification and complexity leveling; care planning, including setting goals and developing interventions; Person Centered Thinking; monitoring, evaluation, and reporting; transfer, discharge evaluation, and case closure; skills practice; and standards of care.
- Phase III: General Systems Training
 - *This training focuses on IT systems and applications that support care management.* Topics include, but are not limited to: system training in customer service, UM, and care management; and secure transfer of information and communications with members of the multidisciplinary team.

Supplemental Training for Specialized Care Managers

UniCare employs designated specialized Care Managers for High-risk OB, CSHCN, and PDM. *In addition to meeting specialized qualification requirements to be hired for these positions, these staff complete supplemental web-based, self-paced modules prior to working with these specialized*

populations. We require High-risk OB Care Managers to complete a module in high-risk obstetrics; CSHCN Care Managers are required to complete a series of modules on CSHCN including enteral therapy, and NICU modules include NICU parent sensitivity training and PTSD screening scenarios. For PDM Care Managers, we incorporate Coleman Care Transitions Intervention® (CTI) principles into our training.

Ongoing Competency Development

The evaluative component of the training program includes a competency evaluation and checklist to document all activities reviewed and assures the Care Manager demonstrates knowledge and understanding of the content. After the initial training of newly recruited staff, experienced Care Managers in our program partner and mentor these new staff on the job. We conduct quality assurance audits for each Care Manager with feedback on their performance and program compliance described in CM030.

UniCare requires ongoing in-service training facilitated by our Medical Directors or other internal experts, or in collaboration with community partners at least monthly on topics relevant to our members. A comprehensive list of UniCare's continuous training for clinical staff is presented in Section BA005. We also encourage and provide tuition support for ongoing professional competency development and certification in care management, such as the CCM credential.

Gold Standard for Care Manager Excellence

Eight of our Care Managers hold the CCM® credential, which is prized as the gold standard for Care Manager excellence. UniCare encourages and supports certification of our professional staff.

CM024	1	The Vendor should describe its process for hiring care management staff including, but not limited to, the following:
CM025	2	Staff qualifications
CM026	2	Plan for hiring
CM027	2	Timeframe for hiring
CM028	2	Total number of care managers to be hired
CM029	2	Maximum case loads and ratios per care manager for Vendor-defined risk tiers

Process for Hiring Care Management Staff (CM024)

We hire local, licensed clinicians with varied backgrounds and experiences to make sure our Care Management team has a diverse knowledge of the West Virginia health care system. We post positions broadly and recruit through career fairs at Marshall University, West Virginia University, University of Charleston, and West Virginia State University. All interested applicants apply for a position through our online application system. We conduct an initial phone interview for those who meet job requirements and select the top candidates for in-person interviews. Interviews are conducted by a combination of peer employees, care management leaders, and Human Resources staff. We select the top candidate based on their match to job requirements, relevance of experience, and organizational fit. Finally, we make an offer. If the candidate accepts the offer, our Human Resources team conducts employment verification and an extensive background check prior to starting, described in detail in Attachment 4.

Care Management Staff Qualification (CM025)

Our Integrated Care Managers are Registered Nurses, social workers, and BH Clinicians licensed in the State of West Virginia. All Care Managers are cross-trained in PH and BH with member assignment based on the member's dominant presenting condition(s). Care Managers are supported by additional trained clinical and non-clinical Care Management staff, enabling Care Managers to work at the top of their license. Care Management team qualifications are described in detail in response to question CM0023 and in Attachment 3: Vendor Qualifications and Experience.

Hiring Plans (CM026)

A key part of our hiring strategy includes a concerted effort to hire and employ Integrated Care Managers with experience in both PH and BH from the communities we serve and deploying them as field-based staff in those communities. *UniCare has a community-based care management presence in all corners of the state.* Figure 6.3-9 depicts placement of our Care Management team staff, including community-based Care Managers, CHWs, Peer Recovery Specialists, and CPs in 20 counties (in blue). In the remaining

Figure 6.3-9. CM Employees Are Based in Every West Virginia County



counties (in white), our Integrated Care Managers work telephonically with our field-based CHWs to provide local care management. As Care Manager positions become available, we target hiring efforts to communities where the most members could benefit from community-based Care Managers, using heat maps to help identify priority locations for hiring and placement. *For example, our membership data indicated a high rate of SUD in the Eastern Panhandle, prompting us to hire a new community-based Care Manager for that region to provide our HOPE program — an intensive, field-based care management program for our most vulnerable comorbid population.*

Please refer to Attachment 4 for the Care Management team staffing plan, which includes tools and processes for position advertising and hiring.

Timeframe for Hiring (CM027)



UniCare currently employs exceptional Care Management staff to support our members in West Virginia. As we move into the new Contract term and recruit additional staff, any new staff will be hired at least three months prior to Contract start date to provide enough

time to complete UniCare's initial training before implementation. Please refer to Attachment 4 for the Care Management team staffing plan.

Total Number of Care Managers to be Hired (CM028)

We will be increasing our Care Management team by hiring over 30 FTEs (based on estimated membership projections). Additionally our Care Management staff will be supported by our new Population Health team of over 15 FTEs including a Director Population Health, Public Health Manager, Community Navigators, Public Health Coordinators, Liaisons for Housing, Employment and Transportation, a Public Health Strategy Leader, Population Health Reporting and Analytics and Population Health Engagement Leader. The responsibilities of this team are outlined in our response to CM044.

Care Manager Case Loads and Ratios by Risk Tier (CM029)

There are many factors that determine the caseload capacity and Care Manager ratio. As an example, intensive care management for CSHCN requires more time and involvement than a member with a controlled chronic condition. A Care Manager who meets with members face-to-face in a rural area will not be able to handle the same caseload as a telephonic Care Manager.

Our person-centered methodology for assigning and maintaining optimal care management caseloads considers several case-mix factors to assure each member's health and safety such as level of care coordination required. These factors include acuity and complexity of the population; language and cultural preferences; geography and population distribution; contact frequency and modalities; amount, scope, and duration of service needs; Care Manager qualifications and experience; access to supportive staff; and proximity to the member.

Members are assigned a Care Manager with experience that best meets their needs. We employ a case-mix methodology that uses a weighting system to inform average Care Manager-to-member ratios but allows for caseload complexity. Figure 6.3-10 presents our caseload guideline including care management staff-to-member ratios by risk tier. These ratios are informed by our current experience and extent of member engagement with the Medicaid population in West Virginia.

Figure 6.3-10. Lower Ratios Allow for Higher Intensity Care Management with Assigned Members

Member-to-Care Manager Caseload by Member Tier Level		
Tier Level	Care Manager	Caseload Staff Ratio
3: High Risk	Integrated Care Manager	1:35
	Community-based Care Manager	1:45
	Complex/Specialized Care Manager	1:45
	CSHCN Care Manager	1:350 in perpetual CM
	High-risk OB Care Manager	1:45
	SUD Care Manager	1:60
	Outreach Care Specialists	1:60
2: Medium Risk	Integrated Care Manager	1:60
	Community-based Care Manager	1:45
	Community-based CHW	1:120
	Community-based Community Paramedic	1:30 est. visits/month
	Health Coaches	1:120
	Housing Liaison	1:30
	Transition Navigator	1:30
1: Low	Integrated Care Manager	1:60
	Community Navigator	1:60
0: Community Well	Integrated Care Manager	1:100

- CM030 1 The Vendor should describe its process for monitoring and evaluating care managers in regards to establishing relationships with members, including, but not limited to, statistics collected and frequency of collection.

Monitoring and Evaluating Care Managers (CM030)

It is important our Care Managers establish ongoing, effective, and supportive relationships with members and demonstrate competency in all aspects of their member interactions. We will leverage our quality oversight and improvement infrastructure and resources to make sure they complete care management activities with attention to each member's unique needs and experiences. We have designed our approach to enhance the member's quality of care though



comprehensive care management with a person-centered treatment plan (care plan) that reduces fragmentation, promotes integrated care, and leads to improved health outcomes and well-being.

We have extensive experience developing, implementing, evaluating, and reporting on numerous quality metrics, including measures of performance and member satisfaction with the Care Manager. We assess Care Managers' performance of key activities throughout the care management process, such as notifying PCPs of member engagement in complex care management.

Our quarterly care management survey evaluates members' satisfaction with their Care Manager. *In 2019 three of UniCare's Care Managers were honored by the West Virginia Association of Health Plans in their inaugural iCare awards ceremony for demonstrating exemplary care management service to members.* See Table 6.3-7 for 2018 survey results.

Table 6.3-7. Care Management Member Survey Findings in 2018

Member Satisfaction Element	Outcome Rate
Satisfied with their Care Managers	93%
Care Manager helped meet their needs and make their lives better	92%
Care Manager treated them with courtesy and respect	98%
Care Managers provided timely assistance in meeting their needs	94%
Care Managers knew about their needs, provided essential information, and helped them access needed care	96%

Approach to Quality Oversight

Our quality oversight and continuous training assure Care Managers have the experience, qualifications, and resources to meet internal and MHT quality goals. We track Care Manager performance daily, and gather monthly, quarterly, and annual data on key performance measures, generating statistical analyses to drive enhancements.

Care Management Oversight and Audits. We establish annual goals for completion of care management activities and compliance with established timeframes. Health Insight supports care management oversight with key indicators, alerts, and manager dashboards that provide an easy-to-review

summary of activities and milestones. We proactively track Care Manager performance with Health Insight alerts, which Care Managers and supervisors review daily to confirm they are meeting required or internally defined timelines. We perform in-process audits on numerous metrics to evaluate newly assigned Care Managers' performance in the opening of a member case, and implement corrective actions as needed. See Table 6.3-8 for a list of our audits, their frequency, and number of audit elements.

Health Insight

UniCare's integrated care management platform, Health Insight, provides a holistic view of the member's whole-person needs — supporting our staff with the tools and functionality to support the delivery of high-quality care and coordination of covered services. This allows for direct care of physical, behavioral, and social services and supports timely communication between all Care Management team members, as well as providers and the members.

Table 6.3-8. Care Management Monthly Audit Elements

Audit Type	Audit Frequency	Number of Audit Indicators
Post-discharge Management	Monthly	35 indicators
Intensive Care Management	Monthly	35 indicators
High-Risk OB	Monthly	35 indicators
NICU Care Management	Monthly	32 indicators
Peer Mock Audits	Monthly	26 indicators

We also provide a sample of our monthly audit review elements in Table 6.3-9.

Table 6.3-9. Care Management Monthly Audit Elements

Care Management Monthly Audit Elements		
Consistent documentation in Care Management Health Insight platform	Application of NCQA and Managed BH Organization criteria	Consistent tool use, completeness, and adherence to established timeframes
Alignment between assessments and care plans	Adherence to MHT policies and federal regulations	Member and provider feedback and satisfaction surveys
Quality case reviews		

Audit results inform the feedback provided to Care Managers and additional training, issue resolution, performance against previous audits, and overall Care Manager performance. We also identify broader issues for re-training or process changes. See our response to CM020, which aligns with this response.

Collecting Statistics and Tracking Performance. We will establish key performance indicators for Care Managers based on MHT SPA requirements and internally defined quality benchmarks to assess their performance against our compliance goal of 95%. See Table 6.3-10 for examples of our proposed

measures, data sources, and monitoring frequency. We also assess a member's progress toward care plan goals and modify the care plan, as needed.

Table 6.3-10. Sample Care Management Performance Measures

Standard	Data Sources	Frequency
Screening Timeliness for Care Management Stratification		
Initial outreach within five calendar days of assignment in care management	Health Insight	Daily
Completion of HRA within 90 days of enrollment and annually	Health Insight	Daily
Member stratification within five calendar days of enrollment (for members with SHCN flagged in 834 file) or five calendar days of initial screening, and refer to care management and Care Manager assignment, if applicable	Health Insight	Daily
Care Managers' Relationships with Members		
Satisfaction with Care Manager	Member Experience Survey	Quarterly
Engagement rate	Health Insight	Monthly
Number of completed outreach attempts by phone or in-person	Health Insight	Monthly
Care Plan Completion		
Completion of initial care plan within 90 days of enrollment	Health Insight	Monthly
Update to care plan	Health Insight	As needed

Care Management Program – Member Experience Survey

An essential component of our care management program is obtaining feedback from members. Survey results provide detailed insights of members' more complex service needs and their care experience.

We conduct a Care Management Member Experience survey with all members who participate in our care management program, including members 18 years of age or older and, for children under 18, their caregiver or authorized representative. UniCare administers the survey at least annually by phone or by mail if we do not have up-to-date telephone contact information. The plan has maximized participation and achieved a representative sample each year.

Members Are Consistently Satisfied with UniCare Care Managers

Ninety percent or more of surveyed members consistently express satisfaction with our Care Managers across multiple measures.

- CM031 1 The Vendor should describe its protocols for addressing a member that would benefit from a care manager, including alternatives for members that do not want a care manager, members who cannot be reached, and members who have missed medical appointments.

Members Needing Care Management, or Who Do Not Engage (CM031)

UniCare's community-based care management program has demonstrated higher levels of member engagement when compared to traditional telephonic care management. *Forty percent of members we contact in the community agree to complete the comprehensive assessment, and 74% of those members complete the full community-based care management program.* Our community-based care management team, comprised of CPs and CHWs have also been successful connecting members to SDOH resources in their area, such as food resources. Access to food is a special challenge since some communities in West Virginia do not have food pantries, some members do not want to access food pantries, while others have had difficulty accessing SNAP benefits. Together with our community-based care management team, we have succeeded in providing early and steady member engagement via multiple outreach calls and letters, with support from providers and community-based organizations.

We track members who are referred to the program but choose to opt out, are difficult to reach, or who repeatedly miss their medical appointments. We respect member and caregiver choices and we value their vital collaboration with us for care management to be effective. We use several strategies to bring care management to members who need it, even when they choose not to engage. Depending on the reason(s) for member disengagement, the Care Management team follows established processes to contact members who are hard to reach and connect them with community-based team members. They also identify other local community supports, conduct targeted phone calls and outreach campaigns, or notify providers about missed care gaps. We continuously update our outreach strategies to proactively, engage with members in weekly rounds to identify new ways to engage members.

Members Declining Care Coordination Services

If a member declines care management, we offer to check in at set intervals, and then follow up with their PCP. We remain in contact with the PCP and help coordinate services through them, as well as with Care Coordinators or Case Managers in other systems of care for adult and child members with SHCN. The Care Management team monitors specific events in real time to identify members who may need care management, tracking indicators such as ER visits within 40 days of an inpatient discharge or two inpatient admissions within 30 days, as well as care management indicators on members in Health Homes. Care Managers will work to schedule face-to-face interventions with members we identify for possible care management and offer help related to their specific events, risks, and other needs.

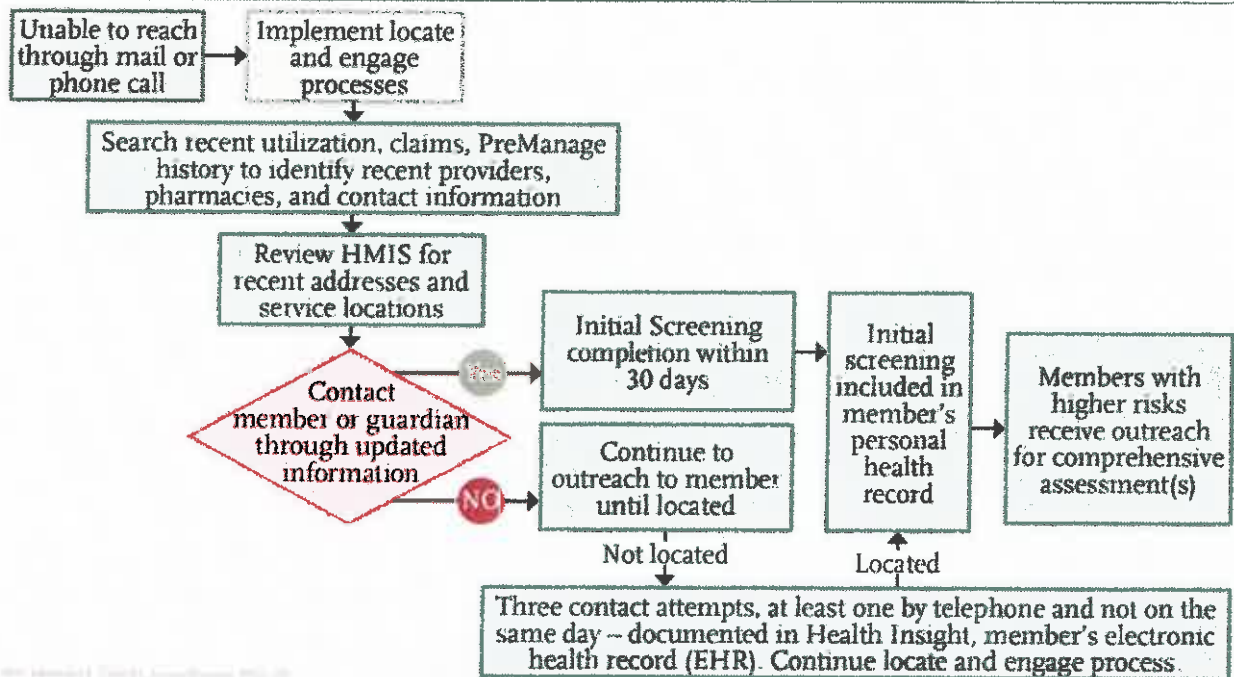
When necessary, we contact PCPs to obtain the most up-to-date member contact information and reinitiate contact. If the member still cannot be reached we alert the PCP. We then monitor claims and authorization data to identify provider encounters to obtain updated contact information and coordinate member follow-up with their PCP.

Engaging with Members Who Miss Medical Appointments

In 2020, Care Managers will use the HMIS “client tracker” to locate members with SHCN who are homeless as described in CM043. If we learn a member is experiencing homelessness, a member of the Care Management team will contact organizations providing housing and shelter services to facilitate proactive care coordination. See Figure 6.3-11 for a workflow of our process to reach hard-to-locate members.

Figure 6.3-11. Hard-to-locate Care Management Process

Hard-To-Locate Care Management Process



Health Insight helps Care Managers track referrals and interventions in the member's care plan. The platform generates alerts (reminders) for Care Managers on their assigned members about upcoming or missed appointments, or needed follow-up care, such as for children who do not stay on schedule with EPSDT well-child screens. Health Insight will help Care Managers with member outreach to remind them about appointments in advance using various methods, such as telephone, email, and text messages. They identify new members' continuity of care needs; help members select providers; schedule NEMT; coordinate well-child screenings and related EPSDT services; complete telephonic screenings about initial and regular checkups; and reinforce the importance of regular preventive visits with PCPs and dentists. See our responses to BA036, and BA044–BA046, which align with CM031.

- CM032 1 The Vendor should describe its process for identifying members in need of treatment plans, and the development, updating, and implementation of treatment plans wherein service coordination is required.

Process for Identifying Members Who Need Treatment Planning, Development, and Implementation (CM032)

Elements of Tiered Care Management



Identifying Members in Need of a Care Plan

UniCare Care Managers identify members in need of a person-centered care plan and provider treatment plan by reviewing the information gathered during the member's initial screening, face-to-face HRA, assigned level of risk stratification, predictive modeling, and through analytic insights, who have been referred to our Care Management team. Care Managers can select from over 200 additional assessment tools depending on the member's individualized needs. They also consult with the member's PCP and other providers for input to inform the member's care plan, access to care needs, and to coordinate with the provider(s) treatment plans. We explain how we identify members for assessment and care planning further in CM001, CM003, and CM005.

We assign all identified members who will benefit from care management to an experienced Care Manager who will work with them to assess their current clinical and biopsychosocial needs. If the member agrees, they will actively participate in the development of their own person-centered care plan in real time, by phone or in-person at a location convenient for them.

Developing, Updating, and Implementing Care Plans

Care plans are living documents, intended to develop each member's individualized goals, inclusive of and responsive to their biopsychosocial needs. In developing the care plan, the Care Manager also consults with each member's treating providers and any identified supports, including interpreters if preferred by members when English is not their primary language. The Care Manager also confirms provider treatment plans align with the care plan and address all the member's needs.

In addition to integrating care needs across health care disciplines, our Care Managers build care plans that are evidence-based, culturally appropriate, and that define and promote outcome improvements within defined timeframes. With input from the member, caregivers, and PCP, the Care Manager develops a care plan with short- and long-term care management goals, actionable objectives, and measurable quality outcomes. They update care plans with the member at least annually, and more often for high-risk members. Care Managers share new care plans and updates with members, caregivers, PCPs, specialists, and others involved in the members' care at least annually. Providers can also access a member's most recent care plan via Health Insight, our information-sharing platform.

The Care Manager has responsibility for executing all care plan linkages via referrals, care coordination, communications, tracking care continuity, and follow-up with members and providers. Implementation of the care plan enhances the member's health literacy, and promotes self-management and care plan adherence.

Our Care Managers hold follow-up meetings on a scheduled basis based on each member's risk tier, or member preference, to discuss their progress toward goals and barriers to achieving goals, such as difficulty arranging for NEMT, scheduling provider appointments, or engaging with providers, and modify the strategies outlined in the care plan accordingly. We set the frequency of meetings and related member-centric care plan updates monthly or quarterly, based on the member's level of complexity and

perceived health needs. The Care Manager goes over any other needed service and related care plan changes in partnership with the member and caregivers and communicates the updates to the member's PCP and any specialists. Care Managers continually assess members for triggers such as changes in condition and reach out to them, updating their care plans as needed. They document updates in Health Insight with new information, the member's current circumstances and health status, and their abilities, desires, and capacity to participate in the process.

The Care Management team holds integrated rounds daily and ad hoc rounds when a member's condition or needs require, to discuss ongoing or new member needs and receive guidance from our multidisciplinary team on how to resolve challenges to coordinating care. Members remain in the care management program until they achieve their desired goals and outcomes or may transition to a higher or lower acuity level as needed or preferred. We provide additional information about UniCare's care planning process in response to CM033 through CM037.

CM033	1	The Vendor should describe its process for the development of member treatment plans, including, but not limited to, the following:
CM034	2	Including Primary Care Providers (PCPs) in the development of treatment plans
CM035	2	Sharing treatment plans with the member's PCP or other providers, as applicable
CM036	2	Staff responsible for sharing treatment plans with the member's PCP
CM037	2	Tracking of completion of treatment plans
CM038	2	Identification, tracking, and remediation of gaps in care
CM039	2	Processes for episodic and/or catastrophic care management interventions

Developing Treatment Plans (Care Plans) for Members (CM033, CM034)

We identify members in need of care plans through a review of information gathered during the intake, screening, assessment, and our ongoing care management contact processes described in CM032. Care Managers help the member, their family and supports, and treating providers to address member care challenges. Through ongoing and regular review of the care plan, we can assure continuity of care. The member's Care Manager continuously monitors the care plan to assure the implementation of services are

provided and monitor the member's condition — supporting the member to meet the expected outcomes and goals of the care plan. *The member and our Care Manager work collaboratively to develop a comprehensive care plan, which includes contributions from the member's PCP and other providers to identify goals and supports to align with the member's service needs.* We initiate care conferences when necessary to collaborate when there are multiple providers involved and to assure we incorporate all of the member's biopsychosocial needs. Care Managers coordinate care with treating health care professionals for members with disabilities or at risk of developing a disabling condition and with chronic or complex biopsychosocial needs, including CSHCN, by collaborating with the member's PCP and treating providers to make sure the member has access to needed treatment such as specialty care. The Care Manager works closely with our UM Clinicians to complete determinations for requested services. Our Care Manager is responsible for monitoring and assessing the member's needs, the status of their care plan, and making sure that their providers are aware of any care plan changes. As new needs arise or we identify changes in member condition, our Care Manager facilitates a meeting with the member to update the care plan and to coordinate necessary referrals to appropriate services and supports.

Collaborating and Sharing Care Plans with Providers (CM035, CM036)

UniCare encourages and supports the PCP's and treating providers' role in care planning as imperative to the efficient coordination of services and the alignment of their clinical treatment plan and our person-centered care plan goals. If the member has a significant change in needs, health status, or level of care, or if they experience ER use or an inpatient admission, there may be a need to adjust or modify the member's existing care plan. *Our Care Manager is responsible for notifying the PCP and other identified treating providers by phone, fax, or email — depending on the member's needs, circumstances, and treatment status — and shares the updated care plan with the member's PCP and*

applicable specialty providers at a minimum annually, or as status updates change the care plan. The member's care plan is available to treating providers through our integrated Health Insight information-sharing platform.

We share care plans with providers to support coordinated service delivery throughout the care planning process. Care Managers incorporate PCP and provider feedback into care plans and assessments. Our integrated Health Insight system provides PCPs access to near real-time claims and encounter data and claims history, so providers can access actionable biopsychosocial health and pharmacy information. This platform houses member utilization data and clinical information including service authorizations, lab results, immunization records, and care management and disease management (DM) data. With consolidated member clinical data from various sources, it provides PCPs a holistic picture of each member's utilization, care plan, and opportunities for care. We provide training to providers on the availability of information on the provider portal about how they can leverage the information to optimize the flow of communication between health care stakeholders — such as professional and facility providers, health plans, pharmacies — through a secure web-based exchange.

Tracking Completion and Updating Member Care Plans (CM037)

Report Monitoring Fields

Identifying Info: Care Manager, Member Name, Plan Name, Secondary Care Management

Active Goals: Person-centered condition-specific goals

Care Plan Priority: A priority with each goal (High/Low)

Milestone Due Date: Outdated care plan will generate a flag

Care Plan Intervention: Each goal is to address barriers to goal completion

We have reporting policies to monitor timely completion of care plans for members with complex medical condition and those identified with SHCN. The care plan is a living document our Care Manager reviews and updates regularly and when the member experiences a significant change in needs. At a minimum, we review and update the member's care plan at least every 12 months. For members identified as higher

risk, we update the care plan either monthly or quarterly and as needs change. We coordinate

reassessments and updates to the care plan with the member, providers, and family or other supports. A review may trigger member outreach and follow-up or engagement in specialized programs such as our Safe Prescribing program as described in CM015, or high-risk OB care management described in CM009.

Care Managers contact the member, and as applicable the PCP or specialist provider, for additional information if we identify changes or potential issues. In collaboration with our UM team, our Care Managers make sure the member's care plan remains current and relevant. The assigned risk stratification level and the Care Manager's activities are fluid, and we can adapt or respond to changes in member's needs. We coordinate reassessments and care plan updates with, and make available to, the member and caregiver, PCP, treating providers, and other applicable system partners. Our Care Management Director provides oversight and completes reporting regarding timely completion of care plans, reviews to assure updated goals, and monitors for outstanding tasks for members in need of services. Monthly, we use Performance Improvement Enhancement (PIE) to audit completion of care plans in compliance with NCQA guidelines, SPA and DHHR requirements, and documentation standards. These audits review our care management processes, care plan completion, and notices to providers.

Experience and Systems Identify Care Improvement Opportunities (CM038)

We leverage our care planning discussions with members and their caregivers, PCPs, or other specialty providers to identify a specific member need or service that is not available in the market. We compile data analytics and alerts within Health Insight, including HEDIS and EPSDT care opportunities or service needs. *Health Insight helps Care Managers track and monitor upcoming or missed preventive care and wellness visits, and services received, including non-covered services.*

Our Care Management team can also track monthly gaps in care through reports, which helps identify upcoming or missed information about the services members need, including pharmacy and dental. We

can identify when a member has an upcoming preventive care screening or had issues filling prescriptions. For members under the age of 21, we closely monitor childhood screenings, including EPSDT Periodicity Schedules. For members who are pregnant, we track pre- and post-natal screenings as recommended. Our Health Insight platform combines this member information from multiple sources into a single record to provide a holistic picture of the member's utilization, opportunities for improvements in care, and authorizations.

Care Managers work directly with our QM and Provider Services teams to identify interventions that address these opportunities to improve care. Our IDT reviews existing care plans for appropriateness of care, to assure clinical services and supports are in place, to continually screen for potential concerns, to identify any opportunities in care, and to engage additional services needed. During this review, Care Managers may contact the PCP or any specialty care providers, including BH providers, to assess the member's current prescribed treatment, services, or care opportunities. For example, if we identify a service in the care plan was not received, we ask the member if there was a barrier to accessing the service, such as transportation or appointment availability, and work to resolve that barrier. All UniCare staff serve as standing resource for members and their caregivers to contact with concerns and will work to address their needs. We provide additional information about our efforts to improve care through community partnerships and programs in CM043.

Episodic and Catastrophic Care Management Interventions (CM039)

Our stratification approach considers management of a member's chronic conditions or illnesses and assigns all who need episodic or catastrophic care management interventions to Tier 2 or Tier 3 risk level. These members are at the greatest risk of poor health outcomes due to complex or comorbid health conditions, multiple inpatient admissions, frequent intensive service use, multi-agency or provider

involvement, and previous or current indications of non-adherence to care plans. Members in Tier 2 or Tier 3 include:

- Children with cancer diagnoses who are technology dependent
- Teens with complex conditions such as anorexia or kidney disease, or who are transitioning from an inpatient stay or a PRTF
- Adults with chronic and comorbid conditions such as diabetes and SUD, extended care in a nursing facility, or other residential facility stay
- Adults recovering from a traumatic injury, serious acute illness, or post-surgical complications

These members may need intensive coordination of services and support, including frequent cross-system collaboration, to avoid a readmission or preventable events. The Care Management team focuses their activities through close, cross-system coordination and collaboration with the Care Manager, serving as the primary point of contact, to simplify health care management and make sure the member's health and social support needs are met. Interventions include targeted education to equip and connect caregivers to the resources needed to provide the most beneficial and appropriate care to the member. As the member's needs change, we adjust the intensity of services and provide immediate and frequent communication to the PCP or specialty provider to help assess the impact on the goals previously outlined in the care plan.



Real Stories

On March 19th, 2019, during our high length of stay rounds at Carilion Roanoke Hospital, we reviewed the case of Anna, a 15-year-old from Lewisburg. She was diagnosed of acute flaccid myelitis and became paralyzed from her neck down — requiring a tracheostomy with ventilator assistance and a peg tube for feedings. After much needed time for physicians to stabilize her medically, Anna's Care Manager, Sidney, in collaboration with other members of our UniCare Care Management team and the staff at Carilion hospital, supported Anna in her transfer to Shepard Center in Atlanta, Georgia — an OON inpatient rehab facility that specializes in spinal cord injuries. After two weeks, Anna received a decannulation of her tracheostomy and had her feeding tube removed. On May 31st, 2019, Anna was discharged from Shepard Center and returned home to West Virginia. Anna made amazing improvements and can now stand, walk small distances, and has full movement of her arms. She attends physical therapy three times a week and completed all of her school work so she could start her sophomore year of high school on schedule. She received a motorized wheelchair to better navigate her high school and to attend events that require longer distances to transport. Sidney continued working with Anna, and during a weekly conversation with Anna's father about her progress, she confirmed the family received reimbursement for travel expenses to Atlanta. He was appreciative throughout his daughter's very emotional and difficult journey to overcome this rare diagnosis. Anna's mom refers to Sidney as her "Angel Lady." Sidney has said that it's "a wonderful feeling knowing that I can make that big of a difference in her life and that of her daughter's."

If a life-limiting illness progresses, and the member has a degenerative condition that qualifies them for alternative or less aggressive treatment options through palliative or hospice care, we collaborate with the member's treating providers to offer education to members and their families or caregivers about their choices to determine their treatment options. We refer members desiring additional pain management supports, with qualifying diagnosis, to receive palliative services and supports to focus on their quality of life by anticipating, preventing, and treating suffering. Any member, with indication from their treating physician as having a life expectancy of six months or less, may elect to receive hospice care in lieu of typical, aggressive, or curative treatment coverage for services related to a terminal condition. Hospice, which is

palliative in nature, can focus on alleviating pain and suffering with care specifically directed toward the biopsychosocial and spiritual needs of the member and their family or caregivers. Hospice services are available and designed to maximize the member's comfort and include anticipatory grief, grief, and bereavement counseling for the immediate family and significant others. The assigned Care Manager works with the member and their family or caregivers during this time to provide education about the

services available the levels of involvement from the hospice team that are available. The Care Manager can also provide support and resources during end-of-life preparation and planning.

We develop evidence-based programs to incorporate into the member's care plan. For example, for pregnant members who are also substance users, we leveraged our local staff and national subject matter experts to create our Anthem NAS/NOWS program — an episodic care coordination program that incorporates evidence-based approaches that seek to avoid child welfare engagement through early identification and resolution of the mother's and baby's needs. The program includes:

- Advanced analytics and predictive modeling
- Peer support and intensive care management for the parent, including facility- and home-based in-person visits for six months post-delivery
- An OB Practice Consultant outreaching high-volume family practice, OB, and pediatric providers
- A primary care toolkit that incorporates SBIRT and prevention and care of NAS and NOWS

CM040	1	The Vendor should describe its protocols for addressing a provider that does not perform coordination activities that includes, but is not limited to, the following:
CM041	2	Identification
CM042	2	Actions taken to improve coordination

Identifying Providers' Coordination Activities (CM040, CM041)

Provider coordination and information-sharing is essential to the member's health. We commit to bridging communication challenges and offering timely information and care management to support this collaboration. We believe our person-centered care planning approach helps the early identification of instances where providers are not coordinating care and can help to improve communication between providers via care conferences through the multidisciplinary team. Care Managers, during ongoing monitoring of care plans, may identify instances of failure to communicate and coordinate, including:

- During care plan updates and scheduled meetings with the member concerning adequacy and satisfaction with providers and services
- Through data analysis, including a review of gaps in care and under- and over-utilization data, such as ER utilization or an inpatient admission, or in review of filled medication scripts
- Through ongoing outreach to support coordination activities:
 - Exchange current clinical information or identification of barriers related to coordination
 - Collaborate on solutions
 - Implement the decided course of action or activities

Our Provider Services and QM teams similarly have processes and tools to monitor and track coordination opportunities to support providers in identifying system or communication breakdowns. We use lessons learned from these experiences in working with providers across the country to develop incentives to promote the delivery of integrated and coordinated care. Our ***Integrated Care Quality Improvement Program (ICQIP)*** is an incentive program for providers in a Provider Quality Incentive Program (PQIP) and outpatient BH providers — such as Comprehensive Behavioral Health Centers, individual BH specialists, and high-volume BH groups — participating in the Behavioral Health Quality Incentive Program (BHQIP). ICQIP offers incentives to physical and BH providers who partner to deliver integrated, high-quality care and service to members meet common goals such as prompt delivery of care, decreased ER utilization, and meeting opportunities for improved care metrics. BHQIP similarly incentivizes eligible BH providers to improve coordination activities to address biopsychosocial needs. These programs support increased communications between providers to help members receive necessary treatment.

Person-centered Care Supports Provider Coordination and Communication

For members who are engaged in care management, the assigned Care Manager identifies when providers, including a specialist serving as a member's PCP, are coordinating with other providers and render appropriate and prompt service to the member. Through care planning, Care Managers reach out to the provider, the member, caregiver, and other providers to support coordination:

- Through current clinical information or identification of barriers related to coordination
- To provide collaboration on solutions
- To implement decided course of action or activities

We also offer providers who have demonstrated cross-system coordination and positive quality outcomes opportunities for recognition such as Adverse Childhood Experiences (ACEs) Provider Champions, Premier Provider Recognition for trauma-informed care providers, and Physician Champions. Provider recognition requires providers to demonstrate an understanding of their care coordination responsibilities and the importance of integrated care as described in PS007.

Describing Our Quality Monitoring of Provider Coordination

Our QM team continually assesses our members' specific utilization data to identify opportunities for improved coordination. For example, we develop targeted provider education, including relevant HEDIS measures and EPSDT visit data to produce lists of children without a PCP visit in the preceding six months. We continually monitor and assess when coordination may not be occurring, such as through regular and annual:

- Review and analysis of complaints concerning a provider's availability or services rendered
- Review of provider profiling reports, as described in QU002
- Review of information obtained through the MEC

Our Clinical Quality Program Consultants may identify opportunities to improve a provider's coordination activities during chart audits. In some instances, a care conference is requested either by the provider or our Medical Director to discuss, collaboratively with the Care Manager, coordination activities, updating care plans and interventions, and assuring referrals and authorizations such as OON care for the member.

Describing Our Actions to Improve Coordination with Providers (CM042)

If we identify improved communication opportunities, we may suggest a care conference or request additional or increased services if the member is inpatient. In these instances, Care Managers work with the PCP and other providers to identify actions which can improve communication and coordination. This process provides training and education, which includes a review of coordination responsibilities such as information from the initial PCP referral that may be missing or results of specialist care and subsequent referrals by the treating provider. Our Care Manager may review the tools and resources UniCare made available to providers which support coordination, including Health Insight and evidence-based guidelines. As opportunities for improved communication may lead to member harm and delays in care, we may require providers with ongoing quality issues to develop a written corrective action plan to demonstrate compliance within a specified timeframe, which may include referring the provider to our Medical Directors for peer consultation as needed.

- CM043 1 The Vendor should describe its programs for coordination of care with community resources and social services for members.

Coordinating with Community Resources (CM043)



We actively collaborate with organizations in our communities to make referrals and to proactively identify community and social services available to support members. By developing and coordinating with community resources and supports for members, we strengthen our existing partnerships and continually develop new relationships with organizations that provide leadership, coordination, or direct services to individuals and families experiencing SDOH barriers to care and improves our ability to serve members. UniCare aligns with the requirements in the SPA to provide coordination services to assist members in arranging, coordinating, and monitoring all medical and support services. We support PCPs and providers by offering trainings about available community resources or social services, including organizations that address SDOH barriers to care.

We identify members needing additional community resources or social services through methods such as during initial or ongoing assessment, during care management interactions, during calls to our Member Call Center, or through our *No Wrong Door approach* to identify needs as described in CM044. Our Care Management team, alongside our Population Health team, provides assistance to members obtaining BH and community services and in the coordination of care. Our Care Managers act as a single point of contact and lead our care teams, who support members to reach their goals, collaborate community resources and social services, and streamline communication for stakeholders.

Coordinating Care in the Community Using Care Management Support

Because we are an experienced West Virginia Medicaid MCO and hire from the local community, we have well-established relationships with community resources, social service agencies, and programs supporting effective service coordination and communications with members and caregivers. Our response to CS004 describes our extensive outreach to community partners, such as community- and faith-based organizations, government agencies, and schools. We value these relationships and work to continue to develop community collaborations, helping create the best possible outcomes for members and their caregivers. We will continue to grow our outreach, engagement, and community support initiatives, coordinating their efforts with the Care Management team to benefit both members and caregivers, and the communities where they live.

Statewide Data Points

- 7,735 community events completed since January 2015
- 1,165 active community partner relationships
- \$437,570 in Anthem Foundation grants and community relations sponsorships (from January 2018 to present)
- \$564,169 UniCare invested in community sponsorships, programs, and donations (from January 2018 to present)

Our fully integrated approach to community-based care management involves UniCare support from

Leading the Way

Our community-based representatives engage with both community stakeholders and members with a primary focus on educating about the coverage, services, and Value-Added Services UniCare offers.

multiple functional areas, including our Health Program

Representatives — whose primary role is to outreach, engage, and provide training for community-based supports and to share information with our Care Management team about these

community-based organizations to best find and connect members with available and necessary

resources and support. We engage our clinical teams to leverage and support community-based

providers, provider groups, Health Homes, and other community-based organizations that provide

physical, dental, pharmaceutical, vision, social needs, and BH supports. If there are coordination needs

with members, we can engage our Care Managers or Member Services Representatives to act as a liaison

for the member, with our UniCare Care Managers as the point of contact to collaborate regarding care needs and community-based resources or social supports.

We developed an *in-service care management training* initiative for 2020, in which we will invite community partners to provide training and education to our team. We scheduled multiple trainings, including topics on health disparities such as *Individuals with Physical Disabilities*, *Mental Health Issues*, and *Aging*. Staff received training in January on *Delivering Mental Health Services Through a Cultural Lens: What Can We All Do?* presented by the Mental Health Technology Transfer Center.

To determine community resource needs, we use internal data and operational processes and multiple critical external sources, such as our advisory groups, provider or community engagement referrals, Member Services contact, provider referrals, and specific community-based outreach. We work directly with community-based organizations to enhance the programs and services that we provide to members, including those experiencing a housing crisis.

Connecting Members to Resources and Social Supports in the Community



We entered into a partnership with West Virginia Balance of State Continuum of Care on two key initiatives impacting all West Virginians. We will join some of our UniCare opioid programming — such as Project ECHO, quality MAT services, and PreManage for overdose monitoring — with West Virginia Balance of State Continuum of Care’s State Opioid Response program. This opioid program will boost their current Street Outreach team, access to housing, and supportive services, paired with a Peer Recovery Support Specialist focused on the most rural areas of the State. We will partner our Population Health and Care Management leadership with West Virginia Balance of State Continuum of Care’s Program Leadership, and together will leverage combined resources from each entity to promote member engagement in programs and services that promote

housing stability and sustained recovery. We will use geographic service areas to co-locate resources and extend community outreach.

Our community-based Care Managers will collaborate with West Virginia Balance of State Continuum of Care's staff who are providing housing supports for members through the Housing Opportunities for Persons with AIDS (HOPWA). We will provide support during weekly case conferences for our members, connecting the member with services and coordination of treatment. For example, the Care Manager can assist in transportation coordination to assure the member attends appointments.

Coming in summer 2020, we will bring an *Interpersonal Violence Reduction Program (IVRP)*, which provides team-based, tech-enabled care extension services to UniCare members who experienced or are at risk of experiencing acts of intimate or interpersonal violence. Our IVRP provides participants with individualized violence and safety-related, SDOH focused, and cost-reducing interventions and tools designed to enhance skills, strategies, and supports to avoid or reduce potentially violent situations and associated avoidable care costs. Under the IVRP, a team of trained individuals work face-to-face with members in their own communities and virtually through secure messaging, phone, email, video chat, and a proprietary technology platform to assure ongoing and appropriate contact throughout the program. The IVRP team works with our UniCare Care Management teams and community-based entities to assure IVRP services extend and complement existing services. Some examples of additional UniCare focused actions to expand access to community-based and social services for members we describe in Table 6.3-11.

Table 6.3-11. Collaborating with Community Resources to Develop Programs that Address Biopsychosocial Needs of Members

Program	Description
Mission WV	UniCare provided funds to Mission West Virginia, Inc. (Mission WV) to implement and support its Teaching Health Instead of Nagging Kids (THINK) program from July 1, 2018, through December 31, 2018. This program helps youth make better decisions regarding their education, substance use, sexual activity, and relationships. It includes a needs assessment and referral process to identify SDOH needs and connect members to community resources.
Overdose Lifeline, Inc.	This initiative addresses the opioid epidemic by targeting adolescents and providing evidence-based education about prescription opioid misuse and identifying and working through personality risk

Program	Description
	factors for SUD. In October 2019, we collaborated with 16 community partners from various organizations for this event, including Marshall Health, Kanawha Communities That Care, United Way, Kanawha/Putnam Family Resource Network, PAAC, and Wetzel County schools.
Rape, Education, Advocacy, Counseling, and Healing (REACH)	We collaborated with REACH to offer events that support women, provide professional, compassionate care to survivors of sexual violence, and work toward a community in which sexual violence is no longer tolerated.
Family Resource Network	UniCare participates in monthly meetings for each West Virginia county and provides sponsorship to health fairs, community baby showers, and smoking cessation programs. During the meetings, we provide updated information about member benefits and services, resources for community needs, sponsorship of community events, and health relative programs. Since 2014, UniCare supported over 300 Family Resource Networks-hosted events and community initiatives.
Boys and Girls Club	Since 2014, UniCare has funded the Triple Play program at local Boys and Girls Clubs, contributing more than \$50,000 in five years. To date, more than 650 kids at six clubs across the state received instruction in healthy living and active learning.
Recovery Point	UniCare staff provided yoga and trauma-informed mindfulness to residents who are recovering from SUD to manage stress and anxiety to support recovery.
Rea of Hope	Our long-standing relationship and sponsorship provides women a place of drug or alcohol recovery in Kanawha County.

Encouraging Early Identification of Members Experiencing Homelessness

Engaging members experiencing housing instability or homelessness is a critical first step toward connecting them to services and supports that lead to healthier lives; however, locating members experiencing a housing crisis can be challenging, particularly if the member is moving frequently or does not have up-to-date locating and contact information on file with DHHR. Upon Contract award, we intend to use our proven methods to rapidly identify, assess, and engage members who are experiencing homelessness, and we will be adding new methods to enhance identification, including the use of the HMIS.

Connecting Members to Social Supports Using Community Resource Link

Members may use tools such as Community Resource Link, offered as a VAS, to search for available resources — Care Managers also use these tools to connect members to necessary supports. Community



Resource Link is a web-based tool that puts resources for housing, food, employment, transportation, independent living, and social services at members' fingertips. Members can access the Community Resource Link directly on our website and through our

member portal. It identifies and describes currently available local community-based programs, benefits, and services to help members manage their lives and become aware of what is available to them beyond Medicaid. *It links directly to our information-sharing platform, Health Insight, so our teams can track the resources members search for and use most.*

We monitor activity on Community Resource Link to learn more about the needs of members. This kind of data tracking helps our Care Managers and community-based Care Management team recommend resources and supports that members search for most and find most useful. Community Resource Link is continually updated to reflect the most current available resources.

CM044 1 The Vendor should describe its approach to address Social Determinants of Health (SDOH).

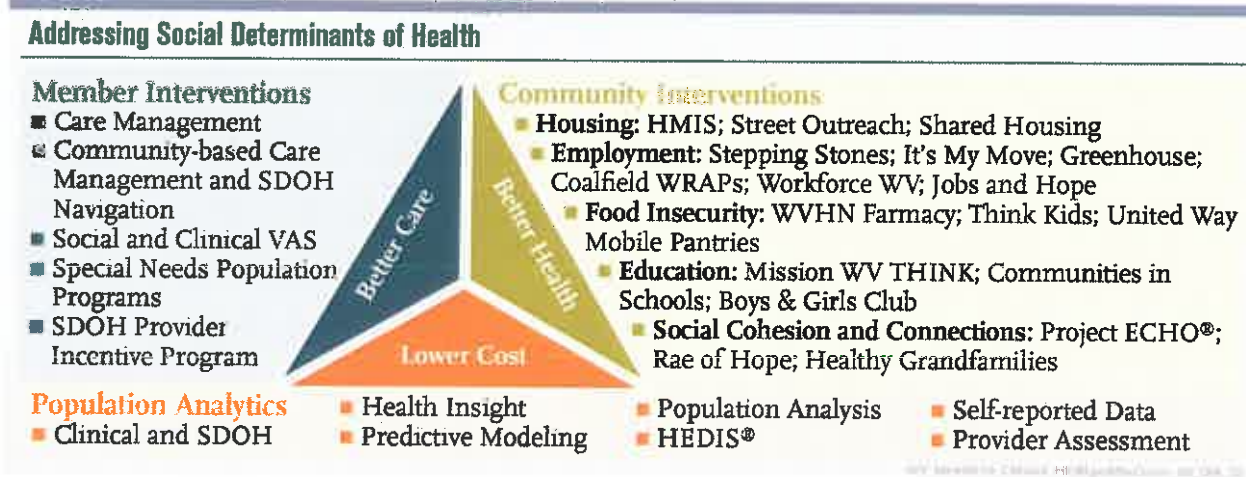
Addressing Social Determinants of Health (SDOH) (CM044)

Addressing SDOH is fundamental not only to our Whole Person Health care management model, but to our broader population health management program focused on driving improved health outcomes for our members and supporting healthier communities. Central to UniCare's strategy for addressing member's SDOH needs are the Population Health and Community Engagement teams, who understand the West Virginia landscape and the care and supports our members need. We engage our members in their communities so that we can be responsive, relevant, and collaborative with members, providers, State, and community-based organizations. This whole-person health approach makes UniCare's interventions informed, relevant, and measurable.

As outlined in Figure 6.3-12, our approach to SDOH weaves together programming across the continuum of member and community interventions, including provider education and incentives, targeted member supports, and community partnerships. These interventions, informed by population analytics, member-level assessments, and provider and stakeholder feedback, work together to achieve

UniCare's goal of integrated, cost-effective provision of supports and services that ultimately improves health outcomes for Medicaid and WVCHIP members.

Figure 6.3-12. UniCare Approach to the Social Determinants of Health



Assessing Need at a Member and Population Level

UniCare's approach to SDOH is informed by data at both the population and member levels. At the population level, we capture and review multiple data elements from community health needs assessments (CHNAs), quantitative and qualitative data from primary and secondary sources including demographics, care gaps, and data elements captured via social mapping tools and predictive modeling. At the member level, we use data elements including encounter data, UM data, risk scoring, provider referral, and member self-referral. Our approach balances multiple data sources to assure a comprehensive picture. We then pinpoint specific barriers and clinical needs to identify areas of greatest need for population-based interventions, as well as targeted programs to meet the needs of individuals.

Employing a "No Wrong Door" Approach to Member Assessment

Many of our members experience SDOH challenges, and we continue to focus our efforts on broadening opportunities to assess and address social support needs for all of our members. SDOH

assessment questions are included in our initial health screening (initial screening), our HRA, and other care management tools. In addition to structured assessment opportunities, *UniCare's No Wrong Door approach* encourages needs identification with every member interaction. Our employees are trained to recognize SDOH needs, and we also work with community-based organizations (CBOs) to refer members who may need social supports to us.



Our expanded Community Engagement team will continue to strengthen our ability to support our CBO partners in their work with our members and communities.

Connecting Members to Resources

When members are identified as needing SDOH supports, they are connected, as appropriate, to our population health management program and staff. Our integrated population health management program focuses on the unique needs of the individual from preventive to complex care, and connects members to the care they need, including VAS specifically designed to support social needs described in CM043 and CM046. Our population health management program is supported by our Care Management, Population Health, Quality Improvement, and Community Engagement teams.

Figure 6.3-13. UniCare's Whole Person Health Approach



Population Health Team

Our Population Health team is on the front line of addressing members' SDOH needs as an integral component of our comprehensive population health management program. Members are identified through analytics and referrals, community partnerships, provider claims, and referrals, as well as through results of the initial screening. They also partner with the Community Engagement and Care Management teams to identify initiatives and to deploy resources in targeted outreach programs. This team includes our Health Promotion Consultants, who are responsible for engaging with UniCare members to remove barriers and to act as a communication liaison between UniCare and referral sources.

Care Management Team

Our Care Managers address members' SDOH needs for those members identified with both clinical and SDOH needs and engaged in care management. The Care Managers incorporate SDOH data into the care planning process during the development of the treatment plan (care plan), including goals and interventions designed to support and meet a member's SDOH needs and reduce barriers to services. Our Care Management team includes community-based CHWs and CPs to meet members where they are and address SDOH. Working across our teams and with the member, we incorporate Medicaid-covered services, community-based supports, and our VAS to help meet identified SDOH needs.

Community Engagement Team

This team of local Community Liaisons collaborates with stakeholders, public health, and counties to identify, design, and implement community programming responsive to member needs, including SDOH needs. They consider health disparities, geographic challenges, and funding streams to build relationships with CBOs to deliver high-quality solutions to our members. As outlined in Figure 6.3-13, these

community interventions address programs and partnerships aligned with the Bureau for Medical Services' (BMS') priorities and the needs of West Virginia communities.

- | | | |
|-------|---|--|
| CM045 | 1 | The Vendor should describe its care coordination efforts that identify and address member access including, but not limited to, the following: |
| CM046 | 2 | Employment |
| CM047 | 2 | Food security |
| CM048 | 2 | Housing stability |
| CM049 | 2 | Education |
| CM050 | 2 | Social cohesion |
| CM051 | 2 | Resources that connect members to social supports and healthcare |
| CM052 | 2 | Environmental needs |

Identifying and Addressing Member Access to Social Services Through Care Coordination (CM045–CM052)

Health is more than just the absence of illness — it is having access to doctors and hospitals as well as stable housing, healthy food, reliable transportation, personal safety, and job support. Individual physical, behavioral, and social support needs vary throughout a lifetime, and our goal is to address these needs with care and services to advance each member's well-being. SDOH are an integral part of our population health management strategy. All staff are trained to identify, connect, or refer members to the appropriate SDOH services.

As described in CM0044, UniCare takes a No Wrong Door approach to supporting identification of members' SDOH needs. We capture SDOH data for care management and population health opportunities through provider claims, ICD-10 codes, new member welcome calls, initial screenings, and interactions with our community-based team(s) and other methods. SDOH needs are often identified through initial screenings (see Figure 6.3-14) and Community Resource Link.

Figure 6.3-14. SDOH Needs Identified Through Initial Screenings and Community Resource Link

SDOH Factors Addressed in New Initial Screening Tool				
 Transportation	 Housing Stability	 Interpersonal Safety	 Food Security	 Employment and Education
▪ Lack of transportation for medical appointments ▪ Travel distance to providers	▪ Alternate shelter ▪ Loss of housing ▪ Inability to pay for utilities ▪ Condition of home	▪ Occurrences of physical or mental abuse ▪ Aggression or behavioral problems ▪ Prone to falling	▪ Access to healthy food ▪ Ability to buy food	▪ Level of education ▪ Training programs ▪ Employment status
Health and Personal Outcomes Quality of Life, Psychosocial Outcomes, Behavior Change, Clinical and Health Status, Productivity, and Satisfaction				

We also capture SDOH screening conducted by contracted providers through Z-codes submitted on provider claims. Figure 6.3-15 shows the number of Medicaid claims received across our affiliates with Z-codes for the first three quarters of 2019. We recognize the value that this information brings for prompt identification of member social needs and as a result, we are launching our Social Determinants of Health Provider Incentive Program (SDOH PIP) in 2020, which will encourage an expanded approach to SDOH screening supported by additional education about referral resources to enable faster connection to needed services.

Figure 6.3-15. Medicaid Claims Received Across Our Affiliates with Z-codes for the First Three Quarters of 2019

Z-codes for SDOH with Resulting Claims Totals to Date		
▪ 946,260 Z590 Homelessness ▪ 35,605 Z591 Inadequate housing ▪ 2,415 Z592 Discord with neighbors, lodger, landlord ▪ 20,855 Z593 Problems related to living in residential institution ▪ 27,945 Z594 Lack of adequate food/safe drinking water ▪ 9,123 Z595 Extreme poverty ▪ 55,671 Z596 Low Income ▪ 8,124 Z597 Insufficient social and welfare support	▪ 50,369 Z598 Other problems related to housing and economic circumstance ▪ 363,705 Z599 Unspecified problem related to housing and economic circumstance ▪ 62 Z60 Problems related to social environment ▪ 16,268 Z600 Problems adjusting to life transitions ▪ 178,005 Z602 Problems related to living alone	▪ 19,737 Z603 Acculturation difficulty ▪ 21,800 Z604 Social exclusion and rejection ▪ 4,560 Z605 Target of adverse discrimination and rejection ▪ 16,910 Z608 Other problems related to social environment ▪ 93,112 Z609 Unspecified problem related to social environment

Connecting Members to Services Through Care Management

UniCare leverages Community Resource Link, an online tool for geo-specific social services, to identify and make referrals for SDOH needs. This tool allows us to monitor the member's engagement with selected services included in their care plan. If a member does not connect with the services, we will follow up with them to mitigate any barriers they may be facing. This service and referral tool helps to connect members to supportive employment, food security, housing stability, education, social cohesion, and environmental needs.

Government agencies also serve as critically important backbone agencies providing services and supports for members facing SDOH barriers. Examples of services we commonly include in member care plans include local health departments, West Virginia Bureau for Senior Services, DHHR offices, and child welfare agencies. Examples of other community benefit and human service organizations that help us address member needs are shown in Figure 6.3-16.

Figure 6.3-16. Organizations Benefitting the Community

Connecting Members to Services Through Case Management	
Employment	▪ Workforce West Virginia, including the Workforce Innovation Opportunity Act ▪ Coalfield Development
Food Security*	▪ Manna Meal ▪ Community Action Agencies** ▪ Salvation Army ▪ Catholic Charities
Housing Stability	▪ West Virginia Communities of Care ▪ Regional Housing Authorities ▪ Kanaway County Homeless Coordinator ▪ Community Action Agencies**
Education	▪ Parents as Teachers ▪ Community Action Agencies**
Social Cohesion	▪ West Virginia University Center for Excellence in Disabilities ▪ Community Action Agencies**
Social Support and Health Care	▪ West Virginia Health Rights ▪ Birth-to-Three ▪ Community Action Agencies** ▪ Appalachian Center for Independent Living ▪ Donated Dentures Project ▪ The Lions Club ▪ New Eyes for the Needy ▪ Starkey Foundation
Environmental Needs	▪ Gabriel Project ▪ Community Action Agencies** ▪ Salvation Army ▪ Catholic Charities ▪ Heart + Hand ▪ Mountain Mission

*See CM053 for additional information.

**Community Action Partnership is a statewide membership organization of 16 Community Action Agencies across the state. Programs include emergency assistance, utilities assistance, food pantries, weatherization, tax preparation, emergency clothing, Head Start, senior programs, and more.

UniCare has also developed a suite of VAS to help address our members' social needs. UniCare offers a total of 22 VAS (shown in Figure 6.3-17) that address West Virginia's top health priorities, such as decreasing obesity and improving management of key chronic diseases; 17 VAS align with our population health model by providing benefits and resources to help support social cohesion, employment, education, food security, and improved health outcomes. Care Managers work to educate our members about the availability of these services and incorporate utilization of VAS into their care planning process.

Figure 6.3-17. VAS Offered by UniCare

UniCare's Unique Value-Added Services Meet Members' SDOH Needs			
Maternal & Child Benefits	Physical Activity & Healthy Weight	Whole Person Health	Community & Social Supports
- Fresh Fruit and Veggies Program* - Preventive Dental Care for Pregnant Members - Mail Order Diapers* - Safe Sleep Kit* - Convertible Car Seat or Portable Crib - Electric Breast Pump Accessory Kit	- Summer Camp Memberships - Youth Club Memberships* - Fitness Coach Program - WW® (formerly known as Weight Watchers®) Memberships	- SUD Recovery Support Program* - Healthy Rewards Program - Oral Care Essentials* - Build Your Own Personal Hygiene Box* - Feminine Care Collection* - Healthy Lifestyle Aids*	- No-Cost Laptop Benefit* \$100 Gas Card* - Family Activity Coupon book* - Online Well-Being program* - Lifeline Smart Phone Benefit - Community Resource Link
*New Value-Added Services			

Expanding the Reach of Our Care Managers

Understanding the importance of engaging our members in care and connecting them to the services and supports they need, we have continued to invest in expanding our Care Management team and resources to meet members where they are. Since 2018, we have been deploying CPs and CHWs throughout West Virginia as an extension of our Care Management team. These valuable resources meet with members face-to-face to address their most immediate needs, assure their

Community Paramedics Support Member Engagement in Care Management

As of January 2020, we engaged 100% of the 460 members we reached in our community-based care management program by Community Paramedics. Over 190 members have completed care coordination and were transitioned to intensive care management upon request. Of the members engaged in the program in just one of our counties (Boone), 50% did not have a PCP and have now been connected to one.

safety, and to connect them to the necessary tier of care management. These team members work in the communities in which they live. Through this approach, we are able to focus on members who are difficult to locate, experience significant SDOH barriers as well as clinical needs, and who may have complex comorbid conditions and social challenges.

CM053 1 The Vendor should describe its plan to develop additional programs for Social Determinants of Health (SDOH).

New Programs to Address Social Determinants of Health (CM053)

We have long demonstrated our commitment to partnering at a local level to address SDOH, focusing on the unique and evolving needs of members as well as investments in programming and capacity to support the communities in which our members live. As described in our population health management approach, our SDOH programming is based on ongoing reviews of internal and external data related to the health and social needs at both the member level and population level. Reviewing these data alongside our program outcomes, relevant studies, and stakeholder feedback helps guide our decisions on program continuation and/or expansion, and assists in informing our strategies on member outreach, assessment measures, staffing, and capacity-building efforts with providers, CBOs, and key service agencies.

Our plans to develop additional SDOH programs are both a continuation of our in-progress and successful programs we have implemented in West Virginia, as well as the design and launch of new programs. Our work is ongoing, and we are continually evaluating and leveraging lessons learned from our own experience, as well as best practices from our 24 national Medicaid affiliate markets.

In many cases, these programs involve a community-focused approach, and we have continually sought partnerships with local stakeholders to not only build upon evidence-based practices (EBPs), but to also think outside the box. For example, we have supported Stepping Stones' Youth Transitions Project with the partnership of the Department of Education, Department of Corrections, Marshall University, and others,

and we have also helped develop a new greenhouse and hydroponic tower farm program. Having launched in November 2019, the vertical greenhouse is a new approach to active engagement, employment assistance, education, and life skills for foster youth in West Virginia. Outlined in the following subsections, our new programs in development span multiple tiers that work together to create a continuum of supports to improve the health, environment, and social connections of our members and communities.

Employment

Coalfield Development

Coalfield Development's mission is to support families in Appalachia through mentorship, education, and employment. Their Workforce Development and Professional Success program provides employment, job training, certifications, and life and professional skill development. We are currently in discussion to expand the program's ability to provide valuable, varied, and empowering opportunities for low-income young adults in Appalachia and add staff to increase participant cohorts, assist with removing barriers to success, and help bridge housing developments within their model in southern West Virginia.

Local Workforce Innovations

West Virginia's projected workforce growth varies region to region as well as across industries. Our goal is to support and make sure our members receive the resources they need while on their career paths. To support this goal, we will expand on our relationships with local workforce boards to leverage resources through the Workforce Innovation Opportunity Act to connect individuals with community needs such as flex funds to address housing, additional transportation benefits, childcare resources, and other support services to allow individuals to be successful and support their employment goals.

Food Security

Making sure members and families in our communities have access to food and nutritious options is a top priority for us. In Kanawha County, 13.9% families experience food insecurity on a regular basis, putting them at risk for cardiovascular disease and other chronic

illnesses. In support of local programs across the state to address hunger insecurity, Table 6.3-12 outlines several of our collaborative partnerships to be implemented in 2020 that are already in process.

Fresh Fruit and Veggies Program

To help address food insecurity and promote nutrition, this new Value-Added Service will provide pregnant members the opportunity to change dietary habits and improve health outcomes.

Table 6.3-12. Collaborative Partnerships to be Implemented in 2020

Program	Description
West Virginia Health Network (WVHN) Pharmacy Program	WVHN's Pharmacy program is initially focused on service areas of Roane General and Montgomery hospitals. WVHN works with selected and enrolled patients with elevated BMI and A1C to connect them with free or reduced health food choices from food banks and local farmers. During program events, participants will receive education on health food options, as well as hands-on group demonstrations on preparing healthy meals with the food they receive.
American Heart Association (AHA) Food Pantry and Supporting Wellness at Pantries (SWAP) Partnership	The AHA has created guidelines around healthy eating and worked to improve access to affordable, healthy foods through advocacy efforts. Our partnership will include the adoption of two food pantries in Charleston, where the AHA will implement a system to provide healthier food choices. UniCare will provide supportive materials that help individuals address food insecurities and related PH education. Additionally, we will support the AHA's SWAP program to provide nutritional rankings that promote healthy food choices. UniCare staff attend pantry events to provide on-site community engagement as well as educational materials to assist with understanding the color-coding system.
United Way of Central West Virginia Mobile Food Pantry	In summer 2019, Clay County closed its last grocery store in the county, resulting in a true food desert. Our contributions will not only help support access to food for Clay County residents, but will also expand their reach to surrounding rural communities in Boone, Kanawha, Logan and Putnam counties. Funding will go directly to United Way, allowing partial financial capital to refurbish the school bus with shelving, refrigerators, and freezers.
Think Kids Health and Hunger Project	We have partnered with Think Kids to support their mission of growing generations of West Virginia's kids to their healthiest potential. This program includes two components: - Phase 1, which is currently underway, includes collection and analysis of surveys that assess provider involvement of assessing patient SDOH needs. - Phase 2 includes a UniCare-convened Food Insecurity Summit with providers and partners across the state to discuss, plan, and coordinate efforts to: address food insecurity among children throughout West Virginia; increase provider participation in capturing and addressing childhood hunger; and recommend policy changes that support food security.

Housing Security

Continuum of Care Partnership Programs

We have formed an active partnership with West Virginia Coalition to End Homelessness (WVCEH) to create a number of different programs to directly address homelessness and housing security throughout West Virginia. Our partnership allows us to strengthen, support, and transform services, resulting in improved quality, efficient use of resources, and improved alignment of community goals.

Through this relationship, *we will be able to access the HMIS across all four of West Virginia's continuums of care and increase our ability to find, connect, and engage with hard-to-reach members.*

HMIS is used to gather and aggregate data on homelessness at both the local and national levels to accurately describe the scope of homelessness and the effectiveness of efforts to reduce it. Participation in HMIS offers us tools for faster, more effective member services by rapidly identifying and improving referrals, interagency case management, and service coordination. HMIS will provide our staff with:

- Tracking functionality to quickly find members experiencing homelessness.
- Insight into a member's experience with homelessness, such as the amount of time homeless, number of times homeless, and number of past and current services utilized.
- Identification of other organizations working with members to allow our staff to reach out and provide proactive care coordination.
- A central location for member services to be logged and to work quickly to fill gaps in care.
- Compilation of member data across the state for trending and gap analysis.
- The ability to share information such as disability certifications, homeless certifications or knowledge of the member's homeless history, and contact information of UniCare Care Coordinators.

HMIS also provides names and contact information for service organizations and providers currently working with our members, facilitating timely connection and coordinated care planning. Moreover, our Health Insight care management platform holds member discharge plans, care management notes, relevant pharmacy and provider data, demographic history, and phone numbers (extracted from claims). Data available through HMIS and Health Insight will facilitate member identification, care management, and referral to health and SDOH resources, resulting in improved health outcomes.

Shared Housing Planning Project

We have also begun modeling a planning project to collaborate with WVCEH to analyze and determine need, involvement, and capacity of a community- and member-specific Shared Housing program. Shared Housing programs are innovative and evidence-based, and can provide both short- and long-term housing options for individuals depending on their needs. It uses existing single-family houses where disabled residents pay a part of their benefit checks or other income for a furnished house, including utilities, a fully-equipped kitchen and laundry, as well as other amenities such as television and computers. Unlike other housing models developed for individuals experiencing homelessness, shared housing does not rely on government programs or subsidies. It provides options for individuals with disabilities who are not chronically homeless or do not have a high enough vulnerability score to be housed in permanent supportive housing or through Rapid Rehousing (RRH) of the Coordinated Entry system. As a co-lead of this initiative, UniCare will be coordinating planning processes and a summit with WVCEH and key stakeholders in the State to evaluate capacity to develop and implement a community-wide Shared Housing program.

To complement the Shared Housing Planning Project, efforts began in July 2019 to develop a *Shared Housing Playbook* to inform and guide local leadership about shared housing types, populations, promising practices, network development, and trainings. The Playbook will build awareness and capacity

to quickly expand housing options for people experiencing homelessness and will be a working summary based on an expansive Shared Housing Toolkit spanning topics such as: model types and populations served; low-income housing to transition out of time-limited RRH and/or transitional housing or sober/recovery housing; roles and responsibilities; and staffing models, peer liaisons, and community self-help networks. Based on outcomes of the Shared Housing Planning Project, this Playbook would be used to inform decisions on implementations, including operationalizing a shared housing model and benefits of shared housing for clients, providers, and community members.

Substandard Housing Program

UniCare shares a common goal with West Virginia Community Action Partnership (WVCAP), a statewide membership organization for the 16 Community Action Agencies, to help low-income individuals of all ages attain the skills, knowledge, and motivation to secure the opportunities needed for self-sufficiency. We are currently designing a program that will concentrate our support in the southern region — starting in McDowell and Raleigh counties, and then exploring Logan, Wayne, Mingo and Fayette counties — in WVCAP's efforts to address substandard housing. This program will include expanding current services to increase engagement rates, addressing deferral issues for households who otherwise would not be eligible for home remediation services, and addressing lead paint, mold, water intrusion, and other home issues that are no longer federally funded but are still in high demand.

Education

Education is an established predictor of life expectancy, with individuals who have a high school diploma living an average of 6.7 to 7.0 years longer than those without a diploma.¹ To encourage

¹ Rostron BL, Boies JL, Arias E. (May 2010) Education reporting and classification on death certificates in the United States. National Center for Health Statistics. Vital Health Stat 2(151). 2010.

members to obtain a high school-level diploma or TASC completion and continue their education, we have created a new ***No-Cost Laptop Benefit*** as part of our VAS to remove barriers for our members interested in continued education. Students who use computers have been shown to attend school more steadily and perform better, promoting continued involvement and progress in education. Moreover, computers help to make learning processes simpler and more efficient by providing added communication methods to support education and job skill learning.

In 2018, we partnered with Green Bronx Machine (GBM), an organization founded by teachers who are strong proponents of preparing children of all ages for their futures. We brought GBM to West Virginia as a partner of our greenhouse program with Stepping Stones, aided by providing an augmented model of the ***GBM School Curriculum Program*** that teaches primary education and nutritious habits through hands-on learning. Anthem has been able to launch GBM's curriculum program in seven markets, and UniCare will be launching it in select West Virginia elementary schools in the 2020–2021 school year.

Social Cohesion and Environmental Needs

Relationships, community context, support systems, and supporting an individual's social involvement are important components of both physical and mental well-being. UniCare's community programs, local outreach teams, and contributions all work together to create a holistic and comprehensive system of resources to identify our members' unique needs and connect them to appropriate supports and resources. By strengthening our community partnerships with organizations that provide leadership, coordination, or direct services to individuals and families, we improve our ability to serve our members and communities.

Medical-Legal Partnership Program

Many of our Medicaid members face SDOH challenges involving housing, employment, education and food. Medical-legal partnerships (MLPs) are an EBP to help lower-income and underserved populations

improve their access to health care and help improve health outcomes by addressing legal issues that adversely affect health. MLPs integrate the unique expertise of lawyers into health care settings to help clinicians, Care Managers, and social workers address structural problems at the root of so many health inequities. Evidence has also showed that legal issues related to poverty can create or worsen health issues, and conversely, health issues can create legal challenges, especially for individuals living near or below the poverty line. Additionally, it is also understood that unrepresented (pro se) litigants in civil matters may obtain significantly worse outcomes than those with legal representation. As a result, many legal needs relating to housing, family, and consumer issues that low-income families face go unaddressed, leading to increased stress and emotional strain.

As a new program, we are designing a community-based MLP program for children and families and exploring partnerships with West Virginia Legal Aid and West Virginia University Law School. MLP attorneys will provide legal representation to address adverse social conditions for which there are legal remedies, and which have the potential to improve or avoid deteriorated health. MLPs have been shown to improve health outcomes, increase patient engagement, and lower health care costs. This social support program has the potential to lessen health disparities and improve health equity.

Interactive Analytic Insights SDOH Tool

To help identify environmental needs through our data capabilities, we use our *Interactive Analytic Insights quality tool*, which is a dynamic, responsive, and scalable tool that provides comprehensive information about QM programs and health plan quality performance. This tool was established to provide critical analytical insights about what QM programs are being implemented across our broader organization, to monitor and improve the effectiveness of these programs, and to identify and implement the optimal mix of outreach programs in order to maximize quality outcomes and member health most

efficiently. It has been expanded to contain a new dashboard with a geospatial visualization that includes SDOH data in six categories — Food Insecurity, Cultural Barriers, Income Inequality, Disconnected Youth, and Health Outcomes. The Interactive Analytic Insights tool gives us a visualization of care gap compliance correlated to SDOH factors sized and colored by magnitude. Using it, we will be able to measure our success in addressing SDOH in terms of impact to HEDIS quality measures.

Resources to Connect Members with Social Supports

Care Managers use our Community Resource Link tool, which is integrated with our care management information system, to capture and store referral data, including resources for housing, food, employment, transportation, independent living, and other social services. *Launching in the second quarter of 2020, we will be enhancing Community Resource Link to partner with CBOs, members, and Care Managers/Care Coordinators for “closed loop referral” tracking*, supporting our ability to track and measure health outcomes of social service referrals. Also in 2020, we will use our *Community Kiosks* to promote the use of our Community Resource Link, as well as West Virginia 2-1-1 and other State and local resources. UniCare will incorporate the Community Kiosks at health fairs and partner with community organizations like Boys and Girls Clubs, Covenant House, and Union Mission, and area businesses such as shopping malls, to host the kiosks to broaden access to and awareness of key resources critical to supporting West Virginians.

We are also excited to launch our SDOH PIP that supports providers in methodically identifying and connecting members with resources that help address SDOH barriers. We value the unique role our network providers play in the lives of our members and believe that collaborating with providers on strategies to achieve our collective goals will lead to better health outcomes, improved member experience, and lower costs. Members’ basic needs must be met before they can fully engage in treatment plans, and meeting these

needs has a direct effect on their health and quality of life. Through incentivizing providers to proactively evaluate member social barriers, we will be able to systematically identify members with positive screens and alert staff to engage these members and link them with additional resources.

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| CM054 | 1 | The Vendor should describe its population health approach including, but not limited to, the following: |
| CM055 | 2 | Engaging members across the entire care continuum |
| CM056 | 2 | Promoting and incentivizing healthy behaviors and disease self-management |
| CM057 | 2 | Integrating care management |
| CM058 | 2 | Advancing evidence-based practices |

Population Health Management (CM054–CM058)

Our population health management program is an integrated, holistic, and comprehensive approach to caring for our community as well as our members across the continuum of care. This means we are committed to keeping and improving the physical and psychosocial well-being of all West Virginians. UniCare knows that improving population health is a long-term process. Our approach is based on extensive data and analytics, including information from outside the traditional health care system. Through data and analytics, and informed by the voice of our members, providers, and community organizations, we identify, develop, and implement interventions for key sub-populations and continuously assess and reassess for improvement and outcomes. We adapt our methods and programs to meet changing needs. We focus on supporting the delivery of culturally competent clinical and social determinant initiatives to drive real change across the care delivery system, improving the health of our members and their communities.

Population Health Management Approach

We have structured our population health management program on a robust multidisciplinary and cross-functional framework that reflects our Whole Person Health model. Population health is embedded in every functional area across UniCare, including Quality Management, Network Management, Community

Engagement, and Care Management. We staff our program with teams of both licensed and non-licensed staff who are focused on improving the health of all West Virginians.

Population Health Guiding Principles

We developed our population health guiding principles (Figure 6.3-18) to inform and guide our care management program and population health strategies. Using population health data, including feedback from community partners, members, and providers, we adopt the following standards throughout all population health activities.

- **Integrate and embed population health** throughout our organization to improve health outcomes and be a good partner to the State, community, and providers
- Provide and facilitate **person-centered care**, informed by **trauma-informed** tenets, driven by **member-identified** needs and goals, and provided through interdisciplinary care teams in the most minimally disruptive and least burdensome manner
- **Focus on SDOH as a gap in care** and integrating them into service planning in all member interactions

Figure 6.3-18. Population Health Management Framework

Population Health Management Framework

- Addressing Health Inequity • Targeting Health Disparities • Cultural Competency • Trauma-Informed Activities • Improved Health Outcomes •



- CHW, Community Paramedics • System of Care Collaboration • Member Voice and Choice • Clinical Workforce Development and Support • Social Determinants of Health •

- Address *health equity and health disparities* through informed programs developed with community partners and member feedback, cultural sensitivity and awareness, integrated training and analytics identifying sub-populations, and developing informed evidence-based interventions
- Develop *strategic connections* with State and community partners, health departments, and providers to design evidence-based, scalable, and sustainable population health solutions

Engaging Members Across the Care Continuum (CM055)

By continuously assessing our population through data analytics and predictive modeling tools, we are able to identify and stratify members into risk tier levels to tailor our approach to address immediate and potential needs of our members. Through early identification, proactive outreach and engagement of members in our care management programs we can support them to engage in their own health and help to remediate the impact of SDOH on their health outcomes. We determine the appropriate mix of care management activities to make sure our members get the right care, in the right place, at the right time.

“Community Well” Members

Our program recognizes that over half of our members are “community well” and benefit most from the programs we offer all of our members: health promotion and wellness reminders, educational opportunities and tools, VAS, and Healthy Rewards member incentives. These programs influence our members’ health behaviors, address their SDOH needs, and improve their health outcomes. This includes regular monitoring and notification of care gaps and care opportunities via phone, text, and web.

Members with Chronic Conditions

Members with chronic conditions receive disease management services through clinical and non-clinical interventions. We analyze and risk stratify our entire member population quarterly, and this helps us to make sure that members receive an appropriate and effective level of engagement in disease

management. This regular screening process also helps us to identify and intervene with members before complications occur and health status declines, including low-risk or rising-risk members before they experience an acute event.

Our person-centered and informed disease management programs offer short-term coordination and care management to prevent progression to higher levels of risk. The program is centered on the concept of motivational interviewing to promote member empowerment and self-care. Motivational interviewing techniques are incorporated into all aspects of member communication, including telephonic outreach, HRAs, development of collaborative tailored plans of care, and routine follow-up communication to measure progress towards goals.

Members with Medium, Complex, or Intensive Needs

As further discussed in CM001–CM003, our comprehensive care management program supports the identification of the member’s support needs and associated risk tier level to make sure our members receive the right intensity of services for maximum benefit. The level of care management provided to our members is determined by their needs and can range from basic system navigation support to intensive care management services.

Our approach to care management stratification is much more comprehensive than models based solely on clinical indicators. We review all available information, including self-reported information, to identify an appropriate level of care management for the members. For those members identified as increasing or emerging risk, either through analytics or referrals, our care management program targets prompt, proactive, collaborative, and person-centered coordination of services.

UniCare’s Care Management team is organized cross-functionally, integrating physical, behavioral, oral health, and social support services in close collaboration with UM, Member Services, and other

supporting staff. This multidisciplinary approach benefits our entire population, but is particularly effective for members with complex or intensive needs.

Members Experiencing Transitions in Care Settings

Part of the continuum of care management services targets the risks inherent when a member is discharged or experiencing a transition of care. Real-time monitoring and predictive analytics help us to identify those at risk for adverse outcomes as a result of the transition. We can proactively build a transition care plan and identify both clinical and SDOH concerns that could negatively affect a safe transition. Our goal is to reduce the risk to the members and achieve an effective and safe transition.

Promoting and Incentivizing Healthy Behaviors (CM056)

Our population health management program promotes and incentivizes healthy behaviors and disease self-management and does not duplicate programs already existing in our communities. We offer members training in healthy living, including fitness, nutrition, smoking cessation, and support in setting and achieving their goals. The programs we offer are personalized and responsive to members and their families and make a significant impact on the efficiency and effectiveness of health care.

Our disease management program holds NCQA Patient and Practitioner Oriented Accreditation for asthma, coronary artery disease, congestive heart failure, COPD, depression, diabetes, HIV/AIDS, schizophrenia, and child/adolescent depression. NCQA Accreditation is an indication that a program is dedicated to giving members and providers the support, education, and other help necessary to facilitate good outcomes and better care.

We also provide our Online Well-being program, available as a VAS to members because we are committed to whole-person health. Online Well-being supports the mind, body, and spirit — because being healthy is about more than just the body. This new program is geared to our members 13 and older and is an online community promoting behavioral health and wellness through instruction, games, goal setting, and monitoring. This convenient tool helps members manage stress, anxiety, depression, substance use, chronic pain, sleep disruption, and other challenges.

Promoting and Incentivizing Healthy Behaviors

The Quality and Community Engagement Lead Trainers and Peer Educators support this innovative diabetes self-management program:

DEEP™ is a diabetes self-management program that has been shown to be successful in helping participants take control of their disease and reduce the risk of complications. DEEP™ was developed for use in low-income, racial, and ethnic minority populations. It includes a training-of-trainers curriculum designed to engage community residents. Lead Trainers train Peer Educators and patients or clients. Peer Educators train patients or clients. Peer Educators can be diabetes patients or community members who want to help other residents understand how to manage their diabetes and avoid complications. In 2020, the Quality and Community Engagement Teams plan to offer DEEP classes to the community and our members. We will also be available to teach any providers interested in holding classes at their office. In addition, we have offered to train office staff to become certified Peer Educators to function under UniCare license to educate our members.

We designed our Healthy Rewards program, offered to members as a VAS, to promote health and incentivize healthy behaviors. Healthy Rewards educates and motivates members into taking an active role in managing their health and wellness. The Healthy Rewards program is fully discussed in QU009. By offering rewards for healthy behaviors, UniCare is giving members an incentive in improving their health status, enhancing prevention and health outcomes, and preventing disease progression. The program offers a variety of rewards ranging from \$10 for adults completing a one-time health screening to \$100 for adults with diabetes who complete their kidney test, eye exam, and HbA1c screening each year. Additionally, the Healthy Rewards platform will be significantly upgraded in 2020 to include new features with health education, a wider range of enticing incentive redemption options, and instantly delivered digital gift cards.

\$100 Gas Card

As a new Value-Added Service, all members enrolled in care management are eligible to receive a \$100 gas card to help them more easily access resources and supports in their communities.

As discussed in CM044, in 2020, we also offer an expanded suite of VAS to promote and incentivize healthy behaviors. With benefits and services ranging from our Fresh Fruits and Veggies Program to \$100 Gas Card to Youth Club Memberships, our VAS program supports our

members by promoting and supporting healthy behaviors.

Integrating Care Management (CM057)

Elements of Tiered Care Management



UniCare’s care management program is integrated within our population health management program because we recognize that care management is congruent with population health. Through our care management program, described in CM001–CM003, we emphasize the delivery of care management services and supports, including health promotion, disease prevention, integrated care management solutions, and targeted programs and interventions to members according to their levels of risk based on their individual needs. Our goal is to engage members in their care, identifying members with increasing health risks and high needs quickly, and connecting them to the right level of care management supports and services. We leverage Health Insight and our suite of predictive analytics to make sure the members receive the right level of support.

Our integrated care management program is person-centered; we identify an individualized “pathway” for each member based on their specific needs, identified through data analytics and person-centered assessments, or through referrals. The level of care management provided is determined by the member’s

needs and can range from basic care system navigation support to intensive care management services. We recognize that members' health and service needs are not static. As the individualized needs of members change, the care management and coordination processes will adapt to the level of support they want.



Our Care Management team offers direct care management for UniCare members. Our experience providing care management for the last 17 years has informed our approach to our current population health management approach, including caring for our members are “community well.” Those members benefit most from health promotion and wellness reminders, regular monitoring and notification of care gaps and care opportunities. For those members with chronic conditions who may have emerging risks or increased uses of services or levels of care, we offer person-centered and informed chronic condition management interventions with short-term care coordination and care management to prevent progression to higher levels of risk. For those members with higher risk or more intensive needs, we provide intensive care management, which is intensive care coordination and targeted interventions to address their complex clinical and social support needs.

Our integrated Care management team, comprised of multidisciplinary, co-located licensed physical and BH staff, is supported by our Population Health Management, QM, and Network Management teams, who work together to assist members to obtain access to the care and services they need. Our Care Management teams facilitate member rounds that incorporate staff from multiple clinical areas, backgrounds, and departments. These rounds assure that Care Managers who are the primary point of contact with a member receive support and can use additional staff resources to meet an individual's needs.

Advancing Evidence-based Practices (CM058)

To significantly impact the improvement of quality in health care, we must advance EBPs across the continuum of care. Without EBPs, we know our members are at risk for variances in care that could

seriously affect their health status and quality of life. At their most basic level, EBPs are part of a problem solving approach that incorporates the conscientious use of current best evidence, a clinician's expertise, and patient values and preferences. Health care that is evidence-based and conducted in a caring context supports the Triple Aim: better care, better health, and smarter spending.

Organizational Culture

Our staff receive regular and ongoing training on the use of EBPs. We also make sure any activities we deploy, or programs we design, in support of our members are evidence-based. Examples of EBPs that care management staff use every day include Person Centered Thinking, trauma-informed care, recovery and resiliency, and motivational interviewing. Our UM team is trained on the use of peer-reviewed, evidence-based guidelines, preventive health guidelines, and EPSDT, as well as evidence-informed level of care guidelines such as MAT and Parent-Child Interaction Therapy (PCIT). These trainings help to create a culture that supports EBPs across West Virginia.

All our care guidelines are evidence-based, peer-reviewed and promoted across all care management activities. Whenever possible, our clinical leadership utilize standardized criteria that has been clinically validated as a best practice and/or the consensus of health care professionals. Our practices are also developed to be responsive to member needs and adopted in consultation with our network providers.

Provider Education

We partner with providers to educate them on the most recent evidence-based practices and protocols. EBPs are recognized by our providers as the “gold standard” in patient care, but are often difficult to operationalize or adapt into practice management processes and systems. We support providers with access to our evidence-based protocols, as described more fully in BA011 and BA014. By using these evidence-based tools, such as MCG Care Guidelines®, preventive health guidelines, and clinical practice

guidelines, providers can help adhere to nationally recognize standards of care. Our approach to supporting providers in the delivery of EBP includes:

- Providing on-demand access through our provider portal
- Providing clinical decision support tools that apply evidence-based protocols to providers, such as through our Interactive Care Reviewer tool
- Offering EBP training, such as trauma-informed care and PCIT

Member Engagement

We designed our healthy behavior incentives on the idea that an engaged member is more likely to be compliant with their treatment and achieve better outcomes. Our members may engage with UniCare through their choice of many methods: phone, website, or personal contact with our staff. To encourage patient activation and participation, our staff are trained to communicate effectively, using EBPs (such as motivational interviewing) and targeted education (such as coordinating the care of pregnant women with OUD) in a culturally responsive manner. We get our members involved in setting their own health goals and support their decisions. We have also incorporated EBPs into our clinical program development, such as our Tobacco Cessation and ADHD and Psychotropic Medication programs. Our analytic models also take a member's readiness for engagement into account. This helps us prioritize members for engagement.

- CM059 1 The Vendor should describe its process to evaluate the member population and coordinate prevention and wellness programs available to all members.

Evaluating Our Member Population to Coordinate Prevention and Wellness Programs (CM059)

We understand the communities we serve, and we design prevention and wellness programs that are responsive to our members' needs. We also draw upon the experience and knowledge of our affiliates in 23 other markets while customizing programs based on the unique needs of our MHT and WVCHIP members. Evaluating the needs of our member population does not occur at a single point in time. Instead, we continuously evaluate the population's health status and social needs to adapt our programs and best support the member in their communities. Our prevention and wellness initiatives use targeted communications from trusted sources to engage the member in improving their health status.

Data Analysis — Measuring Our Impact

We continuously assess our population, collectively and individually, to identify opportunities for improving population health through prevention and wellness programs, and to measure the impact of these programs. We use our continuous review and analysis to inform our strategies and adapt our programs to address new opportunities. We measure our impact through metrics including industry and professionally recognized data sets and measures, such as HEDIS and CMS Adult and Child Core Measures.

Data Sources Used for Identifying Populations and Evaluating Impact

We identify current population needs and impact of our programs through the following data sources:

- **National Standardized Metrics.** Including HEDIS, which establish a baseline of health in our member population locally, regionally, and statewide, and support the development of our improvement targets.

- **State and Public Data.** Such as CHNA, census data, public health department data, health improvement plans, and Behavioral Risk Factor Surveillance System reports.
- **Centralized Data Warehouse.** Including member demographic data (age, gender, race, and language), claims (PH, BH, and pharmacy), encounters, clinical data, and risk stratification results.
- **Member-reported Data.** Collected directly from our members through initial screenings, HRAs, welcome calls, telephonic surveys, CAHPS, and in every interaction with a member, such as Member Services and Care Management interactions.

Define and Establish Baselines and Goals

Combining existing public, industry, and professionally recognized data with our internal data sources, we define and establish measures for overall population and sub-population health outcomes. These advanced analytics create segmentation and develop predictive models — enabling us to set targets and goals when designing our prevention and wellness programs.

We use national Medicaid benchmarks from the NCQA Quality Compass, and we set our goals at the next-highest level of performance from our current rate. For example, a measure exceeding the 75th percentile will have a goal set to exceed the 90th percentile during the following evaluation period. We also consider member, stakeholder, and provider feedback to identify proper performance standards.

Utilization and cost of care outcomes are measured through physical, behavioral, and pharmacy cost analysis, as well as utilization measures such as ER visits, admission and readmission rates, and length of stay data. Clinical outcomes are also measured using national quality measures (such as HEDIS and CMS' Provider Preventable Conditions).

SDOH are often barriers to taking part in and benefiting from our prevention and wellness programs.

We measure SDOH factors such as food insecurity, homelessness, and transportation insecurity to provide baseline data and to inform future program design.

Health inequities are identified by comparing health outcomes data from the same geography across different racial or ethnic groups. UniCare routinely stratifies more than 20 HEDIS clinical performance measures by race and ethnicity, shedding light on areas for improvement in health disparities. We base our annual analysis on measures identified as “disparities-sensitive” by the National Quality Forum, and UniCare will incorporate the findings into our Culturally and Linguistically Appropriate Services (CLAS) and Health Disparities program plan in support of NCQA population health management recognition annually. Prevention and wellness programs can support efforts to reduce health disparities.

We track this data through dashboards to monitor trends over time and review sub-population outcomes. We also share this data with providers to solicit input into social and regional factors that may contribute to health disparities. This process assures that we target new resources to areas most in need.

Identifying Population and Sub-population Health Programs

By leveraging data analytics and predictive modeling tools, we identify sub-populations so that we can respond to our members’ needs in the community. With early identification and proactive outreach to members, our prevention and wellness programs can support them to engage in their own health. Using UniCare’s analytic tools and referral sources, we can integrate our community health strategy into our clinical workflows, supporting an integrated approach to care and service coordination supports.

Measuring Impact

Program outcomes are regularly evaluated through the identification and monitoring of clinical and health status, behavior changes (such as tobacco cessation), clinical and health status, consumer

satisfaction, quality of life, and financial outcomes. Our Whole Person Health model uses data to follow trends over time as well as drill down on specific member populations to monitor improvement in health status and outcomes. Our business intelligence and analytic tools can further stratify this data to deliver ad hoc reports and program analyses. Formal annual evaluations are used to assess the effectiveness of our overall population health management program as well as assessments of targeted programs. These formal and informal evaluations are then used to inform our population health management program improvements and to develop new prevention and wellness programs for our members.

- CM060 1 The Vendor should describe its process to collect and maintain member self-reported demographic, social determinants, and health needs assessment data for aggregate use in, at a minimum, population health management, network adequacy determination, and quality improvement activities.

Using Self-reported Data to Address Population Health, Network Adequacy, and Quality Improvement (CM060)

We collect and use data from many sources to drive our population health management strategy. Self-reported data is central to our efforts to design an effective program that improves the health of our members and our community.

Capturing Self-reported Data

In addition to information contained in our enrollment data from the State, self-reported demographic, SDOH, and health needs data are collected through UniCare's initial screenings, social needs screenings, welcome calls, telephonic surveys, assessments, Adult and Child CAHPS survey data, and in every interaction with a member, such as interactions with our Member Services or Care Management teams and CHWs. We also obtain self-reported data that is captured by health care providers, such as Z-codes, and community partners serving our members.

Maintaining Self-reported Data

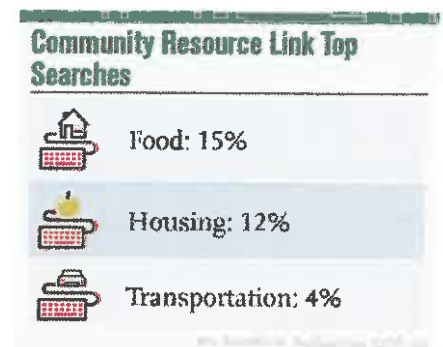
Our Health Insight platform serves as the primary storage and access site for an individual member's self-reported data. This personal health record is accessible to Care Managers, Population Health team members, and providers. Aggregated data is also stored and maintained in our data warehouse for use in analytics and trending over time.

Stratifying and Using Self-reported Data

Self-reported data for an individual member is critical to meeting the needs of that member, and our Care Management team relies heavily on that information. In a similar way, aggregating and stratifying self-reported data is critical to evaluating the effectiveness and design of UniCare's programs and initiatives in support of the MHT program and the State.

Population Health

We design and deploy our population health management programs, such as wellness, prevention, and education offerings, to support the needs of our members and their communities, leveraging information obtained directly from our members. We also rely on knowledge gained from self-reported data in the design and implementation of our Healthy Rewards member incentive program and utilization data from our other VAS.



The self-reported data also helps us to identify key strategic connections with culturally specific community partners. For example, when the Community Engagement team learns that a human service agency is important to certain isolated populations, it means we can improve services to populations who may be otherwise overlooked.

Network Adequacy

Self-reported data is used in evaluating network adequacy, in conjunction with GeoAccess® analysis, to identify gaps in service availability as well as gaps in culturally appropriate service providers. Our CHWs and CPs have their “boots on the ground” in culturally specific communities and are able to track and prioritize network gaps to improve access and overcome barriers to care.

Quality Improvement

Self-reported data, such as member experience surveys, help us to understand the impact of our programs and measure the effectiveness of the program according to member perception of satisfaction or improved health status. Please refer to QU008 for a full explanation of how UniCare uses annual CAHPS data to improve member experience. Self-reported data is one of many types of information we analyze as part of our comprehensive QM approach. It is used to provide baselines and measure the effectiveness of our efforts to maximize access, improve health, and support overall well-being. Member complaints and grievances are also analyzed to improve services in critical areas such as our digital tools, transportation, or provider network issues such as oral health access.

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| CM061 | 1 | The Vendor should describe its process to refer all eligible pregnant members to the Bureau for Public Health's (BPH's) Women, Infants, and Children Program (WIC) for nutrition services during and after pregnancy. |
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Referrals to the Women, Infants, and Children Program for Nutrition Services (CM061)

In addition to providing nutritious food to enrollees, we recognize that the WIC program improves the health of our members by providing education and counseling on nutrition and breastfeeding, as well as health monitoring and referrals. As part of our Whole Person Health model, all eligible newly enrolled

and existing members are educated about the availability and benefits of the WIC program through the member handbook, interactions with our team members, and family planning materials.

Identifying Eligible Members

Caregivers of newborns and newly enrolled children under the age of five receive information about a community and public health resources, including WIC, as part of the welcome packet. We also work closely with our provider network to promote these programs to their patients.

Pregnant members may be identified through eligibility files from the State, health assessments, data and analytics, and provider or member referrals to specialty care. Our Care Management, Population Health, and Community Engagement teams are staffed with trained, culturally competent, and trauma-informed professionals who support our pregnant members to make sure they receive the care and services they need, including referral to the WIC program.

Education and Support

We recognize that our members can face many challenges in their daily lives and pregnancy may further complicate some of those challenges. We often find that our pregnant members and members with young children have specific complex social needs in addition to experiencing the impact of the community's SDOH. To support these members, we take a holistic and person-centered approach to help them access needed services, including WIC.

For example, our Care Management staff are trained in motivational interviewing, a person-centered counseling style to support behavior change by helping clients to explore and resolve ambivalence about accessing available services. With the right motivation, people are more likely to see the benefits of the services available and feel confident in their ability to reap the benefits of those services.

Coordination and Referral

UniCare has existing Memorandums of Understanding (MOUs) for information-sharing and referral pathways within our care management processes to align with the WIC program. Our dedicated staff members have worked with WIC, as well as other agencies, for years. Their background and experience have strengthened the relationships with WIC and other agencies and resulted in improved communication channels and effective referral processes.

- CM062 1 The Vendor should describe its process to coordinate with the Bureau for Public Health's (BPH's) Office of Maternal, Child, and Family Health (OMCFH), Office of Nutrition Services (ONS), and Office of Community Health Systems and Health Promotion (OCHSHP) to link members with necessary public health prevention and support services.

Public Health Prevention and Support Services (CM062)

As an essential stakeholder working with families, partners, and communities, UniCare works together with the Bureau of Public Health's (BPH's) OMCFH, Office of Nutrition Services (ONS), and Office of Community Health Systems and Health Promotion (OCHSHP) to link members with public health prevention and support services.

We have existing MOUs for information-sharing and referral pathways within our care management processes to align with public health services. We have a personal and informed knowledge base of the health and social needs of our most vulnerable members, and we have built our program to complement, not duplicate, existing programs and resources.

We begin by prioritizing education and training so that all members of our Population Health, Community Engagement, and Care Management teams are knowledgeable about available social services and can readily connect with public health agency staff to refer members and co-manage those who can benefit from BPH's programs and services. Our care coordination procedures are established with each agency, and we have a dedicated UniCare Care Manager assigned for these coordination activities. When

a member is identified for referral, or a member is identified as currently receiving services, the Care Manager contacts the agency to discuss next steps, including making arrangements for participation with multidisciplinary team meetings and streamlining the assessment/care planning process to try to reduce member assessment fatigue. When a member has a State-developed care plan, we incorporate that information into the member care plan. We also engage and coordinate with agencies for members transitioning or discharging from facilities to support the coordination of services, including follow-up appointments — and we try to reduce the number of contact points for each member.

Office of Maternal, Child, and Family Health (OMCFH)

UniCare uses several methods to identify children who may be at risk and may benefit from early intervention services. Methods include data analytics, predictive modeling, authorization monitoring, and targeted claims data analysis. We also have a No Wrong Door approach and capture referrals from mothers, providers, schools, county targeted case management staff, as well as RFTS home visitors. In many situations, depending on assessment of the child's needs, we coordinate with public health and targeted case management agencies to arrange for the necessary waiver services.

We have a long-standing and close working relationship with OMCFH's program to help assure that CSHCN have a medical home. Our West Virginia enrollment includes more than 250 members who qualify as CSHCN and 100% have a medical home.

For more than 10 years we have collaborated with West Virginia's Birth to Three program, supporting children who have, or are at risk for, a delay in their development. From spring 2014 to February 2018 we participated in nearly 150 of their events, including baby showers, health fairs, and other parent engagement activities.

Through our member onboarding and assessment process, we promote and inform members about the West Virginia Home Visitation programs. We also use our community and stakeholder relationships to encourage members to engage directly with the West Virginia Home Visitation programs. Our Care Managers incorporate participation in the Home Visitation program in the treatment care plan.

Office of Nutrition Services (ONS)

As discussed in CM061, we are actively engaged with the ONS' WIC program. In addition to working to enroll eligible members in the program, our providers can also refer members to WIC for nutrition counseling and enhanced nutrition services. Enhanced nutrition services include comprehensive nutrition assessments, care plan development, and nutrition counseling beyond the basic WIC nutrition education. These services are essential for nutrition-related medical conditions, and our Care Managers work closely with the Registered Dietitian as part of the member's care plan.

Office of Community Health Systems and Health Promotion (OCHSHP)

We take a comprehensive approach to chronic disease management and prevention. We hold monthly meetings with OCHSHP to collaborate and improve our processes for collaboration. Our Care Managers work closely with OCHSHP care managers on individual members as issues and opportunities arise.

- CM063 1 The Vendor should describe its protocols to coordinate care for members receiving Social Necessary Services (SNS) through the Specialized Foster Care Administrative Services Organization (ASO).

Sharing Information With the Specialized Foster Care Administrative Services Organization (CM063)

We understand the importance of supporting and coordinating care for members who receive Social Necessary Services (SNS) – in particular, the need to have up-to-date records and coordinate care for children with complex or specialized needs. We will partner with the Mountain Health Promise

Administrative Services Organization (ASO) to aid in the maintenance of accurate records, which includes information such as the child's medical or BH conditions, current medications, and other relevant physical, behavioral, or SDOH information. Our Transition Coordinator will serve as primary contact, and will collaborate with ASO staff as authorized. We recognize that there will be a process developed in order to share the list of enrollees receiving SNS with MCOs. Once we are able to verify those on the list who are UniCare members, we will actively engage the members to make sure they have access to a full array of care management services. We will leverage the list of members receiving SNS services and outreach to the ASO regarding coordination of care. We will provide the information needed to conduct and complete individualized strengths-based assessments, make sure children receive needed services, review for duplication of services and provide historical authorization information. By sharing and exchanging information, we can help close care gaps and help make sure children receive needed health care services, such as a comprehensive EPSDT exam within the required 30 calendar days of placement in foster care and a follow-up visit within 90 calendar days of placement in foster care. With appropriate consents and authorization, ASO staff can reach out to the member's UniCare Care Manager or our Member Services Representatives to obtain needed information.

The Transition Coordinator will work with the member's Care Manager regarding services authorized and/or incorporate the SNS services within that member's care plan.

- CM064 1 The Vendor should describe its process to share information for children enrolled in the Specialized Foster Care Managed Care Organization (MCO) including, but not limited to, authorization data, medical history, claims history, medical records, and other patient information.

Sharing Information With the Specialized Foster Care Managed Care Organization (CM064)

Health Insight offers West Virginia MHT providers a consolidated view of the member's physical and BH, pharmacy, and care planning data in an easy-to-navigate dashboard which includes accessible screenings and assessments, HEDIS care alerts, authorization data, medical history, claims history, medical records, and other patient information. This provides a multifaceted perspective on member utilization and pharmacy patterns to prevent service duplication and identify care gaps and trends to coordinate more effective care. Our Transition Coordinator will prepare applicable medical records for members including screenings, care plans, and our Care Manager interactions (if applicable) once the member is identified as active in the Foster Care MCO. If there are any questions related to the transition or continuity of care needs, or UniCare Transition Coordinator can assist as needed.

A health and service record that travels with children over time and across placements can improve communication, avoid redundant assessment processes, and reduce service duplication and fragmentation. We will work with DHHR, and the Foster Care MCO to share information important for smooth care coordination and completion of the member's medical record, such as the health history form, information on the child's birth, health authorizations, care plan, medication forms, and level of care determination forms, among other information.

4. COMMUNITY/STAKEHOLDER ENGAGEMENT

CS001	1	The Vendor should describe its approach to establishing and maintaining relationships with associated Department agencies and State advocacy groups.
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Establishing and Maintaining Stakeholder Relationships (CS001)

UniCare's approach to community and stakeholder engagement is simple: local, active and ongoing engagement. When we see a need, we work with the local community to fill it and we make sure our solution is sustainable so the need is filled long-term. We have provided leadership and strategy, subject matter expertise, resources, and volunteers to community-based organizations across the state to help the West Virginia Department of Health and Human Resources (DHHR) meet its goals to improve the health of West Virginians. We stand ready to continue operations and bring on WVCHIP on day one. In addition to working with DHHR and other State agencies on important issues, we frequently form partnerships that align with DHHR priorities as we learn about them through our vast network of community partnerships, internal data mining and analytics, and emerging health trends. We seek local organizations and agencies that are working on critical health or social issues in the state, narrow our search to those making the most impact, and collaborate to achieve common goals. We evaluate our community partnerships based on program or service impact, number of people served, measurable outcomes, and how well their goals align with ours. We see our partnerships as an opportunity to benefit all West Virginians, not just our members. We seek input and advice from advocates, peers, and members at events like our Stakeholder Advisory Committee meeting that most recently occurred on February 3, 2020, and the Community Engagement Committee that occurred on February 11, 2020, in Mountain State communities.



Figure 6.4-1 illustrates UniCare's three paths to population health, with *Engage* as one of the three components. Our Health Promotion Consultants and Community Engagement Representatives engage with providers, community partners, and social services in West Virginia's communities to understand what factors affect our members. Informed by and in coordination with these partners, the team develops events and projects that improve our communities. The Community Engagement team and Care Managers continuously network and look for resources and agencies that support our

members. UniCare's outreach and engagement team reviews and discusses community engagement opportunities on a biweekly basis, looking for ways to partner with organizations in West Virginia to address the needs of every community. We are in the field, reaching out, attending coalition meetings, and compiling data on available supports in every county. We study each partnership opportunity thoroughly and assess our resources and funding capabilities so our partnerships respond to local circumstances.

Natalie Robinson, our Community Engagement Director, establishes and maintains high-level partnerships with local and statewide key stakeholders to address needs, report trends, oversee marketing compliance with State contracts, and maintain positive rapport with members and partners. She is a member of United Way of Central West Virginia's allocation committee,

Figure 6.4-1. UniCare Has Three Parallel Paths to Population Health and Engages with the Community Impact Members



Experience Matters

Natalie Robinson
Community Engagement Director



Natalie has nearly 9 years of experience in community engagement with diverse populations to address complex issues.

reviewing grants and providing feedback that helps United Way make informed decisions when directing grant money to address the health care needs of local communities.

Meaningful Community Relationships

We are West Virginians serving West Virginians. UniCare associates have worked with State agencies and advocacy groups to help achieve better health outcomes for members, cost savings for the State, and stronger communities for all. We accomplish this through proactive and going engagement, participation on boards and committees, and through networks and the established relationships of our UniCare associates. We understand working closely with our State partners and being engaged in State committees and workgroups allows us a better opportunity to understand the priorities of the various State agencies. We can then collaborate with community organizations and advocacy groups to help impact policy priorities of the State through focused and targeted initiatives. This is essential to creating a lasting and broad impact across the State of West Virginia. Table 6.4-1 provides a summary list of our various relationships and involvement with West Virginia State agencies and advocacy groups.

Table 6.4-1. UniCare Develops Meaningful Relationships with State Agencies and Advocacy Groups

UniCare Employee	State Initiative or Advocacy Group	Involvement
Dr. Jorge Cortina <i>Behavioral Health Medical Director</i>	• MCO Collaboration on Substance Use Disorder	• Participant (2019)
	• Treatment, Recovery, and Research Subcommittee	• Participant (2018-2019)
Megan Lombard <i>Operations Director</i>	• Finders Keepers Task Force	• Member (2018-2019)
	• MCO Collaboration on Substance Use Disorder	• Participant (2019)
	• MCO Collaboration for Unified Interpretation and Implementation of HB 2351	• Participant (2019)
Amber Nary <i>MHT Regulatory Manager</i>	• Finders Keepers Task Force	• Member (2018-2019)
	• MCO Collaboration on Substance Use Disorder	• Participant (2019)

Vicky Gallaher <i>Director Integrated Care Management</i>	• MCO Collaboration on WV Health Information Network Tool	• Participant (2017)
	• MCO Collaboration on SUD	• Participant (2019)
	• MCO Collaboration on WV Health Information Network Tool	• Participant (2017)
	• MCO Collaboration on SUD	• Participant (2019)
	• MCO Collaboration for Unified Interpretation and Implementation of HB 2351	• Participant (2019)
	• Urine Drug Screening Workgroup	• Participant (2019)
Barbara Wessels <i>Contract Liaison/MHT Administrator</i>	• Substance Use in Pregnancy Task Force	• Member (2018)
	• Maternal and Child Health Committee	• Member (2018)
	• American Heart Association	• Board Member (Current)
Julie Deems <i>Community Relations Representative</i>	• Kids Health Partnership	• Participant (2018-2019)
	• The Arc of Mid Ohio Valley	• Board Member (2018-Current)

In addition to the summary of partnerships provided above, the following highlights further examples of Unicare associates being actively engaged with State agencies and advocacy organizations:

- **DHHR, BMS, and the Office of the Insurance Commissioner.** Unicare staff, including Government Relations Director John Canfield and CEO Tadd Haynes are engaged with DHHR, the BMS, and the OIC on a regular and ongoing basis.
- **Pediatric Medical Advisory Board of the Office of Maternal, Child, and Family Health.** MHT Regulatory Manager Amber Nary's timely updates to BMS on UniCare's "go live" readiness for the implementation of the SUD waiver benefit facilitated a monthly report to assure timely and accurate reporting to the State.
- **West Virginia Perinatal Partnership.** CFO Kevin Dean and Contract Liaison/MHT Administrator Barbara Wessels worked on the Perinatal Partnership along with our former Medical Director, Dr. Tracy Dlott. Dr. Dlott's membership on the Association of State and Territory Health Officials

Increasing Access to Contraception committee gave her instant credibility to start the Long-acting Reversible Contraception (LARC) Workgroup and advanced the use of immediate postpartum LARC in West Virginia. Kevin Dean's work assured the integrity of data provided and reviewed by the group. Barbara Wessels served the partnership as

Barbara Wessels with UniCare has been a longtime member of the Tobacco Free Pregnancy Committee, and she promoted Baby and Me Tobacco Free in targeted counties. Barbara was always a resource to guide me to the person and information I needed within UniCare. UniCare has been an active partner with the West Virginia Perinatal Partnership to promote and support improved quality of care for mothers and infants. UniCare is present at quarterly meetings of the Perinatal Partnership All Payers workgroup, which addresses all perinatal and infant health concerns such as substance use disorder and neonatal abstinence syndrome.

Denise Smith, Former Director of Perinatal Programs Office of Maternal, Child, and Family Health West Virginia Department of Health and Human Resources

committee member and member of the Substance Use in Pregnancy Task Force (2014) and LARC Workgroup (2015), initiatives that led to a reduction in babies born with neonatal abstinence syndrome. Barbara Wessels works with the Perinatal Partnership and expanded awareness of their programs because she shared them with our staff and members. Now our Outreach, Quality, and Care Manager staff are trained to offer a safe sleep and SIDS prevention program called Our Babies Safe and Sound, a direct outgrowth of the Partnership. Similarly, she advanced the Baby and Me Tobacco Free program as a public health initiative.

- **Jackson County Family Resource Network.** UniCare Community Relations Representative Julie Deems served as vice president of the Jackson County Family Resource Network for five years. Her work as vice president of the Jackson County Family Resource Network resulted in a signature event, Safety Palooza, which is free and open to the community.

UniCare has been and continues to be a long-standing collaborative partner to our Family Resource Network. We share the goal of serving children and families in our communities and state.

Renee C. DeLong, Director, Jackson County FRN

- **Marshall University and the West Virginia Autism Training Center.** In September 2019, we partnered with both on Disability Mentoring Day to promote career development for students and job-seekers with disabilities and provided them with \$7,500 in funding.

Shaun Collins, UniCare's Planning and Performance Director, was part of a panel discussion called Path to Employment during Parents' Weekend. We had also partnered with the West Virginia Autism Training Center at Marshall University in 2018, and with West Virginia State University and the Statewide Independent Living Council from 2015 to 2017 to make Disability Mentoring Day a reality.

I am continually impressed with the work of this company, the warm (yet professional) demeanor of the people with whom we collaborate, and the advances they are taking to provide opportunities for individuals who may be otherwise overlooked.

Hillary Adams, Ed. D., Employment Coordinator, Marshall University

- **Mountain State Parents, Child, and Adolescent Network (MSCAN).** We engaged with MSCAN and their national partners to gain frontline understanding of resources and gaps for families and children with mental health conditions.

The willingness of UniCare to engage with people with disabilities and advocacy organizations and include us in the process and discussions relating to services and supports has been very valuable.

Ann Watts McDaniel, Executive Director, SILC

- **West Virginia Statewide Independent Living Council (WVSILC).** We also work with WVSILC on Disability Mentoring Day, reviewing and providing feedback on our member materials and improving our ability to locate and engage individuals with disabilities who may not have cell service or stable housing. We have supported WVSILC financially and offer them display space at our annual Healthy Night at the Ball Park, to which we invite non-profit, health-focused organizations to promote health and wellness. Our ultimate parent company, Anthem, Inc., supports the National Council on Independent Living (NCIL) through sponsorship and participation in the national conference as well as initiatives supporting independence and access. We work with the Centers for Independent Living (CILs) around the country in partnerships to assist with home modifications, communication assistance, durable medical equipment, and assistive technology.

- CS002 1 The Vendor should describe its approach to establishing and maintaining relationships with applicable provider and medical associations.

Strong Relationships with Provider and Medical Associations (CS002)

UniCare's Network Relations Consultants regularly engage providers, attend provider association meetings, and actively work to reduce administrative burden, manage contract compliance, and resolve issues so providers can focus on care. In addition to our regular interaction with our individual participating providers, we engage with provider associations and medical groups across West Virginia to address the needs and concerns of members. We do this through active engagement in association meetings and conferences and regular meetings with association leadership. For example, Dr. Jorge Cortina, UniCare's Behavioral Health Medical Director, represents *West Virginia at the American Psychiatric Association Assembly* until 2021.

We build relationships with providers as trusted partners just like we do with our members and advocacy organizations. Quarterly quality meetings with the *West Virginia Primary Care Association* have resulted in strong relationships with its members, and strengthened a provider incentive program with school-based providers. UniCare participated in 32 Medicaid workshops for providers offered by the West Virginia Bureau for Medical Services throughout the state in 2019, as well as the following:

- Senior Leaders Conference hosted by the West Virginia Behavioral Healthcare Providers Association
- Governance and Leadership Forum hosted by the West Virginia Rural Health Association
- West Virginia Medical Group Management Association's 2019 State Conference
- West Virginia State Medical Association



We also engage with provider associations through larger, community-based partnerships, including the ***Kids Health and Hunger Project***. UniCare is partnering with Think Kids to better understand the challenges and opportunities that exist with respect to children’s health, with a focus on food insecurity. ***The West Virginia Chapter of the American Academy of Pediatrics*** is also supporting this initiative, encouraging its members to complete surveys aimed at establishing a baseline for current assessment and referral practice related to social determinants of health. The results of these surveys will inform our approach to the tools and supports needed for our SDOH Provider Incentive Program and action plan development at ***The Health and Hunger Summit*** scheduled for May 5, 2020, in South Charleston.

We have 17 staff members supporting our providers, which gives us a great deal of insight into provider satisfaction, issues that affect provider practice, and the support providers need to deliver optimal care. In addition to our engagement with provider and medical associations, we interact regularly with our individual providers through the normal course of business. If any systemic trends or issues come up through the course of our regular interactions we have the established relationships with the associations to address those issues at a broader level within those associations. This individual provider and association engagement results in UniCare’s well-rounded understanding of care from the provider’s perspective and a high satisfaction rate among our providers.

CS003	1	The Vendor should describe its approach to establishing and maintaining relationships with applicable professional boards.
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Relationships with Professional Boards (CS003)

Members of the UniCare team actively participate on local professional boards to advance our understanding of local issues and build relationships with West Virginia’s leading agencies and organizations. Our activities with these agencies and organizations deepen our awareness of West

Virginia's needs and concerns and enrich our relationships with West Virginians. Table 6.4-2 outlines the engagement of UniCare on the boards of professional boards and organizations.

Our approach to establishing and maintaining relationships with professional boards focuses on collaboration. When we see a need for subject matter expertise and leadership in our community, we do not hesitate to engage with professional boards to fill those roles. As experts in what we do, we are always looking for professional organizations we can join or with which we can engage. We are honored to have been asked to serve or be elected to boards by industry peers. Many roles and relationships have been maintained for several years and our team is ready to continue these relationships and fulfill existing and future commitments.

Similar to our approach to developing relationships with other organizations, we seek out boards with which we feel we'll be able to garner and share best practices that strengthen our communities and our industry; professional boards serve as opportunities to positively impact all West Virginians. As members of the organizations in Table 6.4-2, we can do just that. We use these relationships as spring boards to discuss ideas, community or industry needs, or to discuss potential new programs or initiatives. For example, as discussed in our response to CS001, Dr. Tracy Dlott leveraged her role on the LARC Workgroup to lead efforts in the state to advance the use of immediate postpartum LARC, an initiative that had wide impact outside of Medicaid to all of West Virginia. We remain active and valued members of professional boards and are always seeking out other boards with which we can engage and leverage best practices.

Table 6.4-2. UniCare Activity on Professional Boards in West Virginia

UniCare Employee	Professional Boards and Associations	Involvement
Tadd Haynes <i>Chief Executive Officer</i>	• WV Association of Health Plans	• Chairman (2020)
Dr. Jorge Cortina <i>Behavioral Health Medical Director</i>	• WV District Branch of the American Psychiatric Association	• Elected WV representative at American Psychiatric Association Assembly (2019–2021)
John Canfield <i>Government Relations Director</i>	• WV Chamber of Commerce	• Board of Directors • Health Care Committee • Government Relations Committee
Dr. Tracy Blott <i>Former Medical Director</i>	• Association of State and Territory Health Officials Increasing Access to Contraception Learning Community	• WV Representative (2017)
Amber Nary <i>MHT Regulatory Manager</i>	• LARC Workgroup • Office of Maternal, Child, and Family Health	• Chairwoman (2016–2019) • Pediatric Medical Advisory Board (2019)

In addition to the summary of professional board engagement listed above, the following highlights further examples of UniCare associates being actively engaged in professional boards:

- West Virginia Association of Health Plans (WVAHP).** WVAHP is a state trade organization comprised of the Managed Care Organizations (MCOs) operating in West Virginia. The WVAHP's purpose is to provide assistance to the State in its delivery of managed health care to Medicaid and CHIP recipients, reduce the costs of administering West Virginia's Medicaid system, and to improve the health of Medicaid and CHIP recipients. The WVAHP works closely with DHHR and Bureau of Medical Services (BMS) leaders and staff as a conduit on a variety of issues and projects. The WVAHP also presents the annual iCare Awards, which recognize frontline MCO employees who have demonstrated exemplary care and service in delivering health care to West Virginia's Medicaid members. UniCare CEO Tadd Haynes was elected chairman for 2020. In his role as chairman, he leads the organization as its members and staff work to implement the Association's policies, strategies, goals, and day-to-day operations.

- **West Virginia State University Employer Advisory Board for the Office of Career Services and Cooperative Education.** UniCare Planning and Performance Director Shaun Collins has served on the Advisory Board since 2017. The board is made up of top employers in West Virginia and advises, counsels, and assists in the planning, development, and evaluation of programs and services provided by the Office of Career Services and Cooperative Education.

CS004 1 The Vendor should describe its process to coordinate with agencies providing complimentary services to the member.

Enhancing Services to Members Through Local Organizations (CS004)

UniCare is part of every community in West Virginia. The tight-knit, small towns are where we live, and often, where we are from. Our Community Engagement Representatives proactively reach out to community partners, and social services in our towns and communities to understand what may affect our members and our fellow West Virginians. Informed by and in coordination with these partners, the Community Engagement team develops events and projects that improve our communities. The following outlines some of our coordination with agencies to provide complementary services to our members:

- Understanding the effects of the opioid crisis in West Virginia, in part because of Dr. Cortina's work on the Governor's Council on Substance Abuse Prevention and Treatment, UniCare and the Anthem Foundation have donated more than \$77,000 since 2018 to ***Overdose Lifeline*** to train UniCare partners in two youth substance abuse prevention programs: This Is (Not) About Drugs, a science-based program to address prescription misuse; and Preventure, an evidence-based program that takes a person-centered approach to adolescent substance use prevention. We initially recruited trainees from various substance abuse prevention coalitions, Family Resource Networks, and schools in counties with high opioid use. ***In October 2019, UniCare trained 16 community partners from***

various organizations in Overdose Lifeline's This Is (Not) About Drugs. Overdose Lifeline and plans to train an additional two dozen facilitators on the youth programs in 2020.

- We are also proud of the support we have been able to offer to **Stepping Stones**, a program focused on easing the transition for kids aging out of foster care. A staff member was at a community meeting two years ago when she heard Stepping Stones had lost funding for one of its key positions. UniCare stepped in to fill that need and remained engaged, supporting Stepping Stones throughout planning for their tiny homes village. To assist this community in progress, UniCare donated \$80,000 for a hydroponic garden and greenhouse for the Stepping Stones program, providing youth enrolled in the program an opportunity to learn workplace skills and small-scale agriculture while providing food for themselves and local homeless and recovery communities.
- In partnership with the **American Heart Association**, we are establishing a community dialogue in Kanawha County on the epidemic of youth vaping. UniCare will provide sponsorship support to this initiative, which involves convening stakeholders to discuss how the community can address e-cigarettes, including policy and systems changes to prevent and reduce vaping among teens. These dialogues will bring together regional and local leaders to raise awareness, create synergistic relationships that generate momentum, and develop plans that will reverse the course of smoking and vaping.
- In 2020, UniCare is partnering with **Boys and Girls Clubs** to provide trauma informed training to staff members to help respond to youth with behavioral challenges and anti-social behaviors. UniCare will

It is a humbling experience to find myself again thanking you for UniCare's extremely generous donation of \$80,000 for the purchase and development of the hydroponic tower garden and greenhouse at Stepping Stones. UniCare's continued support of our programs and kids is truly remarkable, and it was difficult to find the words to describe how simple acts of generosity have contributed to our kids' well-being. This project has also already sparked such remarkable outreach. We are so excited by this project, and I cannot wait for the greenhouse to take shape and the first vegetables to make their way to our kids' table.

Susan R. Fry, Executive Director, Stepping Stones

sponsor training in the use of the evidence-based Positive Action program, and other strategies, for at least 24 full and part-time staff members across the state. Goals for the program include:

- Provide staff training in working with opioid addicted families; engage at least 400 youth per year with the Positive Action curriculum
- Utilize the skills of a licensed social worker to provide specialized individual or group sessions for 175 youth and parents/caregivers who are presenting problematic behaviors that could indicate they are struggling with opioid or other substance use problems in their homes
- Provide access to a certified counselor at the Clubs for 100 youth and parents/caregivers with the aim of helping them cope with the most traumatic elements in their lives
- Pilot a parent engagement initiative at a minimum of one site providing small group classes and support to 25 adults

Kiosks for Community Connection. To assist our members and other community residents in identifying local health care or SDOH resources, we will be placing tablets pre-loaded with a searchable directory of community resources and links to UniCare's website, the member portal, and our Healthy



From 2018 to present, UniCare and its philanthropic arm, the UniCare Foundation, have invested more than \$1 million dollars in West Virginia to support community organizations and expand access to health programs.

Rewards program at kiosks during our community outreach events or at

community locations (for example, social service agencies, food and baby pantries, and homeless shelters).

At community events, our Community Engagement and Population Health teams will be available to provide members and community residents with additional information, as needed, regarding these community resources. Because we are actively involved in community life, we continue to grow in awareness of community- and faith-based organizations and local resources. For example, to improve both maternal and infant health, UniCare funds a program called Baby and Me Tobacco Free in West

Virginia, *which is available to all women, not just our members*. We see the benefits to our community in healthier babies: among participants, only 5.5% of babies were born with low birth weight, below both West Virginia's (9.4%) and the national average (8.3%). With our informed perspective on population health and community roots, we are simultaneously reinforcing the work of Contract Liaison/MHT Administrator Barbara Wessels on this public health initiative and Director Integrated Care Management Vicky Gallaher's service as a member of the Policy Workgroup, Substance Use in Pregnancy Task Force, and Maternal and Child Health Committee.

In addition to our coordination with agencies to provide complementary services, we also look for opportunities to help with financial and training assistance to close gaps in care and address populations where they live. For example, we provided funding to assist in training of social workers statewide about the Healthy Grandfamilies program to increase family stability when parents are not able to care for their children. In addition to the training, we funded the printing of Personal Health History journals for grandparents to help them manage their health history. This allows them to easily track and share their complete medical history with the provider so they can best determine what tests, medications, immunizations and other treatments are best for the member. We also provided funding to the *American Heart Association* for training over 1,000 community members, DHHR staff, students, and teachers in Hands Only CPR to advance public health.

We are actively engaged with more than 1,100 community-based organizations statewide. Table 6.4-3 outlines the involvement of various UniCare employees on community boards and committees, all of which advance our understanding of the needs and circumstances of our members.

Table 6.4-3. UniCare Employees Are Actively Engaged in Local Organizations

UniCare Employee	Community Organizations	Involvement
Vicky Gallaher <i>Director Integrated Care Management</i>	• Children's Therapy Clinic	• (2018–2020)
Natalie Robinson <i>Community Engagement Director</i>	• United Way of Central WV	• Community Services Advisory Board (5 years) • Health Team Chair of Grant Fund Allocations Committee (1 years)
Annetta Tiller <i>Community Relations Representative II</i>	• Children's Home Society • Community Crossing • Coalfield Community Action Group	• Paul Miller Shelter Advisory Board (1.5 years) • Parents as Teachers Advisory Board (1.5 years) • Board Member (8 years) • Vice President (1.5 years)
Barbara Wessels <i>Contract Liaison/MIIT Administrator</i>	• American Heart Association • WV for Affordable Health Care • WV Tobacco Free Families	• Board of Directors • Advocacy Committee • Kids Health Partnership (2016–2019) • Committee Member

In addition, our Care Managers spend their time in contact with members and community organizations, connecting members to resources and education and compiling databases of locally active, available resources. Each Community Engagement Representative spends 50%–60% of each week face-to-face with members and partner agencies. Care Managers and Community Engagement Representatives immediately and directly make connections that improve members' lives. Community Engagement Representatives routinely visit statewide agencies like Starting Points, Parents as Teachers, and Birth to Three, to provide UniCare benefit and health information. We collaborate with these agencies to plan and sponsor events, help with supplies and funding, and provide health education for their clients.

Regular Contact with Key Organizations

The Community Engagement team meets regularly with several key organizations in West Virginia:

- **WV Family Resource Networks (all counties).** The Community Engagement team participate in monthly meetings to keep community agencies apprised of changes to covered benefits. During these

meetings, we also inform agencies about new programs and collaborative community events we are supporting and implementing, and work together to address community needs. Family Resource Networks also publish a Resources Guide to help members in need of services to address social determinants of health needs, which we integrate into our database of member services.

- **Workforce WV (county and regional offices).** The Community Engagement team is active in Workforce offices around the state, engaging with clients who are looking for employment or training, or who are laid off and seeking unemployment benefits. Clients learn how to apply for Medicaid benefits through their local DHHR or online at WV PATH, and learn about UniCare's health programs, benefits, and services.
- **West Virginia Coalition to End Homelessness (WVCEH).** The Community Engagement team is partnering with WVCEH on multiple fronts to improve members' connection to services and increase the availability of training on housing resources and supports. UniCare is becoming a registered Homeless Management Information System (HMIS) user in all four Continuums of Care, expanding our ability to connect with hard-to-reach members. We are also partnering with WVCEH to support the expansion of the Coalition Street Outreach services in rural areas and increase care management for individuals receiving Housing Opportunities for Persons with Aids and State Opioid Response services.
- **Strategic Planning in Occupational Knowledge for Employment & Success (SPOKES).** The Community Engagement team gives a UniCare presentation on a biannual or quarterly basis at SPOKES classes around the state. Here we are able to engage with WV Works participants, informing them of UniCare benefits, services, and programs. Some of the questions we answer there are: How do I know which health plan I have? How can I get a new ID card? Can I switch plans? How? How do I receive my Healthy Rewards or Value-Added Services?

- **County public libraries** (all counties) have become a place for people looking for internet services, tutoring, employment, education, and socialization, or simply needing a safe, warm place to relax. The Member Engagement team provides county libraries with UniCare benefit information, health tips and health education, and resource and referral to social services information. We also engage with children and families by co-hosting or sponsoring events like Read-Aloud, child-tailored health and safety education, and interactive play and physical activities.
- **Baby Pantries** in Mason, Tucker, and Hardy Counties; Starting Points Baby Pantries; Tree of Life Baby Pantry; Enact Baby Pantry; Randolph County Baby Pantry and Gabriel Projects (Charleston and Wheeling) provide monetary support, health education, and resources for both moms and babies. We restock the pantries with diapers, wipes, and formula. The Community Engagement team also disseminates information on programs that will benefit expectant and new mothers, such as Taking Care of Baby & Me®, our Healthy Rewards Program, and programs from other agencies such as Baby & Me Tobacco Free and Babies Safe and Sound.

Frequent Referrals to Community Organizations

Some of the most frequent referrals by Care Managers and Community Engagement Representatives are made to the following organizations:

- **New Eyes for the Needy** is a major vision resource that assists members with the purchase of new eyeglasses through their voucher program. New Eyes issues one voucher per year per member at no cost. Social workers obtained more than 80 vouchers for our members in 2019. One 60-year-old member obtained two pairs of eyeglasses from New Eyes. Her social worker helped her obtain an initial pair of eyeglasses, but at her next annual eye exam, her prescription had changed. The member was very pleased to learn she would be able to obtain a second voucher. We also make frequent

referrals to The Lions Club Vision Assistance program that helps members obtain eye exams, eyeglasses, and hearing aids.

- **Donated Dentures** program assists a limited number of low-income seniors and other adults in obtaining dentures or partial dentures through a statewide network of dentists who donate their time. Social workers made approximately 70 referrals to the program in 2019. A 62-year-old member was edentulous for a long period of time when his social worker referred him to Donated Dentures. The member obtained his dentures at no cost within two months of the referral. When the social worker contacted him to determine the status of his referral, he exclaimed with obvious pleasure, “I have the dentures in my mouth right now!” We also make frequent referrals to Federally Qualified Health Centers and local health departments for dental services.
- **Agencies providing personal care services** in the home are a vital resource for our members, as some experience a number of health conditions and often have limited support systems. A 45-year-old member who lives alone with limited support, suffers from diabetes and COPD, and was having difficulty with activities of daily living received personal care services in her home 2.5 hours per day Monday through Friday with the help of her social worker. She also received dentures through the Donated Dentures Program and eyeglasses through the New Eyes for the Needy voucher program.
- **Catholic Charities** often provides emergency cash assistance for our members for things such as past-due utility bills, medications, and medical equipment. They are very active in communities across the state, sponsoring emergency cash assistance, thrift stores, and food pantries as well. Our Community Engagement team provides funding, totes for food, and outreach resources to clients accessing food in rural areas. UniCare provides health education, benefit information, and referral services to clients as well. One member with cancer needed assistance with moving and had no

family or community support system to help her out. Catholic Charities assisted her with moving and volunteered to paint the inside of her new home, then continued to assist her by delivering food to her home. This member and her Catholic Charities representative developed a friendship that continued to support the member in ways she had not been before they stepped in.

- **WV Community Action Partnership** is a statewide membership organization of 16 community action agencies across the state that offer emergency assistance, utilities assistance, food pantries, weatherization, tax preparation, emergency clothing, senior programs, and more.
- **Salvation Army** also helps members with emergency cash assistance, thrift stores, and food pantries from its offices across the state.
- **Food pantries and meal programs.** Our Community Engagement team supports and outreaches to food pantries and food distribution sites around the state: Salvation Army, Mountain Mission, Heart and Hand, Fishes and Loaves/Beckley Dream Center, Tender Mercies Food Pantry, and Manna Meal. In one community, a homeless member reported he had not eaten in two weeks and did not have any money to travel to the local soup kitchen. The Care Manager contacted Union Mission, which was close to the member's walking location, and they brought an emergency food supply. When the member stated he did not have a can opener, Union Mission gave him one the same day they delivered the food.
- **Housing assistance programs.** We identify affordable housing resources available in communities across the state and help our members find navigators and resources when they experience housing instability or homelessness. Telamon in Berkeley County has limited resources, and UniCare had one week to prevent a family from becoming homeless. If this family became homeless, the 15-year-old son could have been separated into a male shelter. After much work the mother found a home but

needed \$1,400 to secure it. Within a week, UniCare found enough resources for the mother to secure the home. Coordination between UniCare team members, community resources, and the mother prevented this family from becoming homeless.

- **Children's Home Society.** A baby boy needed special, expensive formula that was not covered by WIC or any other assistance programs. A social worker connected his mother to Children's Home Society in McDowell County, who purchased cases of the formula for the family. Similarly, a male toddler living in a rural area needed clothing. He was not yet eligible for a clothing voucher through DHHR, but he was large for his age and his mother was unable to use clothing assistance programs in her area. A social worker directed his mother to the Morgantown office of the Children's Home Society, who gathered a box of new clothing for the boy and shipped it to his mother's home.

We see all community organizations' services as complementary to UniCare's mission and vice versa, just as our Care Managers and Community Engagement Representatives interact in mutually beneficial ways. We reach out to community-based organizations and gain valuable insight on population health and member concerns, forging solutions that help eliminate barriers to care and services in a culturally competent way. Community-based organizations know who to contact at UniCare when a member needs assistance with their UniCare benefits or Value-Added Services because they know us and we know them. UniCare services and benefits are highlighted and shared with community-based organizations' constituents, making connections that meet the care and resource needs in small and large communities all over West Virginia.

5. Member Services

MS001	1	The Vendor should describe how they will collaborate with stakeholders to design materials that best meet the needs of the populations being served.
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Designing Materials in Collaboration with Stakeholders (MS001)



UniCare Health Plan of West Virginia, Inc. (UniCare) designs, modifies, and updates member materials with active participation by a diverse group of stakeholders, which includes our members, community partners, advocacy groups, government representatives, and providers. We tailor materials to reach specific audiences in their preferred modes

with easily understood, age-appropriate, and culturally competent content. We invite input prior to developing materials and continuously thereafter through advisory group meetings, listening sessions, independent reviews, and focus groups.

Some materials produced for Medicaid- and West Virginia Children’s Health Insurance Program (WVCHIP)-enrolled West Virginia Mountain Health Trust (MHT) members will include the same content (for example, health education brochures) and differ only in the branding. However, other materials (for example, the member handbook) will differ in both content and branding for Medicaid-enrolled MHT members, as compared to WVCHIP-enrolled MHT members. In these cases, we will develop a separate review process to assure such materials meet the needs and preferences of both Medicaid- and WVCHIP-enrolled members and adhere to the West Virginia Department of Health and Human Resources (DHHR) requirements.

By incorporating stakeholder input across our materials development and dissemination process, we make certain member materials such as brochures, videos, and workshop curricula are tailored to the needs and expressed interests of our members, including subpopulations such as children and adolescents, pregnant

women, individuals with HIV/AIDS, individuals with disabilities, LGBTQ individuals, and individuals of racial, and/or ethnic minority. In addition, we will continue to use our internal Collateral Materials Approval Process (CMAP) to confirm all developed materials are culturally competent, understandable, account for varying health literacy levels, and comply with state, federal, and contractual requirements.

Member Review of Materials

Our *Member Engagement Committee* serves as a key source of input from members related to our materials. Our Community Engagement department, which coordinates this committee, selects committee members based upon their health plan tenure (at least one year) and strives to make sure the committee represents our total membership in terms of racial and ethnic diversity and geographic location of residence, including representation across rural, and urban West Virginia. Representatives of our Community Engagement, Integrated Care Management, and Quality Management departments attend Member Engagement Committee meetings, and agenda items include member-requested topics, review of member materials (such as our member handbook), and updates on member benefits such as our Value-Added Services (VAS) and Healthy Rewards incentive program. Member feedback helps us to adapt materials to best meet member needs and to enhance quality. Discussion questions regarding materials include:

- How easy was the information to understand and use?
- How helpful was the information?
- Did the information meet your gender, age, health, ethnic, and/or language needs?
- What would make the information UniCare sends more helpful?

We will convene four Member Engagement Committee meetings in 2020 (including an upcoming meeting in Charleston on February 11, 2020), and to make sure members continue to have input into our materials, we will continue to conduct quarterly Committee meetings across future contract years.

Community Review of Materials



We invite input from diverse stakeholder groups to assure optimal information delivery across member subgroups, such as children, adolescents, and individuals with disabilities.

We solicit input from groups that work with our members every day — schools, community-based organizations, and advocacy organizations.

Stakeholder Advisory Committee. Our Quality Management department coordinates this committee, which will meet quarterly in 2020 and throughout the contract term to advise UniCare regarding its health education efforts. This includes reviewing member materials for age-appropriateness, understandability, and cultural competency. Membership includes member advocates, providers, community health educators, and health plan members. Current members include McDowell FACES Family Resource Network, Community Crossing Parents as Teachers, Children's Home Society, Communities in Schools, and SAFE Domestic Violence Shelter. UniCare conducted our first 2020 Stakeholder Advisory Committee meeting in Welch, West Virginia with 11 community stakeholders in attendance representing a wide range of our membership. Community stakeholders included representatives from West Virginia Birth to Three, Community in School, the Women, Infants, and Children (WIC) program, Head Start, S.A.F.E, Tug River Valley, Reconnecting McDowell, The Community Crossing, Children's Home Society, Grandparents Support Group, and KVC West Virginia. UniCare initiated the meeting with Medicaid updates, a look back at 2019 achievements, partnerships, sponsorships, and discussed collaborative events, and initiatives for 2020. The stakeholder group provided valuable feedback on our

newly created new member welcome packet and on our “Get Help for Addiction” and “What Are Opioids?” flyers that we will use to enhance our materials, such as including HELP4WV information. The stakeholder group discussed challenges and solutions to SDOH issues in the McDowell and surrounding counties as well as individual program needs and upcoming events, and how we can collaboratively work together to address needs.

West Virginia Statewide Independent Living Council (SILC). To make certain our member materials are understandable and accessible to individuals with disabilities, we have our materials reviewed by advocacy organizations such as the SILC. In a recent review of our member materials, the SILC reviewers noted that our New Member Welcome Booklet is “respectful, clear, and pretty easy to read,” uses graphics as well as cues to topics, and offers step-by-step instructions to access online information. Reviewers also made suggestions for improvement on some materials, such as pointing out to readers that some services require prior authorization our opioid use disorder informational flyer. This spring, we will collaborate with the West Virginia SILC, the Fair Shake Network, and the West Virginia Developmental Disabilities Council to host a discussion to hear directly from advocates on more of our materials to make sure we are sharing relevant information in an understandable and respectful manner.

Schools. Our Community Engagement team is already preparing and delivering health education presentations (on oral health, for instance) in West Virginia schools, and we incorporate any feedback we receive into future presentations. Additionally, recognizing that UniCare has the knowledge and resources to develop engaging materials for students, we have been asked on several occasions to develop new materials and presentations related to emerging issues, such as youth vaping. Moreover, as our Community Engagement and Population Health teams continue to identify the need for new or updated materials for youth, we will invite school personnel to review these materials.

Community Listening Sessions. In 2020, our Community Engagement team will coordinate two listening sessions and will continue to hold at least two such listening sessions annually thereafter. We will hold these sessions in locations across the state to assure statewide input, which will also allow us to focus on topics of regional concern (opioid use disorder, for example) and review of related member materials. We believe this approach will complement the input gathered through the Member Engagement and Stakeholder Advisory Committees.

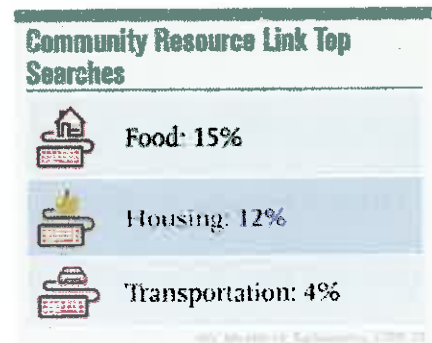
Other Methods. In addition to the methods previously mentioned, our Community Engagement team will coordinate focus groups and request independent review of materials on the advice of our advisory committees and as recommended by our Care Management and Quality Management teams.

Innovative Methods to Gather Input

To assure optimal input into our materials design and review, we will be exploring new methods for broadening our feedback loop in 2020. For instance, our affiliate health plan in California is piloting the use of Facebook to gather feedback on member materials from community organizations and other Facebook friends. As compared to in-person advisory group meetings, providing feedback through Facebook eliminates the need for travel and offers reviewers an opportunity to comment at a time most convenient to them. We will communicate regularly with our California affiliate and, as indicated by its results, work with DHHR to bring this novel use of Facebook to West Virginia.

Leveraging Data to Inform Materials Development

We will leverage member-specific clinical and SDOH data that inform our Population Health priorities to identify specific member needs related to educational materials and community outreach efforts. These data points will inform the identification of specific health education content areas (for instance, diabetes self-management, depression, and opioid use disorder) and the groups for whom the materials will be developed (for example, age groups, racial and ethnic minority populations, and geographic regions). Further, we will examine search statistics from our online tool Community Resource Link, to identify member needs, and concerns related to SDOH.



Community Resource Link, offered as a VAS, provides members with access to a searchable directory of community resources (such as food, housing, and transportation) to address identified SDOH needs. We will monitor data to help make sure that the inventory of our materials address the actual needs and concerns of our members.

Assuring Readability, Cultural Competency, and Compliance

To make sure our materials are understandable to our members, we require that all member materials be reviewed by an interdisciplinary team prior to submission to DHHR for approval. This team, operating as part of our CMAP, reviews materials for cultural competency, accuracy, and compliance with all State program requirements, including compliance with the State-specified reading level of no higher than sixth grade, as verified by the Flesch-Kincaid Grade Level Index. Because we recognize some members may have difficulty understanding their health care information, we use an innovative, interactive software tool called *Health Literacy Advisor* that replaces hard-to-read medical terms and phrases with plain language.

In addition, we incorporate guidance from the CMS Toolkit for Making Written Material Clear and Effective to create written materials that are easier to read, understand, and use.

UniCare earned the NCQA Distinction in Multicultural Health in 2017 and remains the only West Virginia Managed Care Organization (MCO) to hold this distinction. We leverage this unique knowledge and experience to develop culturally appropriate materials. For instance, our writers are trained and equipped with resources on developing materials using people-first language, and members from our organization's Disability Inclusion Associate Resource Group (ARG) are available to review materials for accessibility and appropriateness. We have also included members of our LGBTQ+ ARG in our review process to assure our materials are sensitive to the community and incorporate inclusive language.

MS002 The Vendor should describe how they will leverage information technology (IT) solutions to improve access to member information.

Leveraging Information Technology Solutions to Improve Access to Member Information (MS002)

Members increasingly rely on access to digital sources of information that are available to them any time of day or night – whenever they need them. We provide our members with a variety of technology solutions today, including UniCare's secure member portal and mobile applications (apps) for programs such as My Advocate™ and Healthy Rewards. Also, in 2020, we are introducing a mobile app version of the member portal and My Family Health Record (MyFHR), a member-accessible electronic health record (EHR).

UniCare's Secure Member Portal

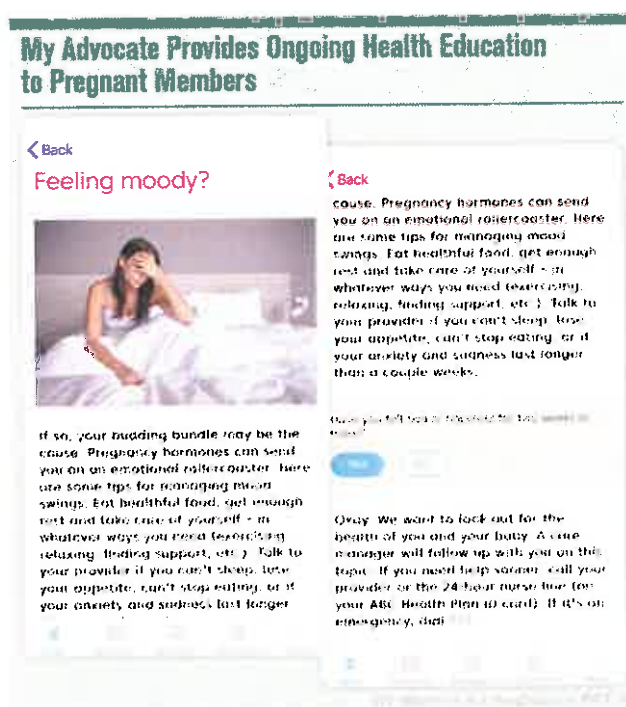
Through our secure member portal, we deliver 24/7 access to information and self-service tools that support member health and well-being. By maintaining a comprehensive and easy-to-navigate member portal, we provide our members greater access to information and facilitate more active management of

their health care. Our portal features vital tools and resources for all our members, providing access to a broad range of information and capabilities in English and Spanish, including health plan enrollment, and covered benefits, digital member ID card, eligibility status, online provider directory, and PCP information. The member portal is configured to be accessible by tablets and smart phones as well, and in 2020, we will offer access to the portal through a new downloadable mobile app. We provide additional information about our secure member portal in Sections MS033–MS039.

Digital Communication Programs and Mobile Apps

Our experience indicates that more than half of our Medicaid members use a smart phone to connect to our member portal, and it is the communication channel of choice with our younger members. UniCare's digital strategy includes initiatives to expand use of mobile apps to provide access to health care information and to support health, wellness, and self-care for pregnant members and those with chronic conditions such as diabetes, asthma, and hypertension.

My Advocate. A multi-channel communications program that includes text messaging and online access via website or mobile app, My Advocate provides ongoing health education to pregnant members and promotes early and frequent perinatal care by facilitating completion of our OB High-risk screener and providing an important feedback loop with our OB Care Managers.



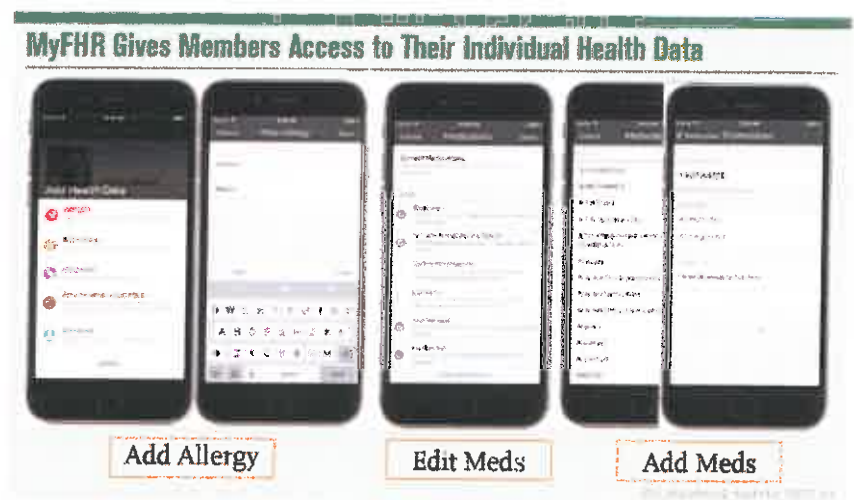
Healthy Rewards. One of our VAS, our Healthy Rewards incentive program, was designed to educate, and motivate members to take an active role in managing their health and wellness. Through the Healthy Rewards mobile app, members can complete health risk screenings and other health-related activities to qualify for a variety of incentive options. In 2020, the program is being expanded to deliver interactive and personally-tailored information to our members, including digital education sessions, access to health living blogs, and other personalized tools to increase member engagement and education.

Health Crowd. Through Health Crowd, we use digital technology to reach out to members to provide targeted health education information and service reminders, including medication refill reminders. Using designated key words, members can use this digital communication channel to request additional information such as PCP contact information, or how to schedule transportation or contact Enrollee (Member) Services.

All our mobile apps are available at no charge to users of iOS® or Android OS™ through the iTunes App Store® or Google Play™. Members must know their MAID and ZIP code to log in.

Member-accessible Electronic Health Record

UniCare believes that empowering Medicaid members to improve their health by giving them easy access to their own private health information is the right thing to do. In 2020, we are implementing a member-accessible EHR—MyFHR. MyFHR, developed



by our ultimate parent company, Anthem, Inc. (Anthem), will give members online and mobile access to a fully-integrated and fully portable individual health record, and provide the member with the ability to:

- Access and update medical records, including details on immunizations, chronic health conditions, allergies, medications, health assessments, psychosocial and family histories, and service utilization
- Download and share records with family and caregivers using Health Level Seven (HL7) international health care data exchange standards Secure Mail or in-app notifications
- Identify and address care gaps
- Send a message or question to Member Services department or to their Care Manager through secure messaging

Exploring Opportunities to Address Internet Disparity

As we expand our technology offerings to members, we are also exploring opportunities to address the internet disparity that impacts many of our members living in rural communities. We are currently assessing the deployment of mobile routers into neighborhoods where we have a high concentration of members to provide a reliable internet connection on a designated schedule.

MS003	1	The Vendor should describe its methodology for assigning members to a Primary Care Provider (PCP) including, but not limited to, claims history, proximity, and within contractually defined timeframe.
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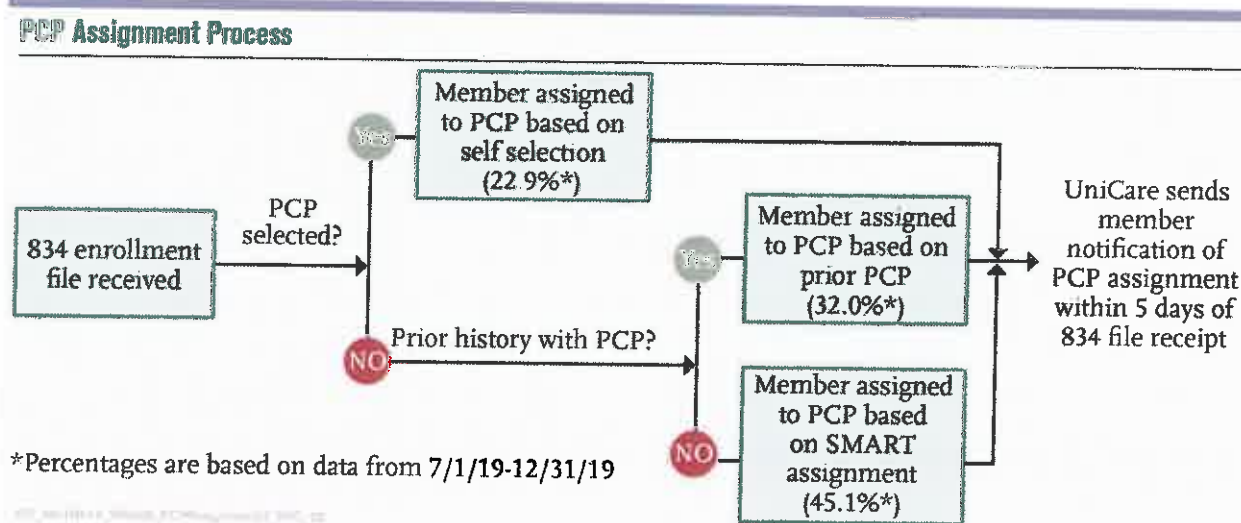
PCP Assignment (MS003)

Proper selection of a PCP and subsequent development of a strong provider relationship has multiple benefits for the member. For instance, studies show individuals with a trusting relationship with their PCP are more likely to adhere to treatment recommendations and engage in healthy behaviors like exercise and

smoking cessation.¹ In addition, chronically ill individuals who feel greater trust and security in their provider relationship feel more empowered, confident, and motivated to manage the demands of their illness.² As an incumbent MCO, we have proven systems, workflows, and algorithms to optimally match new members with a PCP. We base this matching on a three-step algorithm (Figure 6.5-1).

- **Self-selection.** We encourage and assist members to select a PCP within our network, including physicians, nurse practitioners, physician assistants, and specialists for individuals with specialized health care needs, such as a disability, chronic condition, or those who are SSI eligible.
- **Prior member or family relationship with a PCP.** If a member does not select a PCP, we review claims data, as available, to identify a prior relationship (personal or family) with a network PCP who is otherwise a match for the member based on age, gender, and language.

Figure 6.5-1. UniCare Optimally Matches PCPs and Members



¹ Thom DH, Hall MA, Pawlson LG. Measuring patients' trust in physicians when assessing quality of care. *Health Aff* (Millwood) 2004;23(4):124-132.

² Fox S, Chesla C. Living with chronic illness: a phenomenological study of the health effects of the patient-provider relationship. *J Am Acad Nurse Pract*. 2008;20(3):109-117.

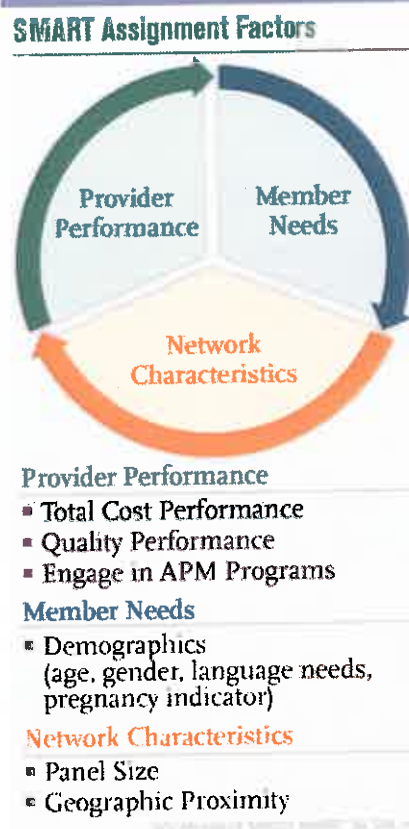
- **SMART assignment.** If the member is not matched with a PCP through either self-selection or prior history with a PCP as described previously, we assign the member to a PCP based upon the SMART PCP assignment methodology described in the following subsection.

SMART PCP Assignment Methodology

Our SMART PCP assignment process matches members with a PCP using multiple, weighted factors, including claims history (if available), PCP proximity, and the member's age, gender, and language spoken, among other factors. This assignment process, coordinated by our Enrollment department, is initiated upon receipt, and review of the 834 enrollment file, verification that the member has not selected a PCP, does not have a prior personal or family relationship with a network PCP, and involves the following steps:

- Creation of an initial pool of eligible PCPs based upon geographic proximity, PCP new patient availability, and specialty
- If the pool includes more than one PCP, the eligible PCPs are scored based upon the following weighted criteria (Figure 6.5-2):
 - Member's geographic proximity to the PCP's office
 - Member's age, gender, language needs, and pregnancy status
 - Claims data (from DHHR, as available)
 - PCP total cost performance, quality performance, and participation in alternative payment model (APM) programs

Figure 6.5-2. Multiple Factors Guide SMART Assignment



- The member is assigned to the highest scoring PCP. If there is a tie, geographic proximity, and available PCP panel capacity are used to break the tie

Our Enrollment department notifies members of their PCP assignment through a written letter and ID card (indicating the PCP's name), mailed within five days of receipt of the 834 file. Our efficiency in this process allows us to assign a PCP well in advance of the 10 calendar days referenced in the Service Provider Agreement (SPA), which provides our members an opportunity to make an appointment with their PCP even earlier.

Self-selection of PCP

We encourage new members to select a PCP, impressing upon them their freedom to choose from our entire network of PCPs and the ability to request PCP changes at any time through a call to our Enrollee (Member) Call Center, where our Member Services Representatives are trained on the PCP selection process and available to assist members. Comprehensive information about the PCP selection process is included in the member handbook, new member welcome booklet, and on our member website, which also includes a short instructional video on how to select a PCP (closed captioned for individuals with hearing loss).

Our provider directory is available in print, electronic file, or through our website. It offers detailed information about PCPs: their specialty, hospital affiliation(s), street address, website address, telephone numbers, office hours and locations, languages spoken, completion of cultural competency training, whether they are accepting new patients, provider group affiliations, and Americans with Disabilities (ADA) accessibility, and accommodations for people with disabilities. Further, through our "Find a Doctor" tool on our website, members can electronically search for PCPs on the basis of provider name, specialty, and office distance.

MS004	1	The Vendor should describe how they will develop protocols to notify members of Primary Care Provider (PCP) assignment.
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Notification of PCP Assignment (MS004)

Protocol Development and Review



As an incumbent West Virginia MCO, we have established protocols in place for notifying members of their PCP assignment. This notification process is outlined in our policies and procedures document, “Default Primary Care Physician Assignment/PCP Auto Assign.” This policy and procedure was last reviewed on April 2, 2019.

During the annual review, UniCare evaluates potential changes to the protocol necessitated by changes in contract or regulation or changes in the notification process, among other factors. Changes in the policy and procedure may also be made outside the annual review timeframe, as necessitated by urgent internal or external factors.

Member Notification of PCP Assignment

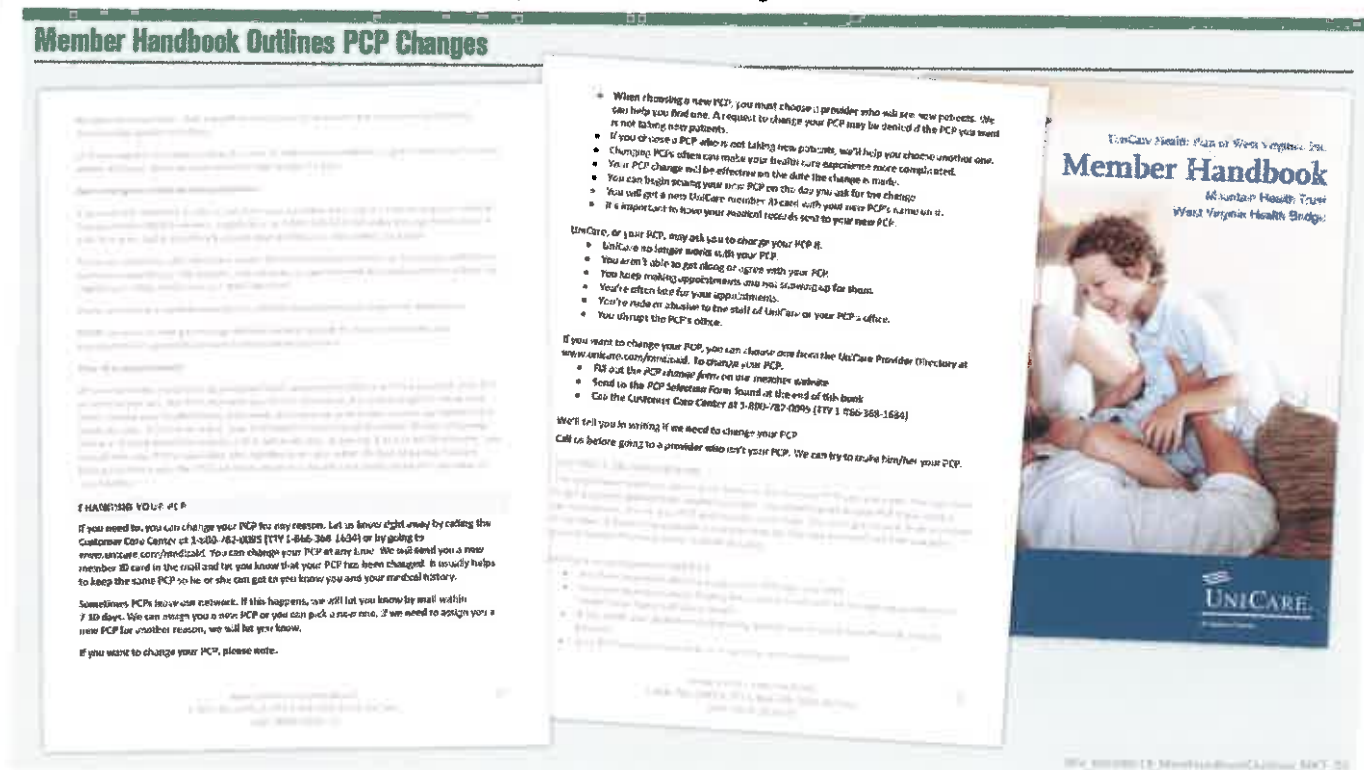
After members are matched with a PCP (described in detail in our response to MS003), we send the member a notification letter and a copy of their member ID card, which includes the PCP name, office location, and office phone number. The ID card and notification letter are sent to the member within five business days of receipt of the 834 enrollment file. In addition, the member can access their member ID card within 24 hours of PCP assignment, through their secure online account on our website or through our UniCare phone app, which will be available to members by July 1, 2020. Members can also verify their PCP assignment at any time after their enrollment is processed by contacting our Member Call Center.

MS005 1 The Vendor should describe how they will educate members of the right to change Primary Care Providers (PCPs).

Notifying Members of Their Right to Change PCPs (MS005)

At every point of contact, we want the member to feel comfortable discussing their level of satisfaction and understand that they have the right to change PCPs at any time. We clearly describe how members can do this in print, online, and telephonic formats. For instance, the notification letter that is sent to members along with their member ID card informs them that they can change their PCP at any time by going on our website or calling the Member Call Center. We also include this information in other written materials like our new member welcome booklet and member handbook, as outlined in Figure 6.5-3. Our website also includes a short instructional video on how to change a PCP, which has closed captioning for members who are deaf or hard of hearing.

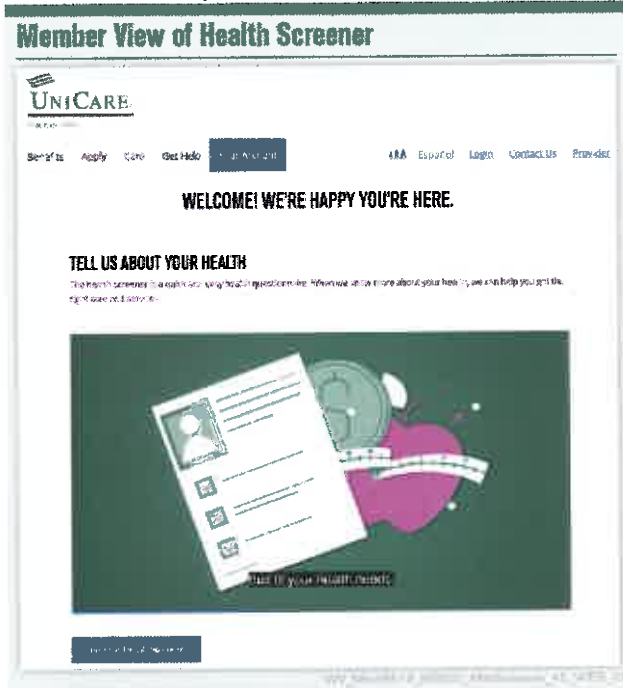
Figure 6.5-3. Member Handbook Outlines Ways Members Can Change PCPs



MS006	1	The Vendor should describe its process for conducting initial and ongoing assessments appropriate for members' circumstances and needs including, but not limited to, the following:
MS007	2	Methods utilized to complete assessments, and variances by risk level
MS008	2	Timeline to complete assessments, and variances by risk level
MS009	2	Identification of the trigger(s) for completion of a comprehensive assessment
MS010	2	How assessments will be used to develop and update treatment plans and confirm the risk stratification level for each member
MS011	2	How data from a member's Primary Care Provider (PCP) will be used to prevent duplication of assessment efforts and assist with identification of priorities for the member
MS012	2	How a member who cannot be reached or who refuse assessments will be handled by the Vendor, including multiple contacts if initial contacts are unsuccessful
MS013	2	How assessment data will be stored and made available to members of the care team in order to coordinate care
MS014	2	How assessment data will be shared with a member's other payer(s), as applicable, in order to prevent duplication of efforts

Initial Health Screening and Assessment Tools Appropriate to Members' Needs (MS006, MS007, MS008, and MS009)

Figure 6.5-4. UniCare Initial Screener Access at Member Portal Makes Completion Easy for Members



Screening and assessment tools are an integral part of our population health and care management programs. We have developed tools, shown in Figure 6.5-4, that are user-friendly and logical, because we understand the potential for assessment fatigue among members who have complex health conditions or SDOH needs that require multiple points of contact. As assessment information is vital to serving each member, we have developed strategies to improve member engagement and completion of vital screenings and assessments at every stage of care.

Timely and complete screening for members is an essential component of our care management program.

Initial Screening Helps Early Identification of Care and SDOH Needs

The initial health assessment (initial screening) assists us in quickly identifying each member's physical, behavioral, and SDOH needs. At UniCare, we are investing in multiple avenues (shown in Figure 6.5-5) for the member to complete the initial screening, making sure we have access to the results as quickly as possible to discern which members may benefit from care management by differentiating members with complex or special health care needs from those who may benefit from our wellness and prevention programs.

We currently have three strategies to encourage member completion of the initial screening. Members can complete the initial health screening using Interactive Voice Response technology, so their responses are captured electronically and incorporated into their personal health record. We also send a letter to new members who do not have a valid phone number to remind them to complete it, as well as reminder cards to members who have not completed it. There is also a screening form on the member portal. We will be adding the following investments for screenings in the second half of 2020.

UniCare Screening Completion

Opportunities by 3rd Quarter

- Initial screening in welcome packet.** The initial screening will be included in welcome packets, so members can complete it and mail it back.

Figure 6.5-5. UniCare Methods for Completion of Screenings

Early and Ongoing Screening and Assessment Identifies Needs



- **Incentive.** Beginning in July, we will offer a \$10 initial screening completion incentive to new members in our Healthy Rewards program as a VAS.
- **Member portal.** The new, revised member portal will have the initial screening form so members can complete it online.
- **Outbound calls.** Members who have not completed the initial screening and have been identified as at-risk or emerging risk by data analytics will be contacted by Community Engagement Navigators.
- **Face-to-face outreach.** After July, our community-based care management staff will visit members identified as at-risk who have not completed initial screenings.
- **Community events.** In July, members will be able to use UniCare iPads® to complete the initial screening and enroll in Healthy Rewards at community events.
- **Reminder texts.** Members will receive texts reminding them to complete initial screenings, preventive care, or other time-driven information related to their health.

UniCare Screening Completion Opportunities by 4th Quarter

- **Member Services Workflow.** Members who have not completed the initial screening will be flagged for Member Services, who will assist in its completion at the time of member contact.
- **Healthy Rewards Link.** The Healthy Rewards website will have a link to the initial screening to engage members for completion and incentive receipt.

Initial screening responses will be captured in the member's personal health record and identified clinical or SDOH needs will result in assignment to our care and population health management work queues for outreach. In CM005–CM016, we describe how members are assigned to care management. We continue to look for new and member-friendly ways to increase our screening completion rates.

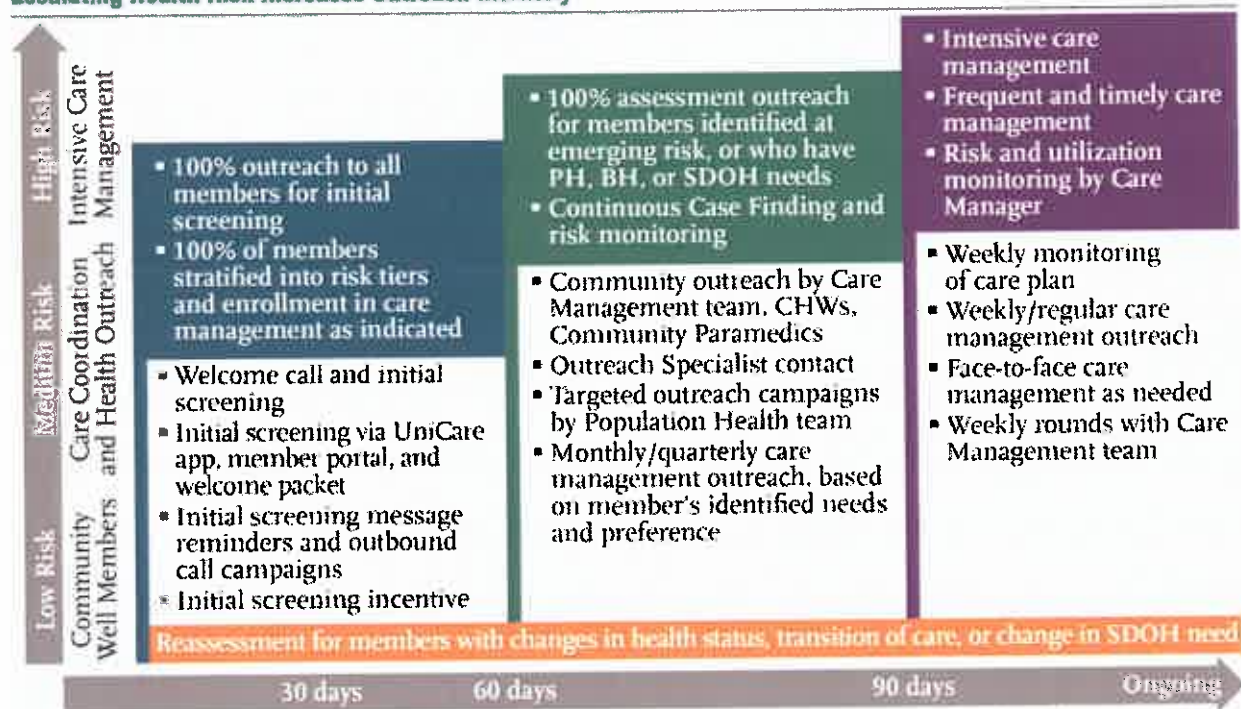
Ongoing Assessments Appropriate for Members' Circumstances and Needs

As members are identified by the initial screening as benefiting from care management, Care Managers will use additional assessments as detailed in CM016–CM021 to determine the level of care management and SDOH supports they may need. Once care management has identified a member for outreach, our goal is to quickly contact and assess the member to address any immediate needs and determine whether care management will be beneficial. UniCare staff are trained to refer members who communicate urgent indicators such as suicide ideation or complex health issues to care management. As we engage with members to conduct assessments, we make the process as easy as possible for them, offering to complete the assessments telephonically or face-to-face in a location of the member's choice. When members who have not completed assessments are identified with emerging or increasing health risk by our analytics and monitoring tools, we will continue outreach up to and including home visits to get more information.

Triggers for a comprehensive assessment include, but are not limited to, a change in health status, risk stratification, SDOH need, or a transition of care. Figure 6.5-6 illustrates our protocol for outreach to members, from the time they enroll to the completion of their person-centered care plan.

Figure 6.5-6. Outreach Increases with Member Acuity or Unavailability

Escalating Health Risk Increases Outreach Intensity

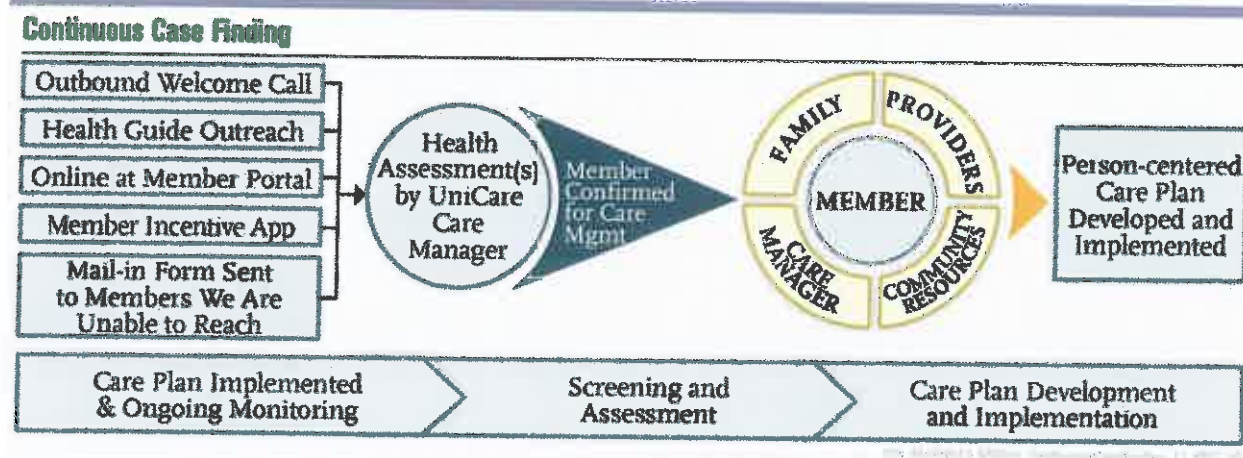


Assessments and Ongoing Monitoring Reaffirm Risk Stratification (MS010)

As described in detail in CM005–CM016, we restratify members by acuity each month and help members to plan their care and services according to their changing needs and preferences. Our Care Managers work with identified members to define the level of engagement the member wants. UniCare has over 200 assessment and reassessment tools for specific conditions, SDOH, lead risk, home- and community-based services, and so on to help pinpoint their efforts. We know that levels of risk can increase or decrease at any point in time, so we run monthly analyses and reports from aggregated data to update every member's risk profile. Members can also call in to let us know about status changes at any time. Our continual case finding process constantly sweeps updated utilization and clinical data from

numerous sources and compiles them into refreshed risk scores for individual members. Figure 6.5-7 outlines the predictive modeling suite that drives UniCare's risk stratification.

Figure 6.5-7. Multiple Assessment Data Sources Inform Care Planning



Care Managers monitor changes in members' predictive scores that may impact their risk-tier status. They will reach out to assigned members and review urgent clinical or support requirements, updating care plans as appropriate. Our Health Insight platform supports care management activities, presenting clear, and actionable information to them as well as to the member's treating providers. Care Managers working with members may identify member or clinical concerns that can result in an escalation or lowering of their risk profile in accord with changes in health status, social needs, or member responses, aligning care plan goals to new interventions as determined by the member.

PCP Feedback Incorporated into Assessments, Care Plans, and Member Priorities (MS011)

PCPs are an integral part of care planning. They are included in all assessment and member care planning activities, which helps us see how well members are accessing needed care and services and prevents duplication of services through coordination with the PCP's treatment plan. Our Care Managers help members articulate specific goals that might improve their quality of life. The goals identified by the

member are the foundation of the member's individualized care plan. We help to incorporate elements of the PCP's treatment plan and outline benefits and services (including community supports) that will help the member reach those goals.

We recognize the value that real-time access to member data can bring to PCPs. Between care planning meetings, PCPs have on-demand access to member utilization of services information as well as timely alerts from our Care Managers when patients are admitted to an ER or an inpatient setting. To make sure providers and Care Managers are quickly aware of ER visits and hospitalizations, we have created daily alert reporting and communication protocols that advise PCPs so they can connect with members for follow-up appointments and care coordination. The Care Manager sends a letter to the PCP notifying them of recent ER activity and location of members in care management. Simultaneously, our Health Insight platform consolidates member data from multiple sources into the member's personal health record, where it is incorporated into ongoing analytics to identify additional or escalating risk.

Using the Health Insight platform, PCPs can access member care plans, assessments, and progress reports, and review a full history of clinical services through comprehensive utilization reporting of medical, behavioral, and pharmacy data. Assessments and PCP notes are incorporated into the care plan through contact with Care Managers to assure consistency and efficacy.



Care Managers also solicit feedback from our physical and behavioral health Medical Directors. They discuss member needs and seek guidance to resolve coordination of care challenges and to break down barriers across systems of care. The team meets daily and reviews identified members with the task of assuring our members are getting the right level of care from the right provider. For example, they brainstorm ways to intervene most effectively with members identified at high-risk for potentially

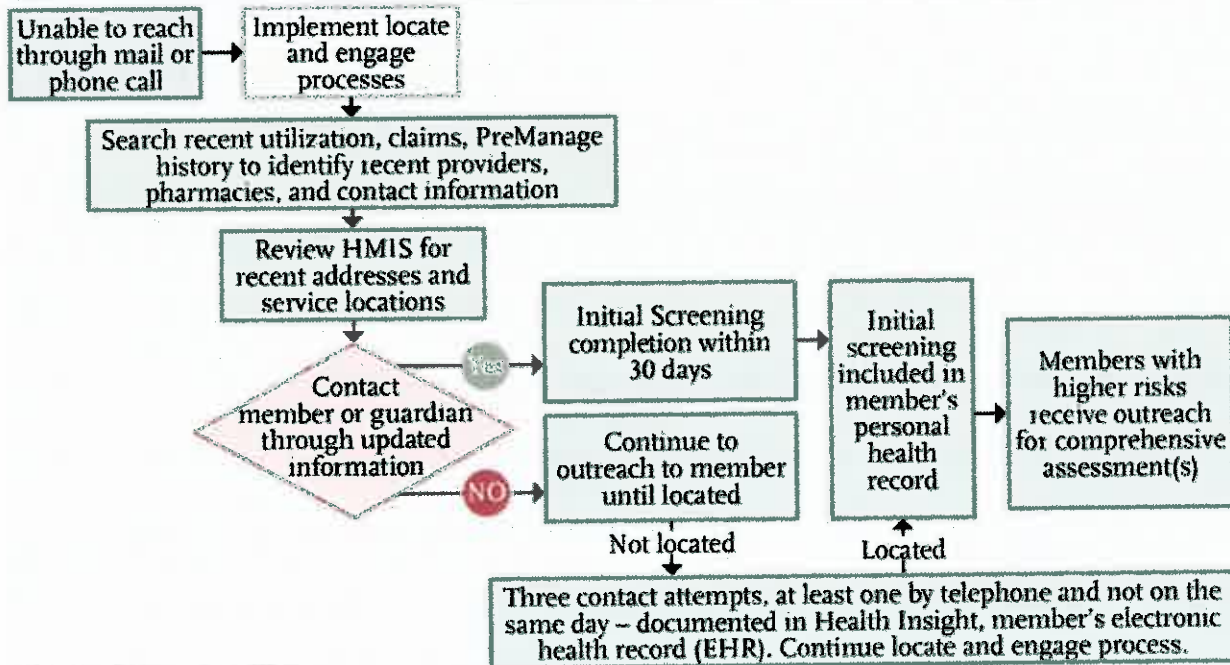
preventable events or with multiple psychiatric admissions in the prior month. The Care Manager and member review and update the care plan at least quarterly for members at moderate risk, monthly for members at high-risk, and when there is a significant change in the member's condition — keeping the member at the helm of the plan and all input individualized, current, and actionable.

Engaging Members Who Are Difficult to Reach or Resistant to Assessment (MS012)

Sometimes members are hard for us to reach because contact information is not current or circumstances, such as frequent moves or homelessness, prevent a timely connection with UniCare. If we are unable to connect with a member or complete an assessment with our initial attempt, our Care Managers make no less than three outreach attempts by mail and by phone at different times a day. If those attempts fail, we search other databases or contact the member's designated power of attorney to see if there is contact information different from what is available from the State. Care Managers reach out to providers and community points of contact to see if the member has recently requested information or care or accessed community services such as a shelter or food pantry. Figure 6.5-8 illustrates our workflow for making contact with members who are difficult to reach.

Figure 6.5-8. UniCare Reaches Out to Members Who Are Hard to Locate

Hard-To-Locate Care Management Process



UniCare continues to work on innovative methods to assist in identifying and contacting members who are hard to reach. In addition to PreManage, a web application based upon the Emergency Department Information Exchange, we will be using the Homeless Management Information System to locate members who are experiencing housing instability. Once they are located, we listen to them to identify their concerns and any resistance they may feel toward care management or accessing care from a provider and collaborate to come up with workable solutions. Sometimes, it is simply a matter of transportation that can be easily resolved to get members on the road to better health.

Members who are hospitalized will be contacted by our co-located, community-based Care Managers to complete assessments as part of the discharge and planning process. Again, we consider the completion of screenings and assessments as central to our ability to identify and address the member's health, psychosocial needs, and personal goals. Therefore, we emphasize, and continue to expand our methods

for connecting with and streamlining assessment of our members. We want members to know who we are, that we are here for them, and how we can help them meet their health goals.

Sharing Important **Care Management** Detail with the Care Team (MS013)

Each provider identified by the member as part of the care team will have access to pertinent information used in the assessment and care planning process through the Health Insight platform. As described in MS011, our Health Insight platform will store and disseminate relevant information to PCPs and specialists acting as PCPs so, for example, specialized behavioral health input will be included in care planning. Multidisciplinary care team meetings will be facilitated by a Care Manager

Health Insight

UniCare's integrated care management platform, Health Insight, provides a holistic view of the member's whole-person needs — supporting our staff with the tools and functionality to support the delivery of high-quality care and coordination of covered services. This allows for direct care of physical, behavioral, and social services and supports timely communication between all Care Management team members, as well as providers and the members.

who will capture and coordinate all screenings, assessments, and feedback from care team members into the care plan and make the information available by fax, email, or mail, according to care team member preference. Members or their representative will also have access to the care plan via the member portal, with printed copies available upon request. At UniCare, we believe a fully informed and involved team has the best chance of effectively addressing members' needs in the context of their communities.

Sharing **Care Management** Information between Payer(s) (MS014)

While UniCare is committed to whole-person, patient-centered care management, we also recognize that members may experience assessment fatigue from multiple, uncoordinated requests for information, assessments, or care planning activities. *We work to reduce points of contact so that members have a single person at UniCare to contact with any questions or concerns.* We try to prevent that fatigue by consolidating processes for the benefit of our members. For example:

- For 17 years, we have shared and collaborated in care planning and coordination according to care management processes outlined in Agency Memoranda of Understanding (MOUs).
- We have established relationships with State agencies and other payers and coordinate with third-party Care Managers who also serve our members.

When a member transfers from UniCare to another MCO, our care management team will provide demographic information, care management information upon request, and all prior authorizations to assure continuity of care. When a member transitions to UniCare from another MCO, we work with the previous MCO to obtain this information. Our care management team, assisted by our Transition Navigator, will review the new member's records and begin the outreach process.

We will engage third-party Care Managers in all discharge planning and transition processes for care coordination, including follow-up appointments, to reduce member burden during transitions and assessments. UniCare Care Managers will work with their counterparts at other MCOs to communicate care plans and authorized services so care is not interrupted. For complicated cases, Care Managers may hold a telephonic care conference or securely email relevant information prior to transfer. Additionally, we participate in any care team meetings organized by third parties as requested to gain a full understanding of the member's needs, current services, and gaps or barriers.

Working together, we holistically address the member's health and service needs and goals, finding solutions using covered services and benefits as well as community resources and supports. At UniCare, members are at the center of our thinking and our processes and the leaders of their care plan. By streamlining requests for information and assessment, we show members their time and energy is valuable to us and an important aspect of their health care.

MS015	1	The Vendor should describe how they will distribute and provide notice of member handbooks on an ongoing basis, according to an established turnaround time, and including, but not limited to, the following:
MS016	2	Updates to the member handbook
MS017	2	Handbooks requested ad hoc by a member

Member Handbook Distribution and Notice to Members (MS015)

Our member handbook, seen in Figure 6.5-9, encourages members to take greater control of their health and wellness by placing comprehensive health plan information at their fingertips.

Figure 6.5-9. Our Member Handbook Serves as a Key Reference Document for Members



The handbook guides the member in selecting a PCP and scheduling a first appointment – key first steps in accessing covered services and benefits. The member handbook also serves as an ongoing reference document outlining covered services and benefits, including VAS, member rights and responsibilities, the grievance system, pharmacy benefits, and other key member resources and information. As an incumbent MCO, UniCare has proven technical capacity and processes for developing and disseminating print and electronic versions of the member handbook for MHT program members and we look forward to working in partnership with DHHR to develop member handbook content for WVCHIP-enrolled members of MHT.

The first way we notify members about the availability of the member handbook is by mailing a welcome packet to all new members within five business days of enrollment notification. The welcome packet includes a new member welcome booklet and a welcome letter, both of which will inform members that the member handbook is immediately available in PDF format on the UniCare member website and a printed hard copy of the handbook can be requested through our Member Call Center. We

also inform members that the handbook can be provided in alternate formats, such as large print, braille, and audio versions, and can be translated into one of more than 200 languages, upon member request.

UniCare will continue to use well-established workflows and quality checks related to updating the member handbook within the contractually required turnaround times and notifying members of handbook updates. We describe these processes in the following sections.

Member Handbook Updates (MS016)

On an annual basis, our Community Engagement Director will help coordinate a thorough review of our member handbook to make certain it is accurate and up-to-date through our CMAP process. Through this process, subject matter experts from departments across our organization (for instance, behavioral health and Quality Management), Compliance employees, and Legal Counsel use an online tracking tool that thoroughly documents each reviewer's approval or suggested changes. If a reviewer has a concern about the member handbook content, they are able to document suggested changes in CMAP, and the handbook is sent back to our writing team to be edited. The tracking tool also allows all reviewers to see the suggested changes and edits made by other reviewers to facilitate discussion and collaboration among the team. Upon completion of the review, and incorporation of any edits, our MHT Regulatory Manager submits the handbook to DHHR for review and approval. Once approved, we mail all members a letter notifying them of the updated handbook, including where they can find it online and how they can request a printed copy. Our Community Engagement team also makes sure the member handbook update is posted to our website.

In addition to the annual review and updating of the member handbook, on occasion we will make inter-year updates due to a variety of circumstances: internal program changes, contractual or statutory changes; or receipt of an updated model handbook from DHHR. We might also update our handbook based on feedback

from our stakeholders. *For instance, we recently received valuable feedback from the West Virginia SILC on updates we could make to our member handbook content that would make it more accessible and easier to understand for our members with disabilities.*

For minor internal changes like the addition of a VAS, we will create a supplemental insert describing the change for both the printed member handbook and the online electronic version (PDF format). Other circumstances justify the development of a fully updated member handbook and notification to our members. As an example, on July 1, 2019, we added a substance use disorder (SUD) prevention and treatment benefit. Prior to enacting the benefit, we revised our member handbook (print and electronic versions) to reflect the change, had the handbook changes approved internally and by DHHR, and then sent all members a letter on May 7, 2019 notifying them of the change. In this case, we provided members with 54 days' notice of the upcoming change – significantly exceeding the minimum 14-day requirement of notice to members. Members were notified in the letter that a print version of the updated handbook was available by calling our Member Call Center and an electronic version was available on our website.



Ad Hoc Requests for the Member Handbook (MS017)

Within our New Member Welcome Booklet and our welcome letter, we let members know that they can access a copy of the member handbook in PDF format on the member website, and they can request a printed copy of the member handbook at any time and at no charge by calling our Member Call Center. In addition, we have a *Put Our Tools to Work for You* video (with closed captioning for individuals who are deaf or hard of hearing) on our website that educates members on the ways they can access the member handbook, including downloading a copy from our website or calling us to request a paper copy. We also

alert members that copies of the member handbook are available in any of more than 200 languages and in large print, braille, and audio format, upon request.

For all ad hoc requests for a printed version of the member handbook, we mail members a copy of the handbook within five business days of receiving the request. We track our turnaround time by logging the date the request was received and the date the handbook was placed in the mail.

MS018	1	The Vendor should describe its warm transfer protocols for its member services, other internal departments, other entities, and subcontractors, as applicable.
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Warm Transfer Protocols (MS018)

Our Member Call Center serves as our primary line of entry through which members can get questions answered, provide feedback, or make requests of the health plan by speaking to our Member Services Representatives or accessing our 24/7 Nurse Line or Behavioral Health (BH) Hotline. To assure optimal customer service to members, our Member Services Representatives receive extensive training (classroom, computer-based, and on-the-job) and follow standardized protocols during calls.

Our goal is to fully address the member's needs during the initial call (first call resolution). When circumstances dictate, however, our Representatives transfer members to other resources. In some cases, the Representatives make *warm transfers* (connect the call while remaining on the line to introduce the member and the situation). In this manner, we assure members are supported by directly connecting them to the resources and assistance they need.

The decision to warm transfer a call is based upon multiple call factors: level of urgency, the caller's emotional state (such as frustration), the nature of the call (clinical or non-clinical), or other factors, such as the need for language assistance. For example, callers with a BH question are often best served through a warm transfer to our BH Hotline, and members calling in a non-English language are warm transferred

to our language line vendor to initiate a three-way call with oral interpretation assistance. Our Member Services Representatives receive training in the escalation process to make certain they can assist members in a variety of circumstances.

Internal Warm Transfers

Often, members require the assistance of other UniCare call lines or departments. For instance, members with non-emergency medical or BH questions may be warm transferred to our 24/7 Nurse Line or BH Hotline for assistance. For members with specific questions about their personal care plan, we warm transfer them to their Care Manager.

Warm Transfer to External Parties

Our Member Services Representatives are also trained to identify circumstances in which callers will benefit from a warm transfer to an external party, such as the enrollment broker, the pharmacy benefit partner, providers, or our vision, and dental subcontractors. This process is facilitated through our integrated desktop platform, which displays member information and other resources in an organized, simplified fashion so the call line representative has immediate access to the information necessary to meet the member's needs. The desktop platform displays contact information for external parties such as our vision and dental subcontractors to expedite warm transfers to those resources. The platform also captures detailed call documentation that expedites potential follow-up actions.

MS019 1 The Vendor should describe how they will train member services representatives.

Training Member Services Representatives (MS019)

UniCare's deep commitment to our members in West Virginia mandates our staff at all levels and all functions be well-trained and conversant on topics and resources that matter to our members. Member

Services Representatives, other employees, and providers currently have access to a wide range of training resources through our UniCare Training Academy (the

Figure 6.5-10. UniCare Supports Learning at All Stages for Our Member Services Team



Academy). Member Services Representatives receive classroom and computer-based training (CBT), followed by a transition period of on-the job training, and supplemented with additional training periodically throughout their careers to expand their skills further, as shown in Figure 6.5-10.

New hires receive training on West Virginia, customer service techniques, member support resources, VAS, policies and procedures, and dozens of additional topics. We will continue to provide an educational experience to Member Services teams that supports West Virginia and builds on our experience and market knowledge.

Giving New Hires the Tools for Success Through Robust Training

Our newly hired Member Services Representatives receive four weeks of classroom and self-directed CBT, followed immediately by two weeks of on-the-job training mentored by peers. Experienced professionals with deep understanding of UniCare policies and procedures, the populations we serve, and customer service lead our training. Table 6.5-1 provides examples of the robust new hire training curriculum we provide in a self-paced environment.

Table 6.5-1. Making Sure Our Team Is Knowledgeable and Conversant on Topics That Matter to Members

New Hire Training By General Subject Area		
Creating the Customer Experience (CCE)	Health Care Fundamentals	Call Center Basics
• Introduction and role-plays • Listen to a Member Call and Discuss • Probing Questions • Resolving Complaints and Appeals	• The Basics of Managed Health Care • HIPAA Introduction and Tools • Other Health Insurance • EPIC (Ethics, Privacy, Information Security, Compliance)	• Call Center Policies • Audio and Video Monitoring • Telephonic Marketing Guidelines • Phone Systems • Performance Management

New Hire Training By General Subject Area

• Knowledge Management Skills Practice • Practice/Review Scenarios • Role-play	• Becoming Culturally Competent • Fraud, Waste, and Abuse • Compliance Orientation • Certificates of Coverage	• Document Request Fulfillment • Privacy Assistance • ID Cards and Address Updates • Finding the Right Provider • PCP Changes • Confirmation Faxes • Searching for Specialists • Provider Tasks (Document Requests) • Access IT Overview • Performing Research • Complaints and Appeals Policies and Procedures • Provider Credentialing Status • Authorization Status • Appeals Status and Submission • Reporting Member Deceased
West Virginia Medicaid • West Virginia Market Specifics • Value-Added Services • Co-payments and Cost-Sharing • Health Promotions • Nurse Line • Behavioral Health • Benefits and Authorization • Pharmacy Benefits • Well Newborns and Unborns • Dual Eligible and LTC Members • Emancipated Minors	Cultural Competency • Serving Members With Disabilities and Chronic Conditions • Positive Behavior Supports; Person-centered Practices • Community Inclusion and the Importance of Maintaining Independence in the Community • Assisting Members with Limited English Proficiency, Members who are Deaf or Hard of Hearing, and Responding to Members with Communication Challenges	

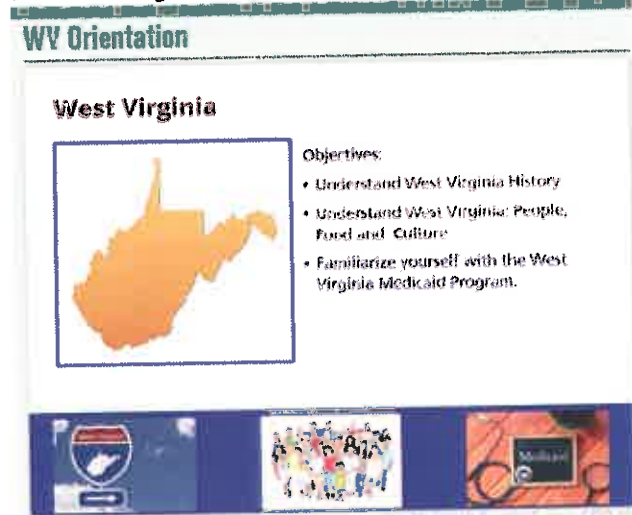
We perform formal employee evaluations periodically during training, with a final exam prior to on-the-job training. Many of the individual learning topics, particularly the CBT modules, include topic-specific evaluations with minimum passing scores. Our trainers also constantly evaluate our new hires informally on customer service skills throughout the process using role-play, which is a critical component of our Member Call Center skills development.

Training That Focuses on West Virginia Residents and Issues

We offer specific training for teams that will serve our West Virginia members, with county-identified, population-specific, culturally competent trainings customized for each audience. Training materials have been developed by fellow West Virginians who have an in-depth understanding of the populations they serve and their local community and regional needs.

We provide training on the West Virginia Medicaid program, including cost-sharing and co-pays. Training also delves into cultural and historical context (as shown in Figure 6.5-11) to help Member Services Representatives assist members in a culturally competent and effective way; historical conflicts that have shaped attitudes and social conventions; how the mountainous geography affects health care access and needs; Appalachian culture and communication; and population health needs and their linkage to food, culture, and socioeconomic status.

Figure 6.5-11. We Provide Training Designed to Orient New Hires to West Virginia's People, History, Culture, and Medicaid Program



We will build a training module related to the WVCHIP program that will cover needs and benefits specific to the population. This training will be provided to existing Member Services Representatives who serve West Virginia and will become part of the core curriculum for new hires.

We maintain a SharePoint site that is readily available to team members and contains additional resources useful to our teams as they discuss options and opportunities with our members in West Virginia. We train our Member Services team on available resources and the situations where they are useful to members. Our West Virginia-focused topics include:

- Using our member website and resources that are available through various functions
- Contacting and working with West Virginia 2-1-1 for finding help and services
- Navigating the Community Resource Link, offered as a VAS, which supplements the services of West Virginia 2-1-1 and provides additional information on resources available for members

Training also includes the full range of VAS we will provide our members in the program, so that

Member Services Representatives:

- Fully understand our wide array of VAS and how members can access them
- Can make recommendations for VAS that may be beneficial to member circumstances
- Can help care teams make sure that member needs are met and that their goals are included in service planning

Supporting New Team Members Through On-the-Job Training

We evaluate Member Services team members throughout their initial four-week training. When they successfully complete the training, they transition to two weeks of on-the-job training. During that phase, Member Services Representatives shadow more experienced team members, partner with others to take calls under guidance, and role-play scenarios with one another in classroom settings. The team regroups at the end of each day to debrief on lessons learned, challenges, and best practices, and to identify areas where additional training could be useful. This on-the-job transition period has been implemented to enable new team members to practice skills they learned during formal training, identify areas for further exploration, and receive vital feedback that sets the stage for success.

Our Member Services Manager evaluates each new hire at the end of the on-the-job training period to determine whether they are ready to begin supporting the Member Services Call Center on their own or if they require additional classroom or on-the-job training.

Expanding Skills Across Our Teams' Careers

Unicare provides many training options for Member Services teams to expand their skills and their capabilities to serve West Virginians and enhance their own careers. Member Services teams are responsible for all annual required training, such as cultural competency training. They also have on-demand access to

our extensive and varied training library. We provide a multitude of expert-developed, customized trainings, accommodating various formats, media, and schedules. Our education modules and materials cover a broad range of topics to continuously advance our teams' knowledge throughout their careers.

MS020	1	The Vendor should describe how they will ensure they are meeting customer use and report to the Department on customer service performance standards including, but not limited to, the following:
MS021	2	Member-to-representative ratios
MS022	2	Call answering time, with a minimum of 83% of calls answered in thirty (30) seconds
MS023	2	Call abandonment rate not to exceed five percent (5%)
MS024	2	Single contact resolution
MS025	2	Turnaround time for member requests
MS026	2	Remediation strategies for performance issues

Meeting Customer Use Performance Standards Using Our Member Call Center (MS020)

We designed our Member Call Center to support the needs of individuals in the West Virginia MHT, including the WVCHIP population. We make it easy for West Virginia MHT members to receive necessary assistance by offering comprehensive, personalized customer service leveraging our ultimate parent company, Anthem's, fully-integrated call center technology. We manage each day to provide the right experience for



members to obtain the best results on our reports. Our toll-free Member Call Center is available Monday–Friday from 8 a.m. to 6 p.m. ET — exceeding the SPA requirements with 25% more availability than required. Our approach to meeting customer use standards starts

with our comprehensive training program outlined in MS019. We monitor and improve on our approach through development, tracking, and reporting on key metrics and performance standards. These performance standard reports are monitored and addressed by the Member Services Manager. The reports are available for

DHHR's review and are submitted as requested and quarterly in our member and provider services functions report as required in the SPA.

In 2020, we are establishing a West Virginia-based call center staffed with experienced representatives who have the skill set and local knowledge to address the more complex needs of our members. Our call center will be comprised of 12 employees located in our Charleston, West Virginia office, alongside the rest of our health plan staff. This co-location enables our CEO, Tadd Haynes, and Member Services Director, Richard Grooms, to be directly connected to the service level and supports that this team provides. Additionally, the team will have immediate access to the health plan staff most appropriate to address the needs of our members, such as our local Care and Case Management teams and Clinical staff. These call center representatives will also be familiar with the local community, including the barriers members may be facing and the local resources available. As West Virginians serving West Virginians, this local knowledge will help make sure our members receive the highest level of service and embrace our philosophy that health care is local. The call center will handle:

- All new member calls, including both inbound calls and outbound welcome calls
- Calls from members that our system recognizes as repeat callers, indicating a previously unresolved issue
- Requests to locate a provider to address unique needs or access issues, as well as assisting when a member's PCP has retired or left the area
- Complaints and grievances
- Member advocacy issues
- Specialized call campaigns geared at members with high-risk health needs
- Assistance when there are program or policy changes (for instance, the upcoming Children with Serious Emotional Disorder Waiver)

- Connecting members with SDOH resources, including our Community Resource Link VAS

We will continue draw on the strength of our national resources to help callers with more administrative tasks, such as fulfilling requests for paper copies of materials or simple PCP changes. This will allow our local West Virginia call center to focus on providing more high-touch and specialized service to our members that need it most. Should these administrative calls become more complex at any point, our national resources will be trained to quickly warm transfer callers to the local West Virginia team. These national resources will also provide our members critical support during business continuity events, such as the tornado that left our office without power in June 2019.

Our operating protocols promote consistent attainment of our service standards, including real-time monitoring of our call-handling performance. UniCare encourages our Member Services Representatives to meet the needs of each caller regardless of the amount of time spent helping the member, and they are not evaluated based on the average length of their calls. We maintain operating protocols that promote consistent achievement of our call center service standards. Our Workforce Management team:

- Tracks metrics specific to the West Virginia MHT program
- Uses metrics to schedule staff appropriately to meet members' needs each hour of each week
- Reviews performance measures in real-time and makes necessary adjustments to meet these measures

Our comprehensive knowledge of using and reporting customer service standards enables us, through frequent measurement, to continuously improve our customer service, which includes resolving issues in a timely manner. Our staff is familiar with West Virginia reporting requirements and submission procedures that are dedicated to collecting data and submitting reports for customer service standards to DHHR for West Virginia MHT, and we will continue this work. Our Automatic Call Distribution system provides multiple call status reports ranging from a report every 15 minutes to quarterly reports to detail our compliance with

performance standards. We use these reports to monitor trends for call volume, average speed of answer, and abandonment rate. We evaluate existing processes for our Member Call Center and make necessary adjustments to meet or exceed all service levels and requirements, which includes exceeding the expectations to improve the quality of services offered by our Member Services Representatives.

Member-to-Representative Ratios (MS021)

Our focus is to make sure we continue to successfully support members with the right number of well-trained, qualified, and compassionate representatives, and we report details on this to DHHR. UniCare is supported by 100 Member Services Representatives trained for West Virginia MHT. As described previously, we will also have a local call center with 12 Member Services Representatives that will manage more complex member calls. We adjust staffing levels using our workforce management forecasting based on our historical data to assure that we are meeting member needs.

Our Workforce Management team meets DHHR's performance standards through the combination of complex forecasting processes and real-time monitoring of our Member Call Center. We rely on systems and tools to respond immediately to unplanned call volumes. Our Workforce Management team functions as an information hub, recognizing trends across all our call centers. We leverage this trend information to forecast staffing for our West Virginia MHT Member Call Center.

We maintain real-time monitoring of call queues and shift resources as needed to confirm optimal customer experiences that meet or exceed required performance standards. When call volume increases beyond the capacity of our scheduled Member Services Representatives, we add additional Representatives to that call queue to provide the capacity needed. This approach enables us to optimize staff efficiency while capably meeting performance standards.

Our Workforce Management team monitors call response metrics to identify peak call times, such as the period following open enrollment; monitors adherence to established metrics; and manages the performance of our Member Services Representatives. In addition, our Workforce Management team monitors the number of calls holding in queue to determine the longest wait time for any caller.

Our Workforce Management team uses technology to:

- Monitor call volume and make real-time adjustments as necessary
- Monitor call center metrics in real-time as well as daily, weekly, and monthly
- Review scheduled versus actual staff and make adjustments to help assure call center metrics are met
- Review multiple call status reports and monitor performance, including both real-time performance and forecasted versus actual performance
- Provide a historical data base used for reporting, planning, and forecasting

Our workload balancing application helps assure that our scheduled staff can meet the forecasted needs. Such capability allows us to be nimble in responding to spikes in call volume, such as during implementation phases, or to business interruptions due to a power failure or natural disaster at any one location. Nationwide, UniCare and our affiliates employ a proven backup plan and system to help assure that, in the event of a phone line failure or outage, members continue to have easy access to Member Services Representatives, and those Representatives are well-trained and continue to have access to program-specific information. ***Our technology enables us to seamlessly route calls to different sites to continue serving members without any disruption of service.***

Through our experiences, we learned that new members typically call more frequently in their first 60 days, so we staff accordingly and stand ready on day one of the new Contract to meet the needs of additional members. Our technology tools enable real-time monitoring of call-handling metrics, so we can

rapidly deploy team members to maintain call service levels within DHHR performance standards. We continuously evaluate existing call center processes and make necessary adjustments to meet or exceed all service level requirements to improve the quality of our service.

Answering Calls Within 30 Seconds with an Abandonment Rate Below 5% (MS022 and MS023)

We have the capabilities to report our metrics to the State as requested for all of our Member Call Center customer service performance standards. Our system currently supports these reports now, and we will continue to do so under the new Contract. *In 2019,*

Exceeding DHHR's Abandonment Rate Requirement
In 2019, our West Virginia Member Call Center had a 0.6% call abandonment rate, far exceeding the requirement that the abandonment rate be below 5%.

our West Virginia Member Call Center had a seven second average speed of answer rate. Our West Virginia Member Call Center consistently exceeds the DHHR requirement of a live agent answering 83% of calls within 30 seconds and an abandonment rate below 5%, as described in Figure 6.5-12.

Figure 6.5-12. UniCare Exceeds DHHR's Member Call Center Metrics

Exceeding DHHR's Customer Service Performance Standards														
2019 Member Call Center Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2019 Total	SPA Goals
Calls Answered Within 30 Seconds by a Live Agent	99.1%	98.9%	98.3%	98.9%	96.9%	95.7%	90.4%	90.6%	88.8%	92.5%	88.4%	92.5%	93.9%	=>83%
Abandonment Rate	0.1%	0.1%	0.2%	0.1%	0.2%	0.4%	1.1%	1.5%	0.9%	0.8%	0.9%	0.5%	0.6%	<=5%

Single Contact Resolution and Turnaround Time for Member Requests (MS024, MS025)

We make every effort to resolve our members' inquiries in a single call, and we have the mechanisms in place to retrieve single contact resolution information from our system. While we do not currently report

on these items for West Virginia MHT, we track this data and we will work collaboratively with DHHR to understand the format and frequency in which they would like to receive this information.

To track our single call resolution efforts, we complete post-call surveys through emailed surveys and outbound, automated IVR calls to members within 24 hours of a phone interaction with our Member Call Center. In this survey, we include questions about issue resolution, first call resolution, ease and effort, and overall member satisfaction. We include a question about how many times the member needed to call for their issue to be resolved. We understand the importance of promptly responding to requests from our members and assure our members' needs are met.

Remediating Strategies for Performance Issues (MS026)

Our primary strategy for remediating performance issues is first to make sure that we prevent performance issues from occurring. To do this, we implement our tracking, monitoring, and reporting processes, as described previously in this section, to assure that we are meeting and exceeding SPA requirements. We use the following to plan and preempt risk:

- Shared markets and training to allow for natural ebb and flow of demand
- Shared resources to reduce risk of hours coverage, absence challenges, attrition, and replacement hiring timing gaps
- Regular evaluations of contact and productivity rates and adjustments to hiring
- The dedication of subset of resources as needed to assure performance

If we miss a performance guarantee in the future, we will develop a corrective action plan, which will include identifying the root cause of issue, remediating the issue, implementing preventive measures, or reporting oversight as needed, and ongoing maintenance. For example, in 2019, our national organization's largest Medicaid service center in Virginia Beach closed for two days due to a snowstorm.

With minimal service degradation, we routed calls for members to other Medicaid call center locations. After the storm passed and service returned to normal, we applied an internal corrective action plan to address any reduction in service that had occurred and determine how we might respond better in the future. The team assigned to this determined that we had too many Member Services Representatives in one location that did not have the capability of working remotely. To address this, we decreased the number of staff in that location and increased staffing in other locations to better balance total capacity. We also increased the number of Member Services Representatives in our Virginia Beach location that have the ability to work remotely to prevent any future weather-related impacts to our Member Call Center locations.

MS027	1	The Vendor should describe its new member enrollment and education process, defined as the time of initial notification of the member's enrollment through the first month of actual enrollment, which includes, but is not limited to, the following:
MS028	2	Member contact, including welcome calls, welcome letters, and/or home visits
MS029	2	Outreach to members how are difficult to contact, including disabled members and members without telephones
MS030	2	Processing and issuing identification cards
MS031	2	Distributing member handbooks

New Member Enrollment and Education Process (MS027)

As a longstanding West Virginia Medicaid MCO, UniCare has proven systems and workflows in place for welcoming new members and rapidly engaging them in their health care. In the sections that follow, we describe these systems and workflows. It should be noted that our approach to the new member education process will be the same for all members — including those enrolled through Medicaid and those enrolled through WVCHIP. However, Medicaid — and WVCHIP — enrolled individuals will receive program-specific member materials with different content and branding, such as member handbooks.

New Member Contact (MS028)

Welcome Packet

Within five business days of receiving the new member enrollment file, we mail all members a *welcome packet*, which includes key documents like the welcome letter and the member ID card. The welcome packet also includes member-friendly documents such as our new member welcome booklet (see Figure 6.5-13), which serves as a

Figure 6.5-13. New Member Welcome Booklet



“quick start” manual to assist members in getting started right away in using their covered services. The new member welcome booklet provides information about key benefits, including VAS, how to choose a PCP, completing their initial health assessment (initial screening), and how to request information in alternate formats and languages. The booklet also informs members that the full member handbook is accessible on our website as a printable PDF file and available in paper form by contacting our Member Call Center. Beginning in the third quarter of 2020, we will also be including the initial screening in the welcome packet, so members can complete it and mail it back.

Welcome Call and Text

In addition to mailing these materials, we have initiated strategies to achieve high levels of engagement with new members. A week after a member is enrolled in our plan, we initiate our Welcome Campaign, which includes telephonic and, as indicated, text outreach. During the welcome call, which is our initial introduction, we verify the member has received the welcome packet, including their member ID card. In addition, we invite members to complete the initial health assessment (initial screening), or if they prefer not

to complete the screening during the welcome call, we inform them of other options by which they can complete the screening (for example, via the secure member portal online or through a mailed questionnaire). Offered as a VAS under the new Contract, we will also notify members they will have \$10 loaded onto their Healthy Rewards card for completing the initial screening. For members whose responses to the initial screening suggest they would benefit from care management, the member is offered an opportunity to speak to a Care Manager during the call or is referred to the Care Management team.

A *welcome text* is sent if we do not confirm the completion of a welcome call. The text provides a brief welcome to UniCare members and provides encouragement for the member to complete the initial screener.

We use our *Campaign Engine* to track and analyze outcomes of these outreach activities. Campaign Engine is an Adobe software application (Adobe Campaign) in which we can load member-level communication touchpoints and program advanced queries to optimize channel delivery and messaging. Currently, we gather data on calls, text messages, and email campaigns; we will be adding the collection of data on mailings at the member-level. This analysis helps us determine which campaigns are the most successful and how we should tailor future outreach strategies based on the most successful set or combination of campaigns, channels, and content. *As of October 2019, we have engaged more than 47,000 individuals in our Welcome Campaign, reaching and retaining 84% of members during the initial 90-day enrollment period.*

Enhancements to the Member Welcome Experience

We recognize that members have varying literacy levels and learning preferences. For visual learners, we have developed and placed a series of videos on our member website. One such video, *Understand Your Benefits*, provides members with information about their benefits and how to get started accessing services.

Closed captioning is already available, and we are in the process of embedding American Sign Language (ASL) translation into the video, as additional assistance to members who are deaf or hard of hearing.

Home Visits

While we do not routinely make home visits to members during their initial 30 days of enrollment, there are selected circumstances in which we schedule an in-home visit. For instance, we schedule home visits to members with complex health conditions or disabilities. We proactively identify these members through an analysis of data available through PreManage (previous utilization history and diagnosis codes) and information from the 834 enrollment file (for example, SSI indicator).

We deploy community-based care management staff, including Community Paramedics (CPs) and Community Health Workers (CHWs) to meet members in their homes as members' needs require. These CPs and CHWs engage with members face-to-face and perform health and home safety assessments, coordinate immediate needs of the member with care management team members, including office visits, transportation, and medications, and reduce risks of potentially preventable events, such as inpatient admissions or ER visits. They also educate members about community resources for needed SDOH supports, obtain vital signs (including current vital functions) and engage the member in care management in coordination with a Care Manager to complete an assessment, as indicated. Together, the Care Manager and CP coordinate community resources, following up with members every two weeks for up to 90 days. Members who need support after 90 days continue to engage in care management. This program has proven successful in helping to connect members with care and services, and in addressing their SDOH needs. Currently, this CP and CHW model is active in Kanawha, Boone, and Putnam counties. In 2020, we are expanding our CP and CHW model into additional counties across the state.

Outreach to Difficult-to-Contact Members (MS029)

We mail a welcome packet and place a welcome call to all new members. However, we recognize and make provisions for reaching out to members who may experience barriers in receiving or responding to our new member information. For this reason, upon enrollment we proactively identify new members who may have difficulty accessing our new member information due to barriers such as disability, homelessness, lack of a telephone, or lack of internet access.

Reaching Members with Disabilities

We have proven systems for communicating with members with a disability. For instance, for members with hearing or vision loss, we will make our materials available in braille, large print, or audio, upon request. Through our 711 relay service, we communicate with members with loss of hearing or speech. In addition, when a Member Services Representative or Population Health team member becomes aware of a member's potential communication difficulty, they update the member's EHR in Health Insight, our integrated care management platform, so we can tailor our future communications appropriately.

According to representatives from our partner advocacy organizations, many West Virginia Medicaid members with disabilities use social media, specifically Facebook, to stay connected. We would like to collaborate with DHHR on how we could use Facebook to communicate with these and other members, possibly to establish a private *UniCare Care Management* Facebook group. Through this group, our members could privately message us, provide feedback on marketing and communications materials, and ask questions. We understand that member privacy and online safety are of paramount importance, and before moving forward with a solution, we would receive prior legal review and DHHR approval.

Reaching Members Experiencing Homelessness

Locating and staying in contact with members experiencing homelessness can be challenging, particularly if the member is moving frequently or does not have an up-to-date address and contact information on file. To identify members experiencing homelessness, we cross-match new member addresses against housing shelters and other known locations of individuals experiencing homelessness. In addition, we will be using the *Homeless Management Information System* to assist in locating members experiencing homelessness. With address information in hand, our Population Health team reaches out to engage the member in key onboarding engagement activities such as completion of the initial health assessment, selection of a PCP, and scheduling of a PCP appointment. In many cases, members experiencing homelessness face barriers in remaining in contact with our Population Health team and with UniCare. Barriers include lack of a telephone, and in some cases lack of internet connectivity. In the following sections, we describe how we address these barriers among our members, including those experiencing homelessness.

Assisting Members with Communication Needs

Once we connect with the member, we work to alleviate any barriers that may contribute to our inability to contact them. For example, if a member does not have a phone, we assist them in signing up for our *Lifeline Smart Phone Benefit*, offered as a VAS. Any member who qualifies for the Federal Lifeline program, which provides cell phones to members meeting certain criteria, will be eligible to receive a free cell phone with minutes, unlimited monthly text messages, and a minimum of one GB of data. The cell phone, minutes, and data are supplied by the Federal Program. As a VAS, our members will receive 200 bonus minutes at enrollment and 100 bonus minutes during their birthday month. Additionally, members will receive unlimited calls to Population Health team members, Care Managers, and Member Services

through our toll-free line. This opens the possibility for our staff to be in regular contact with the member and for UniCare to send text messages to the member regarding important preventive screening tests and appointment reminders, among many other health-enhancing messages. In addition, this benefit helps maximize independence for members by making sure they always have a way to contact us when they need our help.

Gaining internet access can also be difficult for our members, particularly those residing in rural communities. Members may not have a computer or internet connectivity. In these circumstances, our Population Health team members may suggest meeting the member in a public library, a location in which members can access a computer and internet access so our team member can assist the member in accessing our online resources. We are also exploring the opportunity to sponsor mobile routers in rural communities.

Tackling Internet Disparity

We are exploring the opportunity to impact internet disparity by sponsoring mobile routers in rural communities that do not have reliable internet connections. These mobile routers can be attached to cars and located overnight in these communities so members, their families, and their neighbors can gain access to the internet. Improved internet access for our members results in telemedicine opportunities, access to member materials including our member handbook and care plans, and numerous other advantages that internet access can offer, such as the ability to complete schoolwork, schedule doctor appointments, perform online job searches, and complete online job applications.

Processing and Issuing ID Cards (MS030)

Our Enrollment department has developed systems for the timely processing and issuing of member ID cards, and we will be continuing this process in the new contract. On a daily basis, the Enrollment department electronically forwards information received on the 834 enrollment file to our member ID card vendor. Our service-level agreement with the vendor requires production and mailing of the ID card to the member within **three business days** of receiving the 834 file (well within the maximum five-business-day turnaround referenced in SPA, Article III, Section 3.4.2). The ID card includes all required information, including:

- Member name

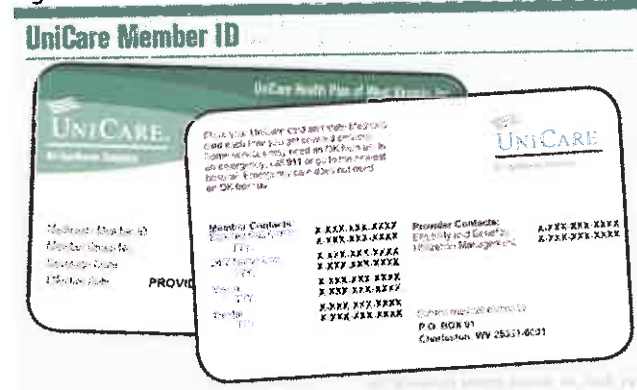
- State-assigned member Medicaid identification number
- MCO name
- Telephone number for 24/7 Nurse Line
- Telephone number for Member Call Center, including TTY number
- PCP name and office telephone number
- Notice that the member must present the MCO card and the Medicaid card at time of service

In addition to the information required in the Article III, Section 3.42 of the SPA, UniCare includes the following information on the member ID card: effective date of enrollment, the member's group number, dental and vision coverage contact numbers, and phone numbers for the 24/7 Nurse Line and dental and vision vendors. A sample member ID card is included as Figure 6.5-14.

An electronic version of the member ID card is accessible to the member through the secure member portal on the UniCare website and, beginning July 1, 2020, through the UniCare smartphone app.

The system also generates a new ID card in the following circumstances: name change (except for middle initial), group number change, PCP change, and re-enrollment after a lapse in coverage. The new information is included on the daily file sent to our member ID card vendor, and the updated ID card is generated and mailed to the member within three business days. An electronic version of the updated member ID card is available to the member via the member portal on the website within 24 hours of the update.

Figure 6.5-14. Member ID Card (Sample)



Distributing Member Handbooks (MS031)

Our member handbook serves as a vital reference document for new members, as it describes many key components of a member's coverage, including but not limited to: covered services and benefits; how to select or change a PCP; member rights and responsibilities; grievance system processes and contact information; key phone numbers; how to access language translation and interpretation and auxiliary aids and services; and how to access non-emergent transportation services. The handbook is written at a 6th grade level or lower, as measured by the Flesch-Kincaid Grade Level Index and is reviewed and edited for plain language to assure readability.

We strive to make the member handbook easily available to members. Our new member welcome booklet and welcome letter inform members that an electronic version of the member handbook (in printable PDF format) is available on our website. Members who prefer a printed copy can request one from our Member Call Center. For print copy requests, our business center ships the copy to the requesting member within five business days. We can also translate the member handbook into any of more than 200 languages, upon request.

MS032	1	The Vendor should describe how they will make information available for members who have Limited English Proficiency (LEP) or limited reading skills, as indicated per 67 Federal Regulation (FR) 41455 (https://www.govinfo.gov/content/pkg/FR-2002-06-18/pdf/02-15207.pdf).
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Limited English Proficiency and Limited Reading Skills (MS032)

Addressing the Needs of Members with Limited English Proficiency

Limited English Proficiency (LEP) should never be an impediment to a member accessing health care services or achieving optimal health. We have developed systems and practices to assure our members are

able to access our information in compliance with 67 FR 41455, and we will continue to build upon these systems and practices in the new contract.

Upon member request, we translate any of our member materials (member handbook and health education brochures, for instance) into more than 200 languages. When we receive a request for translation from a member or one of our member-facing staff, we transmit the order to our translation vendor and track the order to completion.

Facilitating Member Language Needs

In the eastern panhandle, there is a significant population of migrant farm workers, many of whom speak Spanish. When conducting community-based activities in this region, our Community Engagement team brings Spanish-language print materials to workshops and other community events.

We notify our members that materials are available in other languages through our member handbook and our website, and our Member Services Representatives and other member-facing staff also inform members of this availability, as indicated. For materials that require member action or otherwise affect the member's ability to access covered services or benefits (such as the member handbook, PCP change letters, EOBs, and grievance and appeals letters), we attach a BABEL sheet with a tagline that informs members of the availability of language assistance translated in the 15 most prevalent languages spoken by West Virginia residents in 18-point font. Other materials, such as educational flyers, include a DHHR-approved abbreviated version of this tagline, in both English and Spanish.

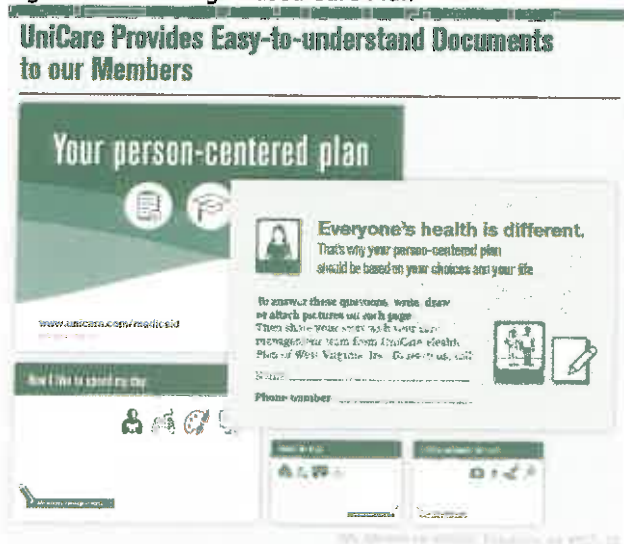
As an organization, we adhere to the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care and have in place culturally and linguistically competent systems and services. In acknowledgement of our organizational cultural competency, ***we have earned the NCQA Multicultural Health Care Distinction***, which recognizes our adherence to collection standards for race, ethnicity, and language data; provision of language assistance; cultural responsiveness; and quality improvement of CLAS.

Addressing Member Needs Related to Literacy

We know that reading literacy and health literacy can be barriers to accessing health services, in health improvement, and in navigating the health care system. For this reason, we have systems in place to assure our materials are created in simple, plain language and are meaningful to the intended audience. To make sure our materials are understandable, respectful, and culturally competent, we require that all member materials be reviewed by an interdisciplinary team prior to submission to DHHR for approval. This team, operating within our process known as CMAP, reviews materials for cultural competency, accuracy, and compliance with all State program requirements, including compliance with the State-specified reading level of no higher than sixth grade (as measured through the Flesch-Kincaid Grade Level Index). In addition, we incorporate guidance from the CMS Toolkit for Making Written Material Clear and Effective to create written materials that are easier to read, understand, and use. Furthermore, to optimize the readability and understandability of our materials, we use an innovative, interactive literacy software tool called Health Literacy Advisor that replaces hard-to-read medical terms and phrases with plain language and scores documents on their general readability.

We also specifically develop materials to meet the needs of members of varying literacy levels. For instance, we have developed a care plan document (see Figure 6.5-15) that relies more heavily on images. Our members have found this document easier to complete, resulting in more effective planning and goal setting. Similarly, we make sure some of our more complex documents, such as

Figure 6.5-15. Image-based Care Plan



claims forms, are developed in plain language. By calling our Member Call Center, members can request audio (CD or MP3) versions of our materials, which provides access to materials across all levels of literacy. Our Member Services Representatives will read materials to members, as well. We also make information available in our “quick tips” videos, which include closed captioning for individuals with hearing loss, and are accessible to individuals across all levels of literacy. Topics include:

- Understand Your Benefits (Using Your Health Plan)
- Put Our Tools to Work for You (New Member Resources)
- Know Your PCP (How to Choose or Change Your PCP)
- Tell Us About Your Health (Completing the Health Screener)
- Emergency Room or Urgent Care?

MS033	1	The Vendor should describe how they will provide a secure member portal that allows members to log in and access benefit information including, but not limited to, the following:
MS034	2	Medical records
MS035	2	Authorization status
MS036	2	Cost sharing information
MS037	2	Temporary identification (ID) cards
MS038	2	Confirmation of Primary Care Provider (PCP)
MS039	2	Provision of access to guardians

Providing Members with Secure Access to the Information They Need (MS033–MS039)

We are passionate about creating a positive and compelling user experience, and we believe that members who register for an online account and use it regularly have better satisfaction and are better engaged in their health care. UniCare provides our members with an accessible and secure portal that complies with federal and State marketing regulations, enabling them to access information about their health care services at the time and place most convenient for them. This mobile-friendly site follows industry web accessibility design standards, including Section 508 of the Rehabilitation Act and Web Content Accessibility Guidelines (WCAG) 2.1 level AA Accessibility standards.

UniCare's Secure Member Portal

As shown in Figure 6.5-16 and described in Table 6.5-2, our secure member portal provides our West Virginia members with 24/7 access to key content and self-service functions. An asterisk (*) marks items that are currently being developed and will be deployed in 2020.

Table 6.5-2. UniCare's Secure Member Portal Content and Functions

Content or Function	Description
Content and Functions Available Through Secure Login	
Eligibility and Demographic Information	Members can access eligibility information including their ID number, coverage effective date, renewal date, and demographic information such as birthday, gender, ethnicity, and other relevant data.
Medical Records* Authorization Status* Cost-sharing Information*	By the end of 2020, members will also have access to MyFHR, UniCare's member-facing EHR solution. Through MyFHR, members will be able to access their individual health information from UniCare's Health Insight platform and update medical records, including details on immunizations, chronic health problems, allergies, medications, health risk assessments, and service utilization. MyFHR will also incorporate the member's eligibility, cost-sharing details (current out-of-pocket total and remaining quarterly/annual balance) as well as utilization management data, including authorization details and status.
Member ID Card	Members can view, download, and print a copy of their ID card, or request that we send them a new one. ID cards are available within 24 hours of enrollment.
Change PCP	When logged into the secure website, the current PCP is displayed as part of the member's information. The member can use the Find a Doctor tool to select or change their PCP preference. The updated PCP is reflected on the member's ID card within 24 hours of the change.
Account Access (Including Guardians)	Members can manage their account settings and change their secure password. For a member who is a minor, the parent or guardian would use the child's member ID to set up a single secure online account for the member that is used by the parent or guardian.
Update Contact Information	Members can update their name, address, and phone number. This information is refreshed with data from the 834 file. When members make changes, the member website prompts them to contact the appropriate State agency to make the changes at the source so they will be permanent.
Secure Messaging	Secure messaging allows members a quick, easy, and secure way to get answers to their questions from a West Virginia Member Services Representative.
Health Resources	The secure member website is being expanded to offer information and tools designed to engage members in managing their health, including: CommonGround* . This is a video library of first-person accounts of mental health recovery and wellness and is designed to encourage and support member self-direction. Member Engagement Platform* . For our members ages 13 and older, this platform is designed to drive engagement, optimize utilization, and improve outcomes. It aggregates data on personal activities like sleeping, exercise, and eating from a member's fitness applications or personal entries, then analyzes the data, delivers insights, and offers tools for users to form and maintain healthy habits.
Spanish Translation	Documents are posted in both Spanish and English on the secure member site.

* Currently being developed and will be deployed in 2020

Member Website Features

We also maintain a public website that provides vital information and tools for our members and potential members. We provide a list of core content and functions that are available on the member website in Table 6.5-3.

Figure 6.5-16. Members Get Access to PCP Information, Member ID Card, and Benefits Information on UniCare's Secure Member Portal

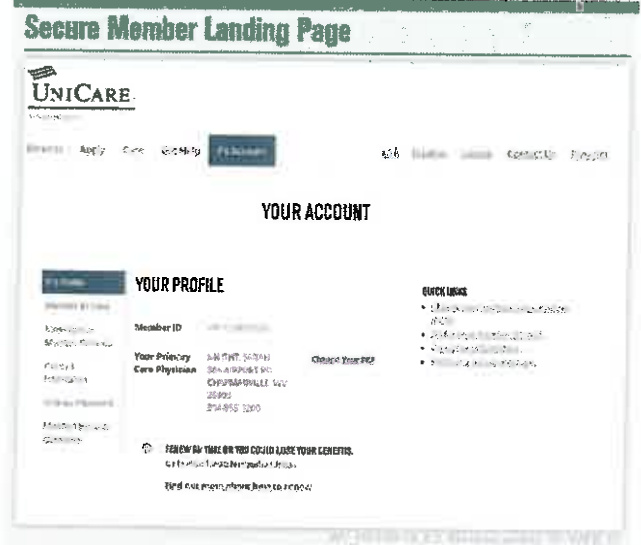


Table 6.5-3. UniCare's Public Member Website Content and Functions

Content or Function	Description
Available for Public Access	
Healthwise A to Z	An easy-to-use online resource that provides: information on many health topics; a symptom checker; and interactive tools such as the Health and Fitness Tool, Lifestyle Checkup Tool, and Pregnancy Tool.
Community Resource Link (VAS)	A tool that members can use to get help finding food, jobs, and housing and more in their zip code area.
Find a Doctor Tool	Searchable online provider directory. Provider information is updated weekly, exceeding SPA requirements.
Enroll and Renew	Provides information about selecting or retaining UniCare as their MCO.
Member Newsletter & Blog	Quarterly newsletters provide members with updates on Medicaid program details as well as information on self-care and common health care concerns. Beginning in March 2020, we are modernizing our communications and will be publishing a weekly blog to provide members with tips on ways to live a healthier life, presented in a format that is seasonal, relevant, and timely.
Informational Videos	A series of short videos that provide a brief overview of the following topics: • Understand Your Benefits • Put Our Tools to Work for You • Know Your PCP • Tell Us About Your Health • Emergency Room or Urgent Care?
Spanish Translation	The public site can be translated into Spanish by using the Español link at the top of any page. There is also information on each page informing users about how to request assistance or materials in other languages and formats.
Member Handbook	Members can download a PDF version of the member handbook, and print it if they desire.

Content or Function	Description
Contact Information	Members can find the toll-free Member Call Center, 24/7 Nurse Line, and the BH Hotline phone numbers.
Complaints and Appeals	Members can access information about how to submit a complaint or appeal, how to get help filing, and what to expect after filing. Members can download and print this and other information available in the website.

Both our member portal and public website are designed and managed by Anthem's Digital Experience team. This team focuses solely on supporting web development for Medicaid and WVCHIP health plans and has designed navigation and content sensitive to the needs of these populations for 22 markets, including West Virginia. The team includes a User Experience and Design (UXD) team that collectively has 70 years of Medicaid web experience and strives to lead the market in website design and usability. The team's thoughtful design and architecture and strong command of plain language has won several prestigious awards for web design for our affiliates, including:

- Our Georgia affiliate's member website earned a 2017 eHealthcare Leadership Award of Distinction for Best Overall Internet Site for HMOs/PPOs. Judges evaluated more than 40 factors related to Information Architecture, User Experience (UX), design, and content. This website also won a 2017 Digital Health Bronze Award for responsive design, a critical consideration given the large portion of our membership who only have access to the internet via a mobile device.
- Our Indiana affiliate's member website won a 2017 ClearMark Award of Distinction from The Center for Plain Language. This honor is awarded to websites that meet stringent standards for user experience design and easy-to-understand content.

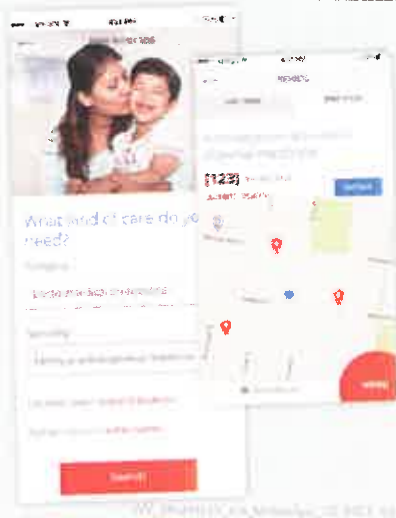


Enhanced Accessible Design

Our public website and secure member portal use responsive design so that users can access all the information, features, and functionality regardless of device (smartphone, tablet, or computer) or connection speed. Our website usage statistics show that nearly 60% of all users accessing our West Virginia Medicaid sites do so using a mobile device. Knowing that members visit our sites using devices with different platforms and operating systems, we code and cross-browser test for the latest versions of Google Chrome, Firefox, Safari, and Internet Explorer, as well as compatibility with iOS® and Android™ mobile browsers.

New Mobile Applications Available in 2020 and 2021

UniCare's New Mobile App Will Use GPS Technology to Help Members Find a Doctor Near Them



By July 1, 2020, members will have access to a mobile application (app) that will provide the same information and functionality available on our member portal. The mobile app is being developed for both iOS and Android users and will take advantage of technology available on these mobile devices,

including GPS and biometric security. Once available, members will be able to download the app from the App Store or Google Play™. The member portal and the mobile app will share credentials so that a member who has already registered with an account for the member portal can use the portal username and password to access the mobile

Embracing Technology Evolution

As technology continues to evolve, so do we. In 2021, we will introduce UniCare members to a cutting-edge mobile app called Sydney.



app without a second registration. After initial login to the app, members will have the option of turning on biometric identification if available on their device, providing easy and secure log on access to the app.

Say Hello to Sydney Member Engagement Platform

Leveraging the power and pace of Anthem’s digital innovation, UniCare will also introduce Sydney to our members in 2021. Sydney is a next-generation member engagement platform that uses artificial intelligence and data science to deliver a customized mobile and web experience tailored to each member’s needs. Sydney brings together easy-to-use care finder tools, clear benefit details, and wellness improvement programs in one simple mobile solution. As members use Sydney, it learns their preferences and provides smarter recommendations about their health care needs. This fully-integrated engagement platform will help lead the way to optimal health with personalized digital experiences that make healthy living easier.

MS040 1 The Vendor should describe its process to inform members that program information is available in paper form without charge upon request and available within five (5) business days.

Availability of Information in Paper Form (MS040)

As an incumbent MCO, UniCare has learned that members have varying preferences in the form which they receive informational materials. Many are comfortable reviewing information online through our website, some prefer audio versions of materials, and others prefer printed, hardcopy materials. No matter the format, we have systems in place to meet members’ needs in the format they choose, and we will continue to meet our members’ needs in the new SPA.

For members who prefer information in paper form, we make certain they are aware of the no cost availability of paper copies and how to request them. Our member handbook specifically references that paper copies of various documents (for example, the provider directory) are available within five business days upon requesting the materials from our Member Call Center. We inform members how they can request paper copies of materials on our website, and also make this information available in our “quick

tips” videos, which are close captioned for individuals with hearing loss, and accessible to individuals across all levels of literacy. Our member-facing employees, including our Member Services Representatives and Community Engagement and Population Health teams, are willing and able to assist members in accessing paper copies of member materials. For members with the capacity to download and print documents, our website includes a variety of key documents — including our member handbook and provider directory — in printable PDF files.

MS041	1	The Vendor should describe how they will make auxiliary aids and services, as well as oral interpretation services, available in all non-English languages to all members and potential members, free of charge, including the top fifteen languages spoken in the State, which are Spanish, Chinese, French, German, Arabic, Vietnamese, Korean, Japanese, Tagalog, Italian, Thai, Nepali, Persian, Russian, and Urdu.
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Availability of Interpretation and Auxiliary Aids in Non-English Languages (MS041)

Neither language nor disability should ever be an impediment for members to fully access our services and benefits. As an experienced MCO, we have proven systems to make certain people with speech, hearing, or vision disabilities, or who speak a language other than English have full access to information about covered services, benefits, enrollment, and healthy living. We will continue using these systems to assure our members have access to language services and auxiliary aids and services at no cost and continue to further enhance these strategies to assure we are connecting our members with innovations that make accessing this information even easier.

Providing Auxiliary Aids and Services and Oral Interpretation

Upon member request, we can produce any member material in an alternate format, such as braille, large print, audio, and electronic or written format. Members can request these alternate format materials by calling our Member Call Center or by secure messaging through the member website. When we

receive a request for an alternate format, we transmit a production order to our Vendor and use internal processes to track its completion.

We support oral interpretation (in-person and telephonic) in more than 200 languages in provider settings and across our member phone lines — Member Call Center, 24/7 Nurse Line, and BH Hotline. This means that members receive assistance in their language for any type of call — ranging from requesting a new ID card to experiencing a BH crisis. Our Member Services Representatives are trained to assist all callers (including but not limited to members and potential members) who do not speak English by warm transferring the individual to our language Vendor. While our Member Services Representative stays on the line, the language Vendor identifies the individual's language, connects the individual with a trained interpreter, and proceeds with oral interpretation between the representative, the trained interpreter, and the non-English speaking individual through a three-way line. Additionally, individuals with a hearing, vision, or speech disability can contact us through the 711 Telecommunications Relay Service (TRS).

Our Provider Services team trains our network providers on how to access language Vendor services — including in-person and telephonic interpretation — during orientation, and we include this information in the provider manual, which is posted to our public website. Neither the member nor the provider is ever charged for oral interpretation services.

Publicizing Auxiliary Aids and Services

To assure our members are aware of our oral interpretation and alternate format materials, we provide information about these services across our member materials: in our member handbook and new member welcome packet, on our member website, and other printed materials. In addition, we train member-facing employees to assist members in accessing language services and alternate formats, and we include this

information in our provider manual to make certain providers are aware of and can assist members in accessing language services and alternate format materials. Lastly, we include a tagline in the 15 most prevalent West Virginia languages, explaining the availability of oral interpretation and alternate formats for all our written materials (see our response to MS043 for additional detail regarding taglines).

MS042 1 The Vendor should describe how they will notify members that oral interpretation services are available for any language, and that written information is available in prevalent languages and braille, and how to access those services.

Notifying Members of Language Services (MS042)

Our promotion of language services begins immediately upon our new member enrollment. The first page of our member handbook includes the following message in English and Spanish: “If you do not speak English, call us at 1-800-782-0095 (TTY 711). We have access to interpreter services and can help answer your questions in your language. We can also help you find a health care provider who can communicate with you in your language.”

The member handbook also includes a message translated into the 15 most prevalent West Virginia languages informing members of the availability of language assistance and alternative formats for written materials at no cost to the member. In addition to the member handbook, we publicize the availability of language assistance and alternative formats on our website, in all official printed member communications from the health plan, in our newsletters, and in our print and electronic health education materials. Our member-facing staff, including our Member Services Representatives, Population Health team, Care Managers, and Community Engagement team also provide this information to members, as do our network providers and partner organizations in local communities across the state.

MS043 1	The Vendor should describe how they will include taglines in all written materials 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 Text Telephone (TTY)/Telecommunication Device for the Deaf (TDD) telephone number of the Vendor.
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Taglines in All Written Materials (MS043)

As an MCO incumbent, we have policies and procedures in place to make certain all our member materials include the following message:

*“Do you need help with your health care, talking with us, or reading what we send you?
We provide our materials in other languages and formats at no cost to you. Call us toll-free at 1-800-782-0095 (TTY 711).”*

For materials that require member action or otherwise affect the member’s ability to access covered services or benefits (such as the member handbook, PCP change letters, EOBs, and grievance and appeals letters), we attach a BABEL sheet, which includes the message above in English and in the 15 most prevalent languages spoken by West Virginia residents in 18-point font. We also include a notice of non-discrimination.

When developing documents or materials that do not impact a member’s access to covered service or benefits, such as an educational flyer, we include a DHHR-approved abbreviated LEP line, which includes the above message in English in 18-point font and Spanish in 12-point font. For materials on our website, the BABEL sheet and HHS notice of non-discrimination are included as 508 compliant PDFs in the footer of the website.

To make certain we consistently include the tagline in our written informational materials, we will continue to utilize our CMAP to review all proposed member and marketing materials. Through our CMAP, a multidisciplinary team of subject matter experts, regulatory, and compliance staff, and Legal Counsel review materials for compliance with all State and federal requirements, including inclusion of

the tagline, prior to submission to the State for approval. We also have a team of proofers who check all materials for requirements before sending to DHHR.

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| MS044 | 1 | The Vendor should describe its policies and procedures related to issuance of member identification cards within contractually defined timeframes. |
|-------|---|--|

Issuance of Member ID Cards (MS044)

As an incumbent MCO, we have developed policies and procedures for the timely processing and issuing of member identification cards and will continue to adhere to these policies and procedures in the new contract. On a daily basis, our Enrollment department electronically forwards via secure transmission member information from the 834-enrollment file to our member ID card Vendor. Our service-level agreement with the Vendor requires production and mailing of the ID card to the member within **three business days** of receiving the 834 file (well in compliance with the maximum five-business-day turnaround referenced in the SPA, Article III, Section 3.4.2).



An electronic version of the member ID card is accessible to the member through the secure member portal on the UniCare website. A new member ID card is placed on the website within 24 hours of enrollment. As of July 1, 2020, members will also be able to access their member ID card within the UniCare mobile app.

The system also generates a new ID card in the following circumstances: name change (except for middle initial), group number change, PCP change, and re-enrollment after a lapse in coverage. The new information is included on the daily file sent to our member ID card Vendor, and the updated ID card is generated and mailed to the member within three business days. A printable, electronic version of the member ID card is available to the member via the member portal on the website within 24 hours of the update and through the UniCare mobile app.

- MS045 1 The Vendor should describe how they will administer a health education program for disease and injury prevention and identification.

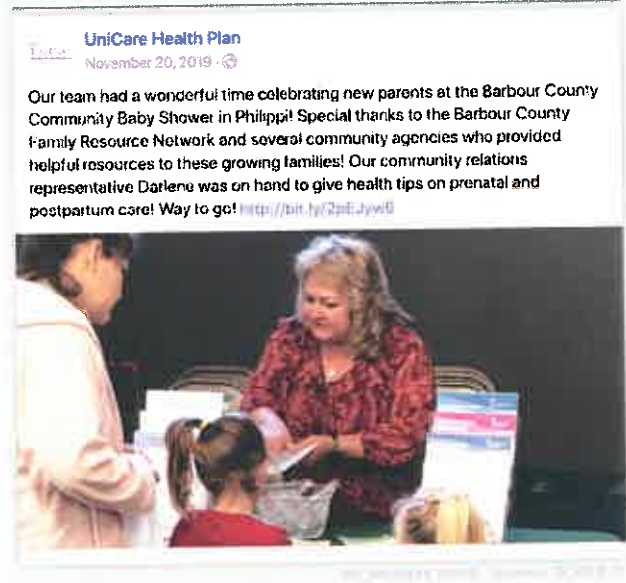
Health Education (MS045)

UniCare administers a health education program informed by our population health management model and augments and reinforces health education messaging members receive from their PCP, other network providers, community-based agencies, and other information sources. Our health education program makes information available through our website and through UniCare-approved phone apps (for example, our Online Well-being program — available as a VAS — that promotes behavioral health and wellness through instruction, games, goal setting, and monitoring). Our member newsletter (transitioning to a blog format but remaining a key source of health information to members) provides timely, actionable health information on subjects such as the health risks of vaping, simple steps to reduce stress, and the value of fluoride in reducing tooth decay. In addition, we conduct text messaging educational campaigns, post health and wellness information on our Facebook page (shown in Figure 6.5-17), offer wellness opportunities through our VAS (such as our Safe Sleep Kits and our Fitness Coach Program which provides online fitness coaching), and provide disease management assistance to members with conditions such as diabetes, high blood pressure, HIV/AIDS, asthma, SUD, and depression.

We reach members in community settings across the state by conducting health education workshops at health fairs, diaper drives, back-to-school events, and community baby showers. In addition, we

Figure 6.5-17. UniCare in the Community

UniCare Facebook



coordinate clinic days and health fairs in conjunction with network providers and sponsor educational conferences, trainings, and workshops. Furthermore, through grant making, we support community-based initiatives which address local health priorities while building local health education and promotion capacity. Virtually all of this work is conducted collaboratively with community partners and stakeholders.

We will be building upon these health and wellness efforts by expanding our partnerships, addressing emerging conditions (such as teen vaping), and continuing to test new methods to enhance our health impact through member education. In the following narrative, we describe in detail how our Community Engagement, and Population Health teams will administer our health education program. Additional information regarding the health education efforts conducted within our care management and QM programs is provided in Sections CM021, CM022, and CM054–CM058 of this response.

Program Planning

As mentioned previously, health education, including both member-level and community-level education, is conducted by several departments within UniCare, including Community Engagement, Care Management, and Quality Management. These departments work in close coordination to address the most prevalent and pressing health problems among our members and across the state. A key touchpoint in the coordination of programming is the population health management model used by UniCare. This interdisciplinary, cross-functional framework is embedded across all UniCare departments and drives the delivery of clinical care, as well as population health outcomes and a focus on health disparities and health equity.

We describe our process for identifying priority focus areas, target populations, and current programming related to focus areas next. In the new contract, we will continue to engage in careful planning regarding the health education needs of our members and the communities in which they reside.

Identifying Health Priorities

At least annually, we conduct an extensive review of data sources to identify priority areas for health education. These data sources include, but are not limited to:

- **Local and state priorities**, as identified in strategic plans, needs assessment, or other documents emanating from DHHR, West Virginia county health departments, WVU, the Centers for Disease Control (CDC), America's Health Rankings, Kaiser Family Foundation, Annie E. Casey Foundation, and Robert Wood Johnson Foundation's County Health Rankings
- **Member needs and concerns**, as reflected in CAHPS® data, input through our Community Engagement Committee, screening results, and as identified through member focus groups
- **Partner and stakeholder input**, as identified through the Stakeholder Advisory Committee, community listening sessions, and independent reviews
- **Clinical data**, including but not limited to HEDIS® data and outcomes data; HEDIS data is stratified by race, ethnicity, age, gender, and other factors to identify areas of health care disparity
- **Emerging issues**, as identified by national and global organizations such as the CDC, the Association of State and Territorial Health Officers, and the World Health Organization

In determining strategies and populations of focus, UniCare staff take the following into account: alignment with our current population health management priorities (including but not limited to mental health and SUD; maternal care, including infant mortality; diabetes; cardiovascular disease; COPD; oral health; food insecurity; housing; and transportation); available evidence-based or best practice

interventions; and health disparities and health equity. In addition, we make certain to adhere to contract requirements related to the delivery of health education, including the provisions outlined in the SPA, Article III, Section 5.2.

Program Implementation

We work across UniCare departments and with community partners and stakeholders to implement health education programming. In particular, our Care Management, Community Engagement, and Population Health teams help coordinate the identification of content for our website, selection of smartphone apps, and selection of VAS focused on health and wellness. On an annual basis, our Community Engagement Director develops a marketing plan that outlines activities involving member based and community-wide education. We describe current health education programs and strategies by priority area next.

Injury Prevention

UniCare shares the concerns of DHHR related to the significant toll injury is taking on West Virginia residents, and we have aligned our injury prevention focus areas to match those of the state: child abuse and neglect; traumatic brain injury; motor vehicle crash injury and death; intimate partner violence/sexual violence; and SUD, including prescription drug overdose. Data supports these priorities. For instance, there is a disproportionately large number of West Virginia residents impacted due to drug overdose.³ In addition, intimate partner violence, motor vehicle accidents, traumatic brain injury, and child abuse continue to be significant sources of preventable injury and death. We currently conduct injury prevention programming, such as distribution of bike helmets and education about child safety and poison control. In

³ Centers for Disease Control and Prevention, National Vital Statistics Reports, Volume 67, No. 8, 2017.

addition, our Community Engagement team has received training in the Our Babies Safe & Sound Program, which educates parents, grandparents, and other caregivers on Shaken Baby syndrome and safe sleep best practices. We distribute safe sleep educational materials at community baby showers, health fairs, and other family-oriented events.

Our Community Engagement team members coordinate women's health and wellness events at domestic violence shelters and women's shelters. In summer 2020, we will bring an ***Interpersonal Violence Reduction Program (IVRP)*** which provides team-based, tech-enabled, and care extension services to UniCare members who experienced or are at-risk of experiencing acts of intimate or interpersonal violence. Our IVRP provides participants with interventions for individualized violence and SDOH, and cost reducing designs to enhance skills, strategies, and supports to avoid or reduce potentially violent situations and associated avoidable care costs. Under the IVRP, a team of trained individuals work face-to-face with members in their own communities and virtually through secure messaging, phone, email, video chat, and a proprietary technology platform to assure ongoing and appropriate contact throughout the program. The IVRP team works with our UniCare care management teams and community-based entities to assure IVRP services extend and complement existing services.

We are currently working in partnership with a variety of agencies to address the ongoing epidemic of overdoses due to ***opioid use disorder*** among West Virginia residents. For instance, we are working in partnership with schools and community-based organizations in building capacity to deliver two youth programs addressing SUD: This is (Not) About Drugs, and Preventure. These initiatives address the opioid epidemic by focusing on educating adolescents about prescription opioid misuse and identifying and working through personality risk factors for SUD. We are working with partners in two of the five West Virginia counties with the highest rates of drug overdose. In addition, UniCare staff members are

partnering with Recovery Point, a 92-bed residential facility for women, in providing yoga and trauma-informed mindfulness training to residents in recovery from SUD.

In June 2019, UniCare hosted a *Safety Palooza* in partnership with the local housing authorities from Martinsburg to Mercer County, Charleston, and other cities in between. Safety Palooza is a series of free events which are open to all community members and features health and safety exhibitors — police departments, fire departments, and health departments, among others, that provide activities, resources, and education. Common themes are sun safety, internet safety, fire safety, car seat safety, suicide prevention, and anti-bullying.

Chronic Diseases

West Virginia has some of the highest chronic condition rates nationally. West Virginia ranks highest among states in prevalence of heart attack (7.5%) and coronary heart disease (8.0%). Fifteen percent of West Virginia adults report being diagnosed with diabetes (second highest percentage in the nation). Nearly one in four (23.8%) West Virginians report being diagnosed with depression (second highest percentage in the nation). Among our members, diabetes, hypertension, cardiovascular disease, COPD, asthma, and depression are highly prevalent conditions, and our member- and community-level efforts to improve detection, treatment, and self-management are key tactics in limiting the impact of these conditions on quantity and quality of life of our members.

Disease Management

Members with chronic conditions receive disease management services through clinical and non-clinical interventions. We analyze and risk stratify our entire member population quarterly and this helps us to assure that members receive an appropriate and effective level of engagement. This regular

screening process also helps us to identify and intervene with members before complications occur and health status declines, including low-risk or rising-risk members before they experience an acute event.

Our person-centered disease management programs offer short-term coordination and care management to prevent progression to higher levels of risk. The program is centered on the concept of motivational interviewing to promote member empowerment and self-care. Motivational Interviewing techniques are incorporated into all aspects of member communication including telephonic outreach, health risk assessments, development of collaborative tailored plans of care, and routine follow-up communication to measure progress towards goals.

Community-based Education

Our Community Engagement team work in communities to address chronic diseases, with an emphasis on chronic disease prevention through healthy behaviors (not smoking, physical activity, and healthy eating) and through timely receipt of age-appropriate preventive screening tests (for example, mammograms) and vaccinations.

Our Community Engagement team members work across the state and interact with members and general community residents in locations such as schools, community-based organizations, and faith institutions, as shown in Figure 6.5-18. Their goal is to improve health literacy and promote healthy behaviors among health plan members and the general community through field outreach activities using targeted quality measures for the health plan. In 2019, our Community Engagement team presented to more than 5,000 individuals related to women's health and wellness, more than 2,300 individuals

Figure 6.5-18. UniCare Visits Schools to Educate about Oral Health



regarding healthy eating and staying active, and more than 1,000 individuals regarding well child and adolescent health.

Our Community Engagement staff work in close partnership with other community-based organizations on specific initiatives. For instance, we work with the American Heart Association (AHA), WVU Extension, and Boys & Girls Clubs on obesity prevention initiatives. With the AHA, we are a sponsor for the West Virginia Heart Walk, Kids Heart Challenge, and Hands-Only CPR trainings. For a program known as Kids Heart Challenge, UniCare helps to sponsor these events within schools to encourage kids to participate and also build partnerships with selected schools for future health promotion initiatives. To date, UniCare has participated in 15 schools with this partnership. We work with West Virginia University Extension on the Eat Smart, Be Active and 4H programs. UniCare Health Plan has also partnered with WVU Extension for Dining with Diabetes, Dental Health Education, and N.E.A.T. Program for Tuesdays for Toddlers, and other health-related activities with the 4H Camps in the southern West Virginia counties. For the Boys & Girls Clubs, our Triple Play program is a wellness program created to engage youth in activities that promote their health and wellness.

UniCare has recently launched a new program called ***Shine Light on Depression***. This program is a multidisciplinary, school-based, public health initiative between Anthem, the American School Health Association, Erika's Lighthouse, the National Parent Teacher Association (PTA), and JetBlue Airways Corporation. These organizations are collaborating to address teen depression and suicide in youth nationwide through the dissemination of the Shine Light on Depression e-toolkit. The goal for this initiative is to bring the Shine Light on Depression e-toolkit to secondary schools nationwide to: 1) increase student knowledge of depression, students' willingness to seek help for themselves or a friend,

and students' awareness of where to seek help; and 2) help parents and families better understand depression and suicide and be empowered to advocate for their children.

The Shine Light on Depression e-toolkit (that is, website) will provide school communities with free, ready-to-use resources and tools designed to raise awareness and acceptance of depression and suicide prevention among middle and high school youth and families in a positive, honest, fact-based, and inclusive manner. This approach will help build a community in which there is open discussion and appropriate vocabulary about the subject of depression and places it in the broader context of good mental health. Our Community Engagement staff will be leveraging our relationships with schools and building new relationships to maximize the uptake of this new program in middle and high schools.

Emerging Health Conditions

Emerging health problems such as *youth vaping* and the recent *resurgence of HIV infections* demand rapid, coordinated action, and we intend to work in partnership with stakeholders and partners, including governmental public health agencies, other MCOs, health systems, schools, and community-based organizations to address these and other emerging health crises. Our Community Engagement team will be incorporating health education information on these and other conditions through our member brochures, mailings, and community health education workshops. Moreover, we recognize the importance of working collaboratively with our partners and stakeholders in addressing health problems on a population basis. We are currently working with the AHA to catalyze community dialogue about youth vaping, and we will continue to identify opportunities to work in partnership with the AHA and other organizations to respond to emerging health threats in West Virginia.

Evaluating Health Education Efforts

All departments within UniCare that participate in health education activities monitor their activities. For instance, our Community Engagement team tracks community education and outreach events by date, location, type of event, topic, and number of participants. For community workshops, our Community Engagement and Population Health teams request feedback from participants following each workshop and, as indicated, refine workshop content and delivery on the basis of participant feedback. For its part, our care management program has a comprehensive evaluation program in place, which includes ongoing, quarterly, and annual monitoring tools to measure performance. This includes quarterly quality audits on a sample of Care Manager cases, monitoring of complaints with the care management process or Care Managers, and an annual care management program evaluation, including member satisfaction.

Promoting and Incentivizing Healthy Behaviors

We know that members can often use some additional encouragement to begin or maintain healthy behaviors or to seek a preventive screening test, and we have designed our incentive program, known as Healthy Rewards, to complement our member education activities. The *Healthy Rewards program* (fully detailed in QU009 of this response) is offered as a VAS and educates and motivates members into taking an active role in managing their health and wellness. By offering rewards for healthy behaviors, UniCare incentivizes members to improve their health status, enhancing prevention and health outcomes, and preventing disease progression. The program offers a variety of rewards ranging from \$10 for adults completing an initial health screening to \$100 for adults with diabetes who complete their HbA1c screening and eye exam each year.

Additionally, the Healthy Rewards platform will be significantly upgraded in 2020 to include new features with health education, a wider range of enticing incentive redemption options, and instantly

delivered digital gift cards. In addition, in 2020 UniCare is offering an expanded suite of VAS to promote and incentivize healthy behaviors. With benefits and services ranging from our Fresh Fruits and Veggies Program, to \$100 Gas Card, to Youth Club Memberships, our suite of VAS supports our members by tailoring services to meet the needs of enrolled populations and providing members with the opportunity to maintain and improve their health.

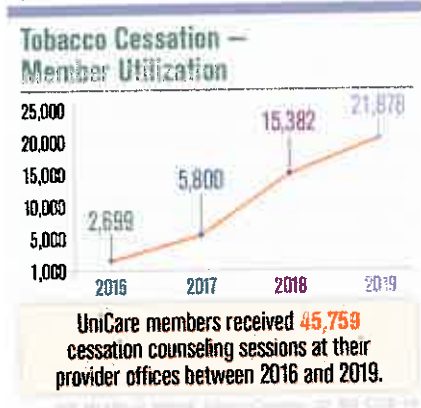
MS046 1 The Vendor should describe its tobacco cessation program.

UniCare's Tobacco Cessation Program (MS046)

West Virginia has a higher rate of tobacco usage than other states, with 14.4% of high school students smoking compared to 8.8% nationally. UniCare identifies members who use tobacco through data mining and screening tools: the initial screening, OB Risk Screener, health risk assessments, through claims submitted by providers, and through our regular disease management, care management, and utilization management activities. We also encourage providers to identify adolescents and adults who use tobacco at all wellness visits.

Our comprehensive approach to cessation is aligned with the CDC's *Best Practices for Comprehensive Tobacco Control Programs*, which combines counseling, incentives for behavioral change, and additional tools and resources. Central to our strategy is early identification of members who smoke and connecting them with support for quitting. When members are identified as tobacco users, we reach out directly to inform them about our tobacco cessation programs and to offer assistance to them in enrolling and remaining smoke-free. Because we recognize the difference providers can make in members' choices and behavior, we encourage face-to-face counseling sessions between

Figure 6.5-19. UniCare Helps Members Quit Nicotine



providers and members. In 2016, we eliminated benefit limits on individualized cessation counseling sessions by providers. As illustrated by Figure 6.5-19, the result was a year-over-year increase in tobacco cessation counseling among our members from 2016 to 2019.

Our Population Health, Community Engagement, Quality Management, and Care Management teams all have strategies in place to identify members and connect them to our cessation resources. When members are identified for care management, our Care Managers use motivational interviewing techniques to identify goals for the member's integrated care plan. In our newsletters and other communications to members, we promote the benefits of tobacco cessation and publicize our support programs and covered medications for members who want to quit. We make tobacco cessation tools readily available on the member portal. We will note members who smoke and periodically reach out to those who may not be ready to quit smoking to encourage healthy behaviors and make them aware of the resources available to them.

One resource we offer for member self-management supports is our Online Well-being program, a VAS for members. It offers a nicotine recovery program that helps members determine their readiness for quitting and tailors activities to their stage of change. The Nicotine Recovery module includes expert videos, interactive activities, and stories of hope from former nicotine users to help individuals reach their nicotine recovery goals. Our strategies are working. ***Between 2015 and 2019, adult CAHPS surveys have shown year-over-year increases in Advising Tobacco Users to Quit (up 7.9%), Discussing Cessation Medication (up 29.4%), and Discussing Cessation Strategies (up 41.4%).***

Tobacco Cessation for Pregnant Members

Smoking during pregnancy is associated with a higher risk for low birth weight, SIDS, and increased incidences of ectopic pregnancy and miscarriage. Prenatal exposure to secondhand smoke is also harmful to

a child's mental development. Children of mothers who were exposed to secondhand smoke have lower scores on cognitive development tests at age two compared to children of mothers living in smoke-free homes during pregnancy. To improve both maternal and infant health, UniCare funds a program called Baby and Me Tobacco Free, which is available to all women in West Virginia, not just UniCare members. Pregnant women who enroll in the program take prenatal smoking cessation classes and agree to a monthly breath test to prove they are tobacco free. If the mother stays smoke-free after her baby is born, she is eligible to receive incentives. The mother's partner, if enrolled, is also eligible to receive diaper vouchers in the amount of \$25 each month upon testing negative for nicotine for up to 12 months post-delivery. The program has proven effective in decreasing the number of women who smoke during and after pregnancy. In an affiliate Medicaid plan, 60% of women enrolled in the program were tobacco free six months postpartum. ***Enrollment in our Baby and Me Tobacco Free program nearly tripled in 2019. Among participants, just 5.5% of babies were born with low birth weight. This is lower than both the West Virginia (9.4%) and the national average (8.3%).***



Provider Engagement in Tobacco Cessation

We take every opportunity to remind providers that tobacco cessation counseling is a covered benefit (billing CPT® codes 99406 and 99407), and we encourage them to counsel smokers at every exam. Reminder bulletins give guidance to providers on how to conduct tobacco cessation counseling, how to refer members who smoke, how to help members set goals and choose pharmacological assistance, and how to direct members to the West Virginia Tobacco Quit Line. They also receive information about authorization requirements and extensions and preferred medications.

UniCare Supports Targeted Tobacco Cessation Programming

Our parent company's philanthropic foundation teamed with the American Lung Association (ALA) to introduce the Smoking Cessation for Low-income Housing Residents Initiative ahead of HUD's smoke-free housing policy, which is designed to reduce exposure to secondhand smoke. In support of the initiative, the Foundation provided nearly \$1 million in funding to ALA's Freedom from Smoking® program to residents in public housing developments located in 14 states across the country. Smoking and vaping, which have social, biological, and behavioral components, require a multi-pronged approach. UniCare strives to meet the challenge posed by each of those components.

MS047	1	The Vendor should describe how they will leverage community events/resources to help improve the health of its member population.
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Leveraging Community Events and Resources to Improve Member

Health (MS047)

UniCare continues to build a network of community partners that can assist members in meeting their health-related needs and goals. Moreover, we believe that optimal health means not only having access to medical care, but also resources that address social and economic needs such as housing, education, healthy food, transportation, and job supports. To address the whole health needs of our members, we: 1) link them with existing community resources, 2) collaborate with partners and stakeholders to systematically address barriers to good health, and 3) fund efforts that create healthier communities for our members. We will continue to expand on these efforts, as described in this section.

Linking Members to Community Resources

Our Community Engagement and Population Health teams continuously build relationships with organizations that make up the health care and social services safety net in West Virginia. We do this by

meeting directly with community partners, by participating in local coalitions and workgroups, and by sponsoring and coordinating local events and programs. Our partners offer community residents, including our members, support and resources related to key health determinants such as safe housing, nutritious food, transportation, education, and employment. These partnerships create reciprocal and mutually beneficial connections with critical community organizations and resources across the state. The following illustrates a sampling of the organizations with whom we partner:

- **Food Pantries.** Tender Mercy Food Pantry, Five Fishes 2 Loaves Food Pantry, Catholic Charities Mobile Food Pantries, Heart & Hand, Manna Meal, Covenant House, Mountain Mission
- **Community Action Organizations and Coalitions.** Coalfield Community Action, Partners in Prevention, Kanawha Communities that Care, Raleigh Co. Community Action
- **Family Resources.** Family Resource Networks, Parents as Teachers, Starting Points, Birth to Three, Tuesdays for Toddlers, Mountain Heart Community Services, East End Family Resource Center
- **Children's Services.** Children's Home Society, Healthy Grandfamilies, Children's Therapy Clinic, Boys & Girls Clubs, Baby Pantries, Camp KnoKoma, YMCA, Wade Center
- **Organizations for Individuals with Disabilities.** Down Syndrome Network of West Virginia, the Arc, West Virginia Centers for Independent Living, SILC, and Mental Health America/National Alliance on Mental Illness (MHA/NAMI)
- **Other Organizations.** Goodwill, Salvation Army, Backpack Buddy Program, YMCA, Crittenton Services, Rape, Education, Advocacy, Counseling, and Healing (REACH), House of the Carpenter, Workforce West Virginia Latrobe Street Mission, Strategic Planning in Occupational Knowledge for Employment and Success (SPOKES)

We are active participants in the communities we serve with broad reach into West Virginia communities. *Since January 2015, we have participated in more than 7,700 community events.*

Collaborative Program Development/Coalition Building

We work collaboratively with community-based organizations and other agencies in developing programs and initiatives that will benefit our members and communities. In many instances, these collaborations leverage the resources of multiple agencies, creating cost-effective services and resources for community residents. The following are some examples of these collaborative programs and initiatives:

Federally Qualified Health Center (FQHC) Diabetes Workshops. UniCare is working with a West Virginia FQHC in publicizing a series of diabetes workshops the FQHC is sponsoring and would like to see well attended. UniCare has agreed to text message all members residing in the county in which the FQHC is located, alerting them to the opportunity to attend this diabetes workshop series. This is the first time UniCare is using text messaging to announce community events being held by other agencies, and as such represents an opportunity to evaluate the impact and potential of this form of collaboration for use in partnership with other agencies. UniCare already uses text messaging for appointment reminders and to notify members of the need for preventive screening tests such as colon cancer and breast cancer screening.



American Heart Association (AHA). In conjunction with the AHA, we trained more than 1,000 community members in Hands-Only CPR. These community members included high school and college

students, DHHR staff, and staff of social service and other government agencies. In addition, we are partnering with the AHA to establish a community dialogue in Kanawha County on the epidemic of youth vaping. UniCare will provide sponsorship support to this initiative, which involves convening stakeholders to discuss how the community can address e-cigarettes, including policy and systems changes to prevent and reduce vaping among teens. These dialogues will bring together regional and local leaders to raise awareness, create synergistic relationships that generate momentum, and develop plans that will reverse the course of smoking and vaping.

Community Coalition Participation. UniCare staff members participate in community-based coalitions as a means to collectively address health-related problems, some of which are not resolvable by one organization or through medical intervention only. We currently have staff who are members of the following coalitions: REACH, the ARC of Three Rivers, and many other coalitions addressing diabetes, substance use prevention, and Healthy Grandfamilies. Because we have begun establishing relationships with housing coalitions, we will participate on homelessness coalitions, housing advisory committees, and food security collaboratives.

School Partnerships. Through our partnership with various schools and school nurses, we gain information and insight to child and adolescent health issues and the resources and approaches necessary to address these issues. For instance, as the opioid epidemic continues in West Virginia, teachers and staff have seen an increased need for supplying students with basics such as food, clothing, and hygiene products. We understand that when basic hygienic needs are not met, students are less likely to attend school, less likely to participate in discussions, and more likely to be exposed to peer bullying. To help address those needs, UniCare has created health education presentations and health tips on hygiene, presented by our Outreach Specialists in school settings. UniCare will be partnering with Communities in

Schools to further bridge the gap on SDOH by assisting the organization to build capacity to deliver wrap-around services.

Kiosks for Community Connection. To assist our members and other community residents in identifying local health care or SDOH resources, we will be placing tablets pre-loaded with a searchable directory of community resources and links to UniCare's website, the member portal, and our Healthy Rewards program at kiosks during our community outreach events or at community locations (for example, social service agencies, food and baby pantries, and homeless shelters). At community events, our Community Engagement and Population Health teams will be available to provide members and community residents with additional information, as needed, regarding these community resources.

UniCare's Healthy Night at the Ballpark. Initiated in 2016, UniCare hosts an annual Healthy Night at the West Virginia Power Park in which we treat children, families, schools, and representatives of community-based organizations to a minor league baseball game. We invite local community-based organizations such as the AHA, West Virginia University Extension Services, Heart & Hand, United Way, West Virginia SILC, the Fair Shake Network, and Mission WV to exhibit and provide healthy interactive activities and education to engage families prior to start of game.

Family Resource Networks (FRNs). The Community Engagement Team works collaboratively with the FRNs to assist in health promotion goals for the state as well as their county-specific health and wellness needs. Since we began serving West Virginians, we have successfully planned, implemented, and supported health and wellness projects in all 55 counties providing funding, resources, and expertise in health care matters, which has helped improved the lives of our statewide communities. Since 2014, UniCare has directly supported and participated in close to 340 FRN initiatives and projects to include community baby showers, health fairs, SUD prevention programs, smoking cessation programs, food

security initiatives, physical activity programs and challenges, community safety events, and child literacy initiatives. The Community Engagement Team also works with FRNs to help bring community resources and information to UniCare hosted events.

Safety Palooza Event. This UniCare signature annual event is a partnership with local housing authorities and FRNs. The event provides residents of low-income housing with a full-day of health and safety activities for children and families. Participating organizations include police and fire departments, health departments, highway safety agencies, libraries, and extension services. Common themes include fire safety, anti-bullying, internet safety, seatbelt and car seat safety, ATV safety, sun safety, and gun safety.

Investment in Local Programs and Infrastructure

Meeting the whole health needs of our members requires broad community collaboration and capacity. UniCare has a history of investing in local programs and capacity-building that can benefit community residents and our members. Since January 2018, Anthem Foundation grants and community relations sponsorships have provided \$437,570 towards community programming, and UniCare has invested \$564,169 in community sponsorships, programs, and donations. These investments are based on community need, priority health conditions, and priority populations. We describe some of these investments in the following paragraphs.

Stepping Stones. We are providing grant support to Stepping Stones, an organization that serves youth aging out of the foster care system. With support from UniCare, Stepping Stones is introducing a first-of-its-kind commercial greenhouse and tower garden farm to be operated by foster care youth and designed to provide fresh vegetables year-round. Stepping Stones' youth will grow food not only for themselves as residents of the village, but will also donate excess fresh vegetables to the area's homeless and recovery

community. Youth in the village will also have the opportunity to pursue a certification in agriculture in partnership with the West Virginia Department of Education Office of Diversion and Transition.

Overdose Lifeline. This program provides training to key partners in selected counties to implement two SUD prevention programs: This is (Not) About Drugs (a universal science-based program specifically designed to address prescription opioid misuse) and Preventure (an evidence-based program that takes a personality-targeted approach to adolescent substance use prevention). To date, 12 community partners have taken the introductory training. UniCare has supported the cost of training and supplies for community partners. Community agencies receiving support include Marshall Health, Partnership of African American Churches, United Way, Kanawha Communities That Care, school educators, and staff. This support allows for trainees to implement opioid prevention programs in middle and high schools across the state.

Healthy Grandfamilies. This is a new partnership. This program offers a free nine-session workshop to grandparents raising their grandchildren. Participants of the program receive a certificate of completion, a gift card, and follow-up services for three months. UniCare is supporting training costs for statewide social workers for the Healthy Grandfamilies program. By supporting these training costs, we are enhancing the capacity of social workers to assist at-risk children and adolescents in accessing health and social services. UniCare has already supported the printing costs for training materials for community partners/coalitions of Health Grandfamilies program statewide.

Mobile Grocery Program. UniCare has provided a grant supporting this new mobile grocery program. This program will directly reduce food insecurity and improve health outcomes by providing healthy and nutritious foods to residents of Clay County. The last grocery store in Clay County recently closed, creating a true food desert. This grant will help support access to fresh meats and produce primarily for

Clay County residents, and will also expand reach to surrounding rural communities in Boone, Kanawha, Logan, and Putnam counties. Currently, Clay County residents have to travel 45 minutes to an hour (one way) to the nearest grocery store. Funding will support refurbishing of a school bus (donated by Kanawha County Schools) with shelving, refrigerators, and freezers. The school bus will be donated through Kanawha County Schools. With the Mobile Grocery Store, communities will have access bi-weekly to purchase healthy food (cash, credit and/or SNAP benefits accepted for payment).

School-based Health Centers (SBHCs) Well Child Incentive. In 2018, 152 schools offered clinic services (including mobile units) in 38 West Virginia counties. The largely rural geography of the state made SBHCs an ideal community partner to increase access to high-quality primary care for children and adolescents. Serving youth at school where they are already spending most of their day reduces transportation needs and minimizes lost instructional time. For each completed checkup, eligible families earned a \$25 incentive. SBHCs earned a \$25 incentive for each completed medical record for a well-visit. In the 2018-19 school year, the host school of an SBHC with the highest percentage of completed medical records with well care visits received a \$3,000 — an increase over previous years. After four years, the contest demonstrated dramatic improvements in three HEDIS measures. Members completed more than 8,000 exams that likely would not have otherwise been completed. Associated HEDIS rates increased more than 11 percentage points, exceeding state goals of achieving 5% increases over baseline rates. During the fourth year, we distributed more than \$89,000 in incentives to schools, members, and school-based clinic providers.

West Virginia Health Right. We support the rural area clinic day annually, which offers medical services, such as eye exams and dental care, to hundreds of uninsured or underinsured community members.

In summary, UniCare has established strong relationships with many partners and stakeholders across West Virginia; relationships that benefit our members in achieving optimal health and wellness. For our part, we collaborate with these and other partners on programs that address persistent societal issues, such as homelessness and housing insecurity and highly prevalent chronic conditions such as diabetes. Finally, we provide financial support to programs supporting at-risk children and adolescents, communities with food deserts, and individuals at-risk for opioid overdose, a significant problem for communities throughout West Virginia.

MS048 1 The Vendor should describe how they will foster cultural competency among staff.

Cultural Competency Among Our Staff (MS048)

We foster cultural competency through a local, multi-faced approach (Figure 6.5-20) that values West Virginia's culture and diversity.

Since we began serving West Virginia members, UniCare has continuously worked to foster cultural competency among our staff, making sure that culturally

Figure 6.5-20. Cultural Competency



competent practices — such as honoring members' beliefs, fostering inclusion and diversity, and adopting attitudes and interpersonal communications styles that respect their cultural backgrounds and linguistic preferences — are part of our organizational culture. Our policies and procedures incorporate all 15 federal culturally and linguistically appropriate standards regarding cultural issues, languages, and readability across our organization, so that we provide culturally competent, high-quality care that is responsive to our members' needs and preferences.

Training and Education to Foster Cultural Competency

All of our staff receive cultural competency training as part of new hire orientations and annually thereafter. Our training includes a local, tailored curriculum developed by fellow West Virginians who have an in-depth understanding of local communities and regional needs. Our training delves into local geography (such as how mountainous regions affect health care access and needs); cultural and historical context that have shaped attitudes and social conventions; and demographics, so that our member-facing staff are fully prepared before they begin taking calls. Similarly, as part of our extensive training, all employees who directly interact with members must attend a full-day orientation, which covers the cultures of West Virginia and our membership, such as Appalachian culture and communication, and their needs and linkage to food, culture, and socioeconomic status. For example, we customize our training to local details enabling our employees to learn and embrace the Appalachian culture and nuances in dialect, preferences, and values. For any of our staff who have not been exposed to all types of West Virginia cultures, we provide the information they need. For example, our local West Virginia leadership takes team leaders from our national call center on a tour of West Virginia, to immerse them in the culture and geography of the area, giving them firsthand experience to shape their training and customer service approach. As we implement a new local call center in our Charleston office, we will hire from the local community and make sure these new employees are fully trained and knowledgeable about West Virginia culture and the populations we serve.

Further, as part of training, we met with community leaders, community and faith-based organizations, and local providers to increase our staff's knowledge and understanding of West Virginians. For example, we identified training on Appalachian Culture and Disability Etiquette through the West Virginia University Center of Excellence in Disabilities, and are exploring ways to bring this training to our staff.

We also focus on providing training to enhance competencies relevant to disabilities, chronic conditions, and unique or specialized health care and service needs. For example, our Member Services staff participate in training that includes role-playing exercises designed to enhance their understanding and skills in serving the needs of members with disabilities. Our Mental Health First Aid training presents an overview of mental health and substance use disorders, and gives participants the key skills to help someone experiencing the onset of a mental health condition or experiencing a mental health crisis.

Recruitment and Retention

We foster culture competency beginning with the people we hire. We use recruitment and retention strategies designed to build an inclusive, culturally diverse and competent workforce that reflects the culture, races, and ethnic backgrounds of our members. We make it a priority to hire and train individuals from West Virginia communities. For example, we routinely recruit from local universities and attend career fairs at Marshall University, West Virginia University, University of Charleston, and West Virginia State University. In September 2019, we also partnered with both Marshall University and the West Virginia Autism Training Center on Disability Mentoring Day to promote career development for students and job-seekers with disabilities and provided them with \$7,500 in funding.

Associate Resource Groups

- African American Professional Exchange (APEX)
- Asians Committed to Excellence (ACE)
- Disability Inclusion Network (ABLE)
- Healthcare Young Professional Exchange (HYPE)
- Promoting Respect, Individuality, Diversity, and Equality (PRIDE)
- SOMOS (Hispanic/Latino)
- Veterans of Anthem (VOA)
- Working @ Anthem in a Virtual Environment (W@VE)
- Women's Inspired Network (WIN)

As part of our retention efforts, we foster an inclusive culture where all employees feel welcomed, respected, and valued for their unique perspectives. We offer them the opportunity to share their ideas and build relationships relevant to their culture and values through our

Associate Resource Groups. These groups also contribute to cultural competency. For example, the PRIDE resource group is currently providing input around LGBTQ as part of our cultural competency training.

Communication

Communication skills are the best way to fully understand a member's needs, values, and preferences. We use a person-centered approach, which focuses on identifying the needs of the individual, as well as their beliefs, communication styles, decision-making preferences, the roles of family in their culture, and other factors. West Virginia has seen a range of cultures in its immigrant populations, from Germany, India, China, and the Philippines. We know that culture can influence everything from what members are willing to talk about, what medications they are willing to take, what food they are willing to eat, and how they prefer to receive bad news. We take time to listen to our members and make sure we fully address their questions and concerns. Support needs vary from person to person, and we staff our Member Services and Care Management departments to be responsive to individual uniqueness. Further, we make certain clinical assessment and care plans reflect relevant cultural issues, as well as each individual's unique strengths and needs, as part of a person-centered approach. *In June 2019, our clinical staff attended training on Person Centered Thinking® by the Learning Community for Person Centered Practices, which offered hands-on learning to integrate person-centered thinking into their day-to-day practices and interactions with members.* Our written communications are developed to be culturally relevant and easily understood, and are available in a member's language or preference, and in various forms (large print, audio, or braille).

6. ENROLLMENT AND DISENROLLMENT

- ED001 1 The Vendor should describe its policies and procedures regarding enrollment of members, including the processing of 834 enrollment files.



UniCare has served West Virginia for 17 years and has implemented robust policies and procedures that enable us to successfully meet the State's expectations and program enrollment and disenrollment requirements. We will continue to partner with the State to make sure the enrollment and disenrollment process is not only compliant, but also as straightforward and transparent as possible for our West Virginia members. The extensive experience of the Enrollment and Billing team of our ultimate parent company, Anthem, Inc. (Anthem), coupled with our deep familiarity with West Virginia's Medicaid Management Information System enables us to continue collaborating successfully with the Bureau for Medical Services (BMS) on member enrollment. Our Enrollment and Billing team is experienced in receiving and processing incremental and full roster files from the enrollment broker under the current contract. We regularly receive membership data for West Virginia Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB) through electronic media. We support transmission of enrollment data using the HIPAA-compliant ASC X12N 834 (834) transaction, or any other formats required. We obtain these files using an automated SFTP process that monitors for their availability and transfers them to a predefined location for processing by our Core Services System.

Experience Matters

Richard Grooms
 Member Services Director



Richard has more than 10 years of experience leading activities related to member services operations.

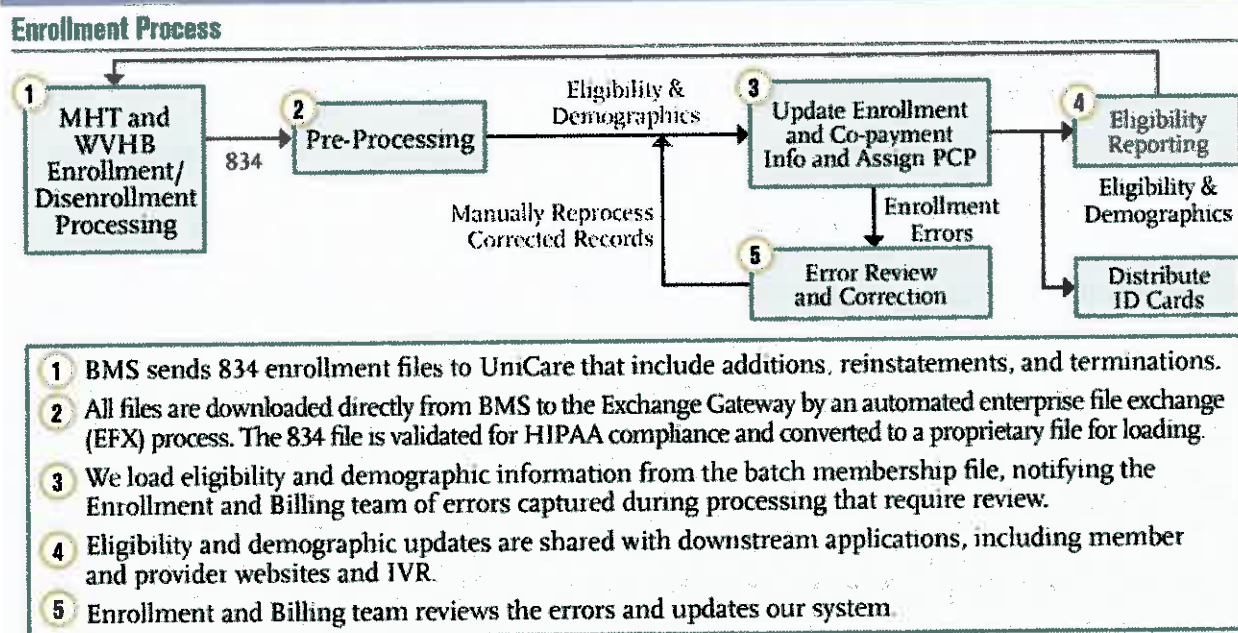
UniCare employs enrollment policies and procedures that support the loading and processing of enrollment records promptly and accurately to give our members immediate access to services. Accurate and prompt enrollment also begins critical processes that engage our members in their own health care, such as new member welcome calls, initial health assessments, and connections to PCPs. We maintain

operational systems for processing and reconciling member enrollment that consistently exceed existing contract requirements, and we will continue to process enrollments using these operational systems.

Processing Enrollments Efficiently to Support Various Functions

Processing enrollment information quickly is critical to both member engagement and effective operations. UniCare currently processes 99.9% of the approximately 160,000 enrollment and disenrollment transactions we receive each month without any manual intervention, enabling us to transition new members into care smoothly and making sure they have access to the services they need. UniCare's approach to receiving, processing, and loading member enrollment data on 834 enrollment files from BMS is already in place under our current Service Provider Agreement and has been refined in partnership with BMS. Our processes comply with the requirements for 834 transactions, and we acknowledge all enrollments become effective on the dates specified in the 834 enrollment file. Our comprehensive process is depicted in Figure 6.6-1.

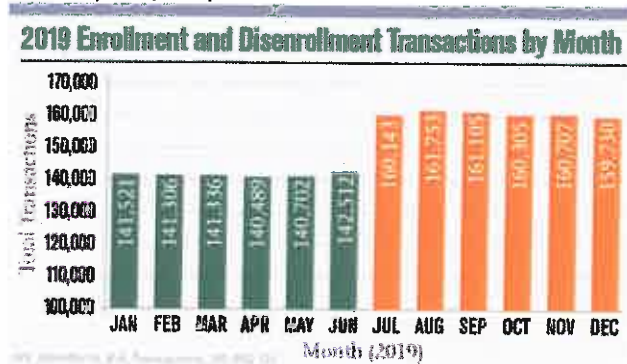
Figure 6.6-1. Our Well-honed Processes Support Accurate and Timely Enrollment for Our Members



As noted in Figure 6.6-1, UniCare retrieves BMS 834 enrollment files through an EFX process. We validate each 834 enrollment file for HIPAA compliance, and convert it to a format suitable for loading in our systems. The two 834 enrollment files we receive monthly include member additions, reinstatements, and terminations. We load each member into the correct group within the Core Services System based on tier level and demographic information provided in the 834. While loading each record, we note potential enrollment errors, which are sent to our Enrollment and Billing team for analysis, resolution, and reprocessing. Once each record has been successfully loaded, we auto-assign a PCP based on a series of business rules that consider previous PCP relationships, location, and other relevant factors, and process ID cards for distribution to members. The enrollment information is also shared with a variety of downstream applications, including our provider and member websites and our IVR.

Exceeding Expectations on Automated Enrollment Processing

Figure 6.6-2. UniCare Enrollment Transaction Volume Is Currently 160,000 per Month



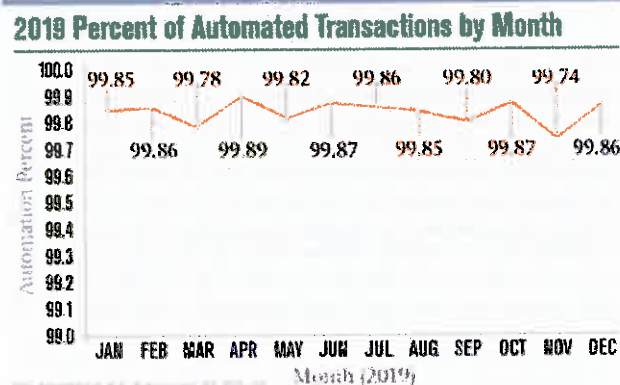
We currently process approximately 160,000 individual enrollment and disenrollment transactions every month, more than any other MCO in West Virginia, as noted in Figure 6.6-2. The significant increase in monthly transaction volume in July 2019 represents an influx of members related to the exit of West Virginia

Family Health from the market. In 2019, we processed 99.9% of each month's transactions without requiring any manual intervention, as noted in Figure 6.6-3. Such high levels of automation help us to make sure our members receive the services they need, when they need them.

We process 834 enrollment files monthly and load this information to the Core



Figure 6.6-3. Our Robust Processes Enable 99.9% Processing of Transactions Without Manual Intervention



Services System. Our systems are configured to process and load 834 enrollment files as often as they are provided. As noted in Table 6.6-1, we exceeded the SLA requirement of loading the 834 enrollment files in fewer than three calendar days in every month in 2019, typically loading within a single calendar day.

Table 6.6-1. UniCare Exceeded the Contract Requirement for Loading 834 Enrollment Files in Every Month in 2019

834 Enrollment File Load Time	2019											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Days	1	1	1	1	1	2	1	1	1	1	1	2

Our Core Services System provides a fully integrated database for all our members and supports key business functions such as member reporting, claims processing, PCP assignment, and utilization management (UM). When we are notified of a new member through receipt of an 834 enrollment file from BMS, we accept and process the unique State-issued Medical Assistance ID (MAID) to track and manage the individual throughout all systems within our span of control, including our relationship with subcontractors. This unique number stays with members even as they move between products or if they are disenrolled for any reason and then return.

Processing Enrollment of WVCHIP Members

UniCare will build on existing enrollment processing procedures and work closely with the West Virginia Department of Health and Human Services (DHHR) and West Virginia Children's Health Insurance Program (WVCHIP) to implement necessary updates to our WVCHIP load processes. We will

continue to meet or exceed our internal goal of processing at least 99% of enrollments without manual intervention and our SLA requirement of loading all records within three calendar days of receipt.

UniCare has a track record of successfully bringing new populations into our membership. In each of these transitions, particularly after the West Virginia Family Health exit in July 2019, which had a short transition window, we were successful in loading the additional enrollment volume of new members efficiently and accurately, meeting or exceeding automated processing goals, and meeting our SLA requirements. Examples of significant transitions include:

- The Medicaid Expansion population in 2015
- The Supplemental Security Income Aged, Blind, and Disabled population in 2017
- The assumption, most recently, of former West Virginia Family Health members in 2019

During those implementations, our Enrollment and Billing team was proactive in asking DHHR for the detailed information needed to facilitate a smooth, accurate transition from fee-for-service (FFS) into our systems for our new members. Our Enrollment and Billing team has established contacts with DHHR by collaborating regularly, enhancing our ability to communicate effectively back-and-forth.

Monitoring Accuracy of Information Received and Processed

We retrieve all 834 enrollment files from BMS through SFTP, and we subject all files to HIPAA compliance edits before processing. If the file passes HIPAA compliance checks, we perform additional edits against BMS-specific criteria, such as field length and type, and required data elements. If the file does not pass these checks, our Core Services System stops processing the record and places it in a queue for manual review. Our Management Information System team performs a review of the error or reason for fail. If the reason is external (for example, missing data), we contact BMS and request a corrected file. If the error appears to be an internal issue, we log and correct it.

We evaluate each record on the 834 enrollment file and execute appropriate business rule checks, whether it is an addition, termination, or change, and update the Core Services System accordingly. Our process includes logic to compare member demographic data on the incoming 834 enrollment file against our member data to make sure we record the most current information. The enrollment file load process establishes “begin” and “end” dates for members under their current MHT or WVHB program eligibility category. Members’ eligibility information may change periodically as they move between programs, and that information is captured promptly and accurately while maintaining historical data. This level of detail enables us to provide appropriate services and accurately process all claims, even when the member’s eligibility changed after the claim date of service.

Our process generates batch enrollment reports that list member-level activity and identifies any errors. Our enrollment data analysts who specialize in West Virginia data review the reports, investigate errors, and work closely with the lead enrollment business analyst to resolve issues.

UniCare in Action: Proactively Collaborating with DHHR To Avoid Interruption of Member Services

We continuously work closely with DHHR any time a concern or issue is identified. Our Enrollment team considers these requests high priority and makes every effort to make sure members’ services are not interrupted.

Several years ago, during the transition to MAXIMUS as our Medicaid Enrollment Broker, we experienced a significant and unexpected increase in 834 data issues that caused challenges in our enrollment file load process, such as duplicate records reported, incorrect or invalid data values, and extra spaces in the file layout.

We convened a working group with our Compliance team and DHHR to identify and correct root causes, with an immediate goal of making sure member enrollment data was loaded accurately each month. We conducted regular status meetings, and DHHR asked other MCOs to join us, as they were experiencing similar issues. These meetings have continued and become the regularly scheduled status meetings that DHHR now conducts with all MCOs.

We continue to receive requests for research or process updates on a regular basis, and we involve DHHR, as needed, to resolve them quickly and efficiently. We also use this research and process improvement opportunity to refine our internal processes, which has increased our automation load success rate and reduced manual intervention required.

WV, 20200119, 834, 20200119, 834, 20200119

- ED002 1 The Vendor should describe its policies and procedures regarding disenrollment of members, including processes for reconciliation of members against the monthly 820 capitation file.

Efficiently Processing Member Disenrollment Transactions (ED002)

UniCare notifies BMS through the monthly Member Status report when we become aware of a change in a member's circumstances that may trigger disenrollment. Typical changes in circumstances that are brought to our attention by our Member Services team or our providers may trigger a loss of eligibility or a transition to a different eligibility category under FFS. UniCare specifies the reason for the requested disenrollment, so that BMS can assess whether the disenrollment rationale is consistent with permissible reasons specified in the contract. BMS makes the final decision to approve or deny the requested disenrollment.

After notification of disenrollment rationale by UniCare, BMS notifies the enrollment broker of the member's loss of or change in eligibility. The enrollment broker processes the managed care disenrollment transaction, notifies the member or family, and updates the 834 enrollment file sent to UniCare. Once we receive the updated 834 enrollment file that no longer includes that member, we update our Core Services System, which effectively processes the disenrollment with appropriate updates to PCP enrollment rosters. On established schedules, we report current members to applicable vendors and subcontractors as part of our normal communications about member eligibility, specific to each vendor or subcontractor, so that any members no longer enrolled will also be processed by their systems.

UniCare's Finance team reconciles membership on a monthly basis, using the following steps to compare the latest 834 enrollment file to the detailed 820 capitation file received from BMS:

- Calculate estimated premiums by multiplying 834 enrollment and latest contractual rates
- Compare to capitation payments received in the detailed 820 file
- Remove known variances for rates or timing differences
- Identify remaining variances

- Send variances to our Enrollment and Billing team for research

Our goal is to make sure capitated payments are appropriate and accurate. In 2018 and 2019, our reconciliation process indicated there was no significant unknown payment discrepancy.

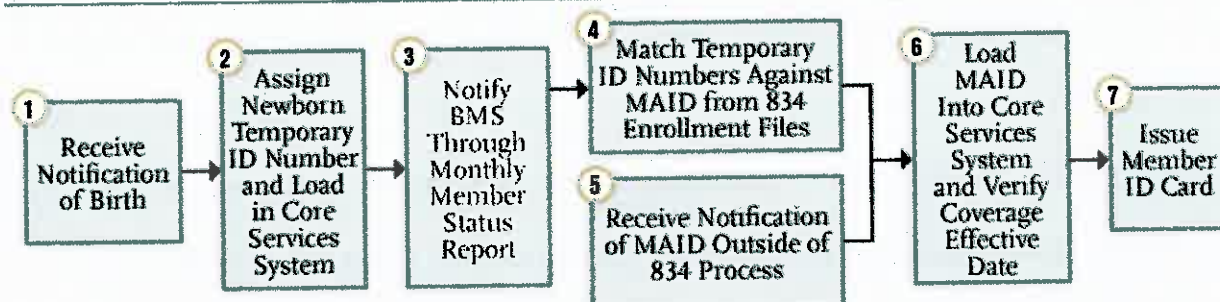
- ED003 1 The Vendor should describe its written policies and procedures and protocols for enrolling newborn children of members retroactively to the time of birth, and transferring newborn information to the Department for processing.

Enrolling Newborn Members Accurately (ED003)

UniCare has developed and refined protocols, as shown in Figure 6.6-4, for enrollment of newborns as part of our existing contract, meeting the program requirements of enrolling newborn members retroactively to time of birth and transferring that information to DHHR for processing.

Figure 6.6-4. UniCare Makes Sure Newborns Are Enrolled Promptly, So They Can Receive the Services They Need

UniCare Newborn Enrollment Process



- 1 Providers notify UniCare of births through the claims submission process.
- 2 Newborn information and temporary ID numbers linked to the mother are loaded into Core Services System with coverage beginning retroactively at date of birth.
- 3 The Enrollment department forwards newborn information to the Regulatory department for notification to BMS through the monthly Member Status report.
- 4 Standard rules match temporary ID numbers against MAIDs in the 834 enrollment files.
- 5 Occasionally, UniCare is notified of MAID assignment outside of the normal 834 enrollment file process, and MAIDs are entered into Core Services System manually.
- 6 Coverage effective date is verified to be retroactive to the newborn's date of birth.

Enrolling Newborns and Establishing Temporary IDs

UniCare enrolls newborns when hospitals notify us of births related to any member, when a claim is received, or occasionally when we receive notification through our member hotline. Providers notify us of the delivery of newborns via the Newborn Enrollment Notification report, which is available online. Providers complete the form and fax it to our UM Intake department. UM Intake then notifies our Enrollment and Billing team via the Enrollment SharePoint site established for newborn notification. The effective date of the enrollment is retroactive to the newborn's date of birth.

The Enrollment and Billing team verifies the mother's eligibility and manually loads each newborn's information into the Core Services System under the newborn membership group with a temporary ID number, which we use until the permanent MAID is received. The temporary ID number consists of the first eight digits of the mother's MAID with the last three digits indicating NB1 or NBx with x representing additional newborns in the case of multiple births. We load all available identifying information into the Core Services System.

Notifying DHHR of Reported Newborn Members

Each weekday, the Enrollment and Billing team faxes copies of the Newborn Enrollment Notification forms to MAXIMUS. By the 15th of each month, our Enrollment and Billing team enters information on the "Reported Newborn" tab of the monthly Member Status report. The Member Status report was originally initiated and created by UniCare as a process improvement, working with DHHR and other MCOs, to facilitate consistent and accurate information sharing with DHHR. Our Enrollment and Billing team forwards the information to our Regulatory department, which reviews the assembled information and is responsible for submitting the monthly Member Status report to DHHR.

Confirming Newborn Enrollment

To confirm enrollment, we use our Enrollment SharePoint site to identify newborns with incomplete information, typically related to name or MAID. We call the hospital of birth to obtain missing information on name and MAID and update the Enrollment SharePoint site, as applicable. Our Enrollment and Billing department monitors the SharePoint site for updates; if a permanent MAID becomes available, the team terminates the temporary ID and manually adds the permanent MAID under the appropriate membership group linked to the same Core Services System subscriber ID.

We receive official confirmation of newborn enrollment and the assignment of the permanent MAID through the 834 enrollment files. We have configured detailed process logic in our Core Services System to find a match between permanent MAIDs obtained through the 834 enrollment file and temporary newborn information that was assigned in the Core Services System. All newborn MAIDs received are added to the Core Services System, so that newborn members are accurately enrolled. When we find a match between an MAID and a temporary ID, we terminate the temporary ID and manually add the permanent MAID under the appropriate membership group linked to the same Core Services System subscriber ID. During that process, we also manually verify the enrollment date has been set correctly to the date of birth and generate the newborn member's ID card.

Reconciling Permanent MAIDs and Temporary Newborn IDs

Each year, DHHR requests a report that crosswalks temporary and permanent MAIDs. At that time, our team identifies, reviews, and validates any temporary newborn IDs that have not been linked to permanent MAIDs.

The monthly Member Status report provided to DHHR also contains a tab for "Newborns Needing Reconciliation," which is a list of newborns who have temporary IDs in our system but have not yet

received permanent MAIDs. Our Enrollment and Billing team reviews this list monthly, researches each temporary ID to verify whether a permanent MAID has been received but not linked, and contacts the hospital of birth to obtain the MAID and other relevant newborn information. We also conduct regularly scheduled system jobs that search for temporary newborn IDs open in our Core Services System that have been active and eligible for 90 days or more without linkage to a permanent MAID. This process provides an additional data point for researching whether the member is actively enrolled in UniCare.

While the information contained on the “Newborns Needing Reconciliation” tab is useful to UniCare internally, we believe it would also be a beneficial tool for DHHR to use in reconciling and communicating accurate newborn enrollment and demographic information across MCOs. We are open to discussing with DHHR and the other MCOs a consistent way to use this tool to streamline the newborn enrollment process.

- ED004 1 The Vendor should describe its protocols to cover newborns even if the mother does not remain enrolled after the newborn's date of birth.

Covering Newborns Whose Mothers Are Disenrolled (ED004)

Once a newborn has been enrolled with UniCare, we consider them an individual member whose enrollment status is not affected by the status of other family members. We continue to cover newborn members regardless if their mothers remain enrolled with us, in accordance with program requirements. As long as a permanent MAID has been assigned to the newborn, our eligibility process continues to verify the newborn as an eligible member.

- ED005 1 The Vendor should describe its written policies and procedures for transferring relevant member information, including medical records and other pertinent materials, when a member is disenrolled from the Vendor and enrolled with another Vendor.

Seamlessly Transitioning Members Who Change MCOs (ED005)

UniCare has been responsive to requests for transition assistance from members and other MCOs when members switch to another MCO. We know when a member is disenrolled from UniCare, but we do not know if they have become ineligible or moved to another MCO. Therefore, we rely on outreach from other MCOs before we can provide information.

Typically, our Member Services Representatives handle requests for transition assistance or the transfer of clinical information and medical records. We make every effort to facilitate this process, and we reach out for similar support from other MCOs when members switch to UniCare.

Making the Transition Process Smoother for Members and MCOs

We believe there is an excellent opportunity to make the transition process smoother for DHHR, all West Virginia MCOs, and most importantly our West Virginia members. Some of our affiliate plans, for example, have developed templates, in collaboration with other MCOs and State agencies that provide consistent sharing of data when members transition between MCOs. We are open to working collaboratively with DHHR and the other MCOs on a more formal approach to communicating member transitions. We suggest developing shared guidelines and protocols for easing the administrative burden on DHHR and making the transition process more seamless for members. We suggest considering the use of a standard template that specifies information to be transferred, and the use of the monthly Member Status report as a communication tool so that MCOs can be proactive in sharing relevant information.



Resolving Member Concerns to Minimize Transfers between MCOs

We acknowledge, of course, that members can move freely between MCOs without restrictions and are committed to making the transition process as smooth as possible; however, we believe it is in the best interest of quality and continuity of care for West Virginia members to remain more consistently with the same set of providers, case managers, and other support teams in the long-term. We make efforts to develop relationships with our members that enable us to address concerns that might otherwise cause them to switch MCOs. We also use our excellent customer service and processes, our Value-Added Services, and abundant community partnerships to encourage members to stay with UniCare long-term, because we believe consistent care is the best option for them.

7. NETWORK DEVELOPMENT

- ND001 1 The Vendor should describe how they will establish and maintain a provider network that provides statewide access to geographically accessible hospitals, primary care, specialty care, dental providers, and all other required provider types and specialties.

Establishing and Maintaining an Accessible Network (ND001)

The long history of UniCare Health Plan of West Virginia, Inc. (UniCare) of partnering with the West Virginia Department of Health and Human Resources (DHHR) and developing and maintaining comprehensive provider networks that meet the evolving needs of our members is testament to our ability and commitment to provide a multidisciplinary and comprehensive network for the MHT programs.



UniCare's Comprehensive Physical and Behavioral Health Network

UniCare offers a well-established, comprehensive, statewide MHT network of more than 14,100 unique Medicaid-enrolled providers and facilities contracted and able to serve our all populations under the MHT



program. Our geographically accessible network of hospitals, primary care, specialty care, dental providers, and other required provider types and specialties, includes providers for all MHT covered services and supplemental Value-Added Services (VAS).

Maintaining a robust provider network assures members have timely access to quality care from qualified providers for all program covered services.

Our network meets current State access standard of 100% accessibility (time and distance) for PCPs, hospitals, dental providers, and behavioral health (BH) providers. Our network includes all West Virginia substance use disorder (SUD) providers and Federally Qualified Health Centers (FQHC)/Rural Health Clinics (RHCs), including more than 3,700 PCPs — of which 3,447 are PCPs serving adults at over 1,500 primary care locations and 3,392 are PCPs serving children at over 1,400 locations. Our network also includes more

than 990 BH providers, including psychologists, psychiatrists, licensed professional counselors, and licensed clinical social workers, of which more than 920 of these serve children. Our network includes 5,040 non-BH specialists, with more than 4,800 serving children. Other specialties include 362 OB/GYNs at more than 230 locations, 530 pediatricians, and more than 180 pediatric/child/adolescent specialists.

We contract with 27 urgent care centers across the state. Our Network includes all West Virginia residential treatment providers, including the three Psychiatric Residential Treatment Facilities (PRTF). We contract with all 75 West Virginia FQHCs and RHCs, and 12 of 13 Comprehensive Behavioral Health Centers (COMPs) as well as Licensed Behavioral Health Centers (LBHCs).

Hospitals, PRTFs, and BHCs

Our network provides access to the full range of specialty and facility service providers for members in applicable populations with complex needs. We contract with all West Virginia hospitals, including 79 acute care hospitals, 40 tertiary hospitals, and 12 inpatient psychiatric facilities, including children's hospitals. UniCare's network includes all three West Virginia PRTFs and 12 of 13 West Virginia COMPs. The only non-participating COMP, Northwood, accepts our members as an out-of-network (OON) provider, and we are in discussions with them regarding network participation.

Dental and Vision

UniCare subcontracts with SKYGEN USA, LLC (SKYGEN) for member dental services; Vision Service Plan Insurance Company (VSP) is our vision benefits manager. Through SKYGEN and VSP, our members have access to a network of over 580 dental providers, including 48 oral surgeons, 42 orthodontists, and 140 vision providers. Our subcontractor oversight program facilitates a culture of compliance and high performance, with effective processes, tools, and controls to prevent, detect, and correct non-compliance with legal and regulatory requirements, program integrity, and standards of

conduct, as described fully in our response to Attachment 3, Vendor Qualifications and Experience.

UniCare's Network Development Approach

UniCare's network development approach is an ongoing process of assessment and recruitment. We prohibit providers from segregating Medicaid members from any program service or manner and timeliness of such services or based on personal attributes. This includes prohibiting providers from closing panels for Medicaid members only.

Our Provider Services department, overseen by Network Development Director, Terri Roush, establishes and maintains our provider network. Our staff utilize our network development and contracting strategy (Figure 6.7-1) to establish, maintain, and enhance our network through extensive one-to-one outreach.



Figure 6.7-1. UniCare's Network Development and Contracting Strategy

UniCare's Network Development Strategy	
1	Review expected membership and expected distribution across the state
2	Determine the number of providers, by type and location, needed to properly support the program based on access standards and travel distances
3	Engage providers currently serving our West Virginia Medicaid members to determine referral patterns and get recommendations for additions to our network
4	Proactively communicate with potential providers regarding our strengths and experience in Medicaid, including our hands-on approach to provider relations and our focused support of providers
5	Develop contract terms and conditions that clearly define UniCare's expectations for performance and hold all parties accountable for the success of the program
6	Continuously monitor and adjust our recruitment focus to confirm our network meets West Virginia Medicaid access standards and the needs of our West Virginia Medicaid members
7	Thoroughly onboard and proactively train new network providers through our UniCare Training Academy
8	Provide exceptional ongoing technical assistance and support

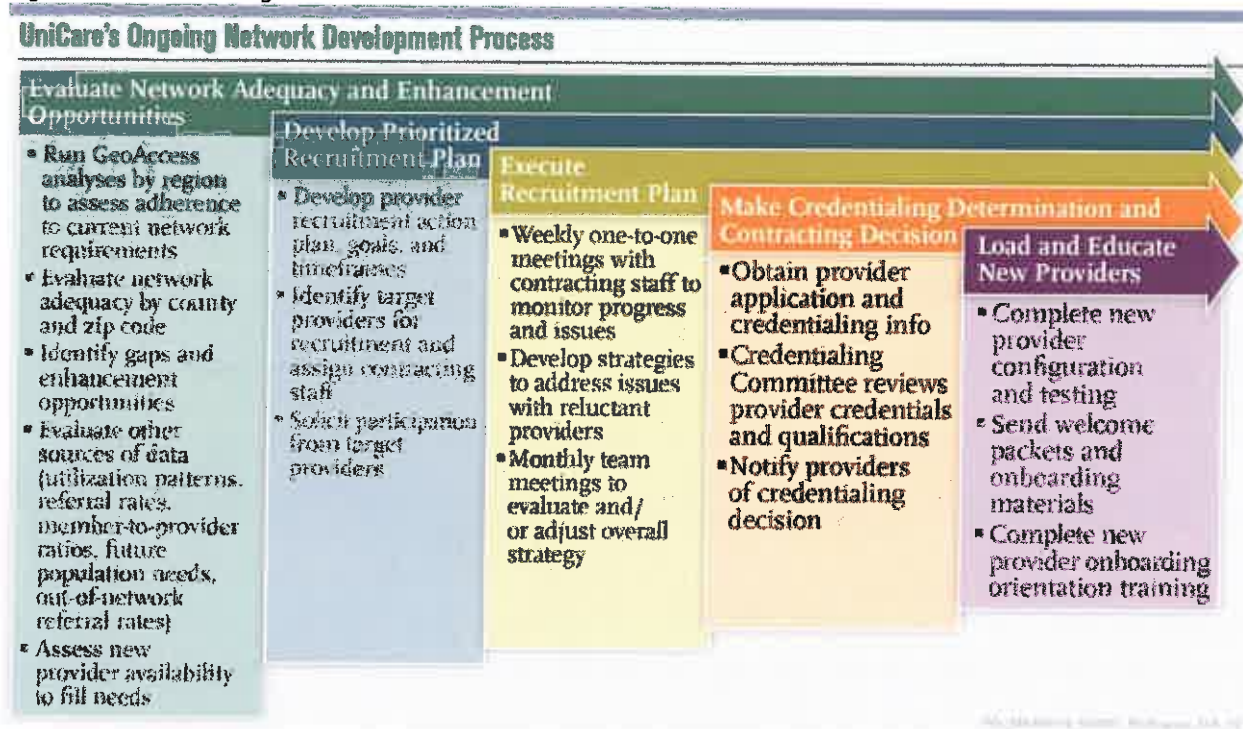
Our Provider Network Managers are responsible for developing, maintaining, and enhancing our provider network. Under the leadership of our Network Development Director, our Provider Network Managers develop and enhance the provider network through recruitment, relationship development and maintenance, and contract negotiations with complex providers, including large institutional providers, large medical groups, and ancillary providers. We build a cost-effective, high-quality provider network

and make sure network composition includes an appropriate distribution of providers across all required specialties. We refine our network adequacy assessments, provider-specific recruiting strategies, contracting and credentialing processes, and provider outreach and education approaches. We identify potential new providers through input from our internal staff (including member outreach, provider services, and medical management), input from existing network providers, members and their families, community-based organizations, advocates, and regulatory boards of licensed providers. We stay actively engaged with numerous provider associations, including the West Virginia Office Manager's Association and West Virginia Behavioral Health Association, to identify and recruit providers who are trusted and respected, offer appropriate and accessible services, and meet geographic access needs. We also identify providers who are not enrolled as West Virginia Medicaid providers for recruitment consideration.

Our Network Relations Consultants help maintain and strengthen our network relationships by conducting regular face-to-face visits with our providers and their staff, communicating administrative and programmatic changes, facilitating and delivering provider education, and resolving provider-related issues. They also assist providers and their staff with contracting questions, prior authorizations, claims submission, and processes related to credentialing, needs assessments, and electronic remittance advice (ERA)/electronic funds transfer (EFT). Most important, they live and work in their local communities and personally know their providers. This approach is key to building collaborative long-lasting provider relationships. Our Provider Services department is described more fully in our response to PS001.

Understanding all providers must be enrolled with the State as a Medicaid provider in order to participate in our network, we encourage them to enroll, explain the enrollment process, and direct them to the State website. Once State-enrolled, we recruit them to participate in our network. Our network recruitment, contracting, credentialing, and monitoring processes are summarized in Figure 6.7-2.

Figure 6.7-2. Monitoring Our Provider Network



Maintaining and Enhancing Our Network

We assure statewide access to geographically accessible providers, including hospitals, PCPs, specialists, dental providers, and all other required provider types through ongoing and continuous monitoring of our network against the Bureau for Medical Services (BMS) access standards and general network requirements prescribed in Service Provider Agreement (SPA) Appendix J, using Quest Analytics® software, as well as our network assessments and provider and member feedback. We report the results of our network analysis to BMS as required. We develop action plans to address any deficiencies, which may include submission of exception requests to BMS, as applicable, if no appropriate providers are available within the specified travel time standards.

Our analysis includes geographic access mapping, gap analysis, and review of availability of potential new providers by type to respond to member needs. We contract with all eligible providers, including out-of-state providers with locations both within and outside the access standard, to provide enhanced access for

our members. For example, we contract with 25 hospitals located in Ohio, Pennsylvania, Maryland, Kentucky, and Virginia, including Shriners Hospitals for Children. UniCare has contracts with over 3,600 unique PCPs and specialists outside of West Virginia to support members seeing providers near their home, and to support a strong provider network with specialty types that may not be available in West Virginia.

Network analysis is ongoing, with a targeted focus in instances of deficiencies in access, changes in membership, loss of a significant provider, or changes in DHHR time and distance standards. Based on this ongoing statewide network adequacy evaluation, we identify areas of focus for ongoing network development activities to further assure gaps are addressed proactively.

Addressing Access Challenges

UniCare continuously monitors network access for all provider types and services. Our network is robust and meets 100% of current time and distance (minutes/miles) standards for adult and pediatric members for PCPs, hospitals, BH providers and facilities, outpatient SUD providers, and general dentistry and other services, as previously described. Our specialist network meets access standards in areas across the state where specialty providers are available; however, in rural West Virginia, specialist access is less than 100% of the State access standards due to the lack of available providers in those areas.

UniCare is committed to assuring adequate access to services in West Virginia's rural and mountain areas. We recognize a challenge plaguing rural communities is the lack of existing Medicaid providers, particularly specialists, which increases appointment wait times and displaces demand for specialty services to urban communities. Where deficiencies exist, we take concrete steps to analyze the deficiency and implement action plans to expand access. We report to BMS all identified instances of a county, area, or region with accessibility deficiencies. Our Network Relations Consultants assesses provider referral and member care utilization patterns to identify contracting opportunities in underserved areas through:

- Contracting with providers new to the area or county
- Contracting with out-of-state providers in border states
- Collaborating with network providers to expand hours or open a second location in underserved areas
- Collaborating with providers offering part-time office hours
- Promoting the use of physician extenders, including physician assistants, nurse practitioners, and certified nurse midwives
- Promoting and expanding access to telemedicine to bring care to patients
- Facilitating access through single-case agreements (SCAs) with OON providers

We also leverage the experience and best practices of our affiliates to inform our West Virginia strategies. For example, our telemedicine strategy (described in our response to ND014) expands access to specialty providers by offering for virtual consults for PCPs through our relationship with ConferMED. A similar strategy is being implemented in our California, Indiana, and Kentucky affiliates markets.

Below are recent examples of ongoing efforts to enhance our network and address access deficiencies.

- **Jackson County. OB/GYN** — Member-to-provider ratio gap and travel time standard gap. **Action:** Our Network Relation Consultants, Patient Centered Care Consultants (PC3s), and Provider Network Managers determined an OB/GYN gap. They researched providers in contiguous counties and identified a current provider group that was opening a satellite office in Jackson County with a certified nurse midwife (CNM) on staff. We worked with the current provider group to get the CNM credentialed and the additional office location added to their provider profile. Additionally, we identified an existing provider group in Jackson County that was expanding their current staff with an OB/GYN. We worked one-on-one with the group to make sure the provider was credentialed and added to the existing location. These two new providers resolved the access gap in Jackson County and increased access to care in contiguous rural counties.
- **Nicholas County. ENT** — Travel time standard gap. **Action:** The monitoring by our Network Relations Consultants identified a participating ENT in a bordering county that recently opened a satellite office in Nicholas County. We worked with the practice to add the secondary location to our

network, adding access for our members in that county.

- **Wood County.** Audiology — Travel time standard gap. **Action:** Upon identifying a travel time standard gap for audiology in Wood County, our Network Relations Consultant worked to credential and contract with an audiology county practice not enrolled with Medicaid. The practice is now participating, which has resolved the access gap.
- **Mineral County.** OB/GYN — Member-to-provider ratio gap. **Action:** There is one OB/GYN in Mineral County; two OB/GYNs are required to satisfy the county member-to-provider ratio. We evaluated our Mineral County provider referral patterns and identified members were receiving care in a contiguous county with an OB/GYN provider in our network and within the travel time standards, but not with the county. We continue to monitor for new providers and additional office locations in Mineral County.

ND002 1 The Vendor should describe how they will establish and maintain a network of accessible, contracted, and credentialed providers for all covered services including supplemental services such as value-add services for, or on behalf of Mountain Health Trust (MHT) members.

Establishing and Maintaining a Network for All Covered Services, Including Supplemental Services (ND002)

UniCare’s Provider Services department assures our network includes all provider types necessary to offer access to all covered services, including supplemental services. With the addition of WVCHIP to the MHT program, we will work to ensure that our network has the providers and accessibility to provide all WVCHIP covered servings in addition to our current MHT program members. To do so, our Provider Network Managers evaluate our network by provider type, assessing number and location of providers, to assure access by evaluating provider-to-member ratios on a county and zip code level. We review data from Quest Analytics® reports, Provider Concierge Program Account Service Coordinators, satisfaction survey

results, and provider feedback and act based on analysis of data as well as provider or membership changes. Ongoing we assure network gaps are identified and resolved through our network development strategy, described in our response to ND001. For example, when a network gap is identified, our Provider Network Managers immediately close it by identifying prospective providers in the affected geographic area, and negotiate an SCA to assure immediate available care. We then work to close the gap on a long-term basis by fully contracting and credentialing these providers, including out-of-network providers.

As noted in our response to ND001, UniCare subcontracts with SKYGEN network to provide pediatric dental services; VSP is our vision benefits manager. Our member access for pediatric dental services is 100%.

Our subcontractor oversight process includes effective processes, tools, and controls to prevent, detect, and correct non-compliance with legal and regulatory requirements, program integrity, and standards of conduct, as described in our response to Attachment 3, Vendor Qualifications and Experience. UniCare's subcontractor oversight includes end-to-end processes, as we retain ultimate responsibility for adhering to federal and State regulatory requirements and the terms and conditions of its contractual agreements.

We work with SKYGEN and VSP and the State to assure our members have practical, reasonable geographic access to network dental and vision providers. Our Network Development Director has oversight responsibility for making sure access standards are met for these subcontracted services.

Value-Added Services (VAS)

As part of our evaluation of offering any supplemental services, including VAS, to our members, we determine how those services will be provided and any applicable regulatory, network contracting, and credentialing requirements impacting the offering of a VAS to our members. For example, we identified the need for additional dental services and currently offer a VAS of preventive dental services for pregnant members through our SKYGEN vendor.

- | | | |
|-------|---|---|
| ND003 | 1 | The Vendor should describe how they will establish network development and monitoring processes that ensure adequacy of covered services and includes the following considerations, including, but not limited to, the following: |
| ND004 | 2 | The anticipated MHT enrollment and the appropriate PCP provider-to-member ratios for adult and pediatric members |
| ND005 | 2 | The expected utilization of services for the anticipated MHT populations assigned to the Vendor for care |
| ND006 | 2 | The number of providers not accepting new patients |
| ND007 | 2 | The geographic location of providers and members, considering time and distance, and transportation needs |
| ND008 | 2 | The location of providers with physical access accommodations for members with disabilities and/or other requirements set forth under the Americans with Disabilities Act (ADA) |

Network Development and Monitoring Processes That Assure Adequacy of Covered Services (ND003–ND008)

UniCare values member access to care when and where they need it. We monitor our network to assure covered services are available to serve our members, in compliance with BMS access standards. Our Network Development Director, Terri Roush, oversees the development of our network adequacy analyses and submission of our network adequacy documentation to BMS. We analyze data reports, provider, member, and stakeholder input, as well as survey results to identify areas that may need enhancement or are at risk for not meeting access requirements. One example is the Jackson County OB/GYN access gap discussed in our response to ND002. This process involves the following elements:

- **Projecting the anticipated enrollment using our predictive modeling of current and projected members (ND004).** Our anticipated enrollment determines the composition and capacity of our network, including PCPs, specialists, hospitals, BH, and other providers. Our efforts are guided by the State standards of the provider-to-member ratios, including key data elements of expected populations, their current health needs, and the providers and services required to meet their health needs. We can then identify available providers by type and specialty for network recruitment. For

example, the CHIP program would require sufficient pediatric coverage and child specialists to assure access in all geographic regions. We evaluate PCP-to-member ratios by county for our adult and pediatric members, and for OB/GYNs for our female members. We compare those results to BMS' established provider-to-enrollee standards to make sure our network has sufficient number of providers in each county to meet the needs of our anticipated enrollment. Based on this analysis, we have determined our PCP network has sufficient capacity to serve all current MHT members across the state. Our OB/GYN network has sufficient capacity in all but two counties: Mineral and Mingo.

- **Evaluating the current and expected utilization of services (ND005).** When evaluating current and expected utilization, we take into consideration accessibility, quantity, and the types of providers needed to provide the necessary services. We evaluate the utilization of services, including PCP, specialist, and hospital services of our current and anticipated populations, to make sure we have sufficient number and types of providers. We analyze hospital and specialist referral patterns to understand where members are receiving care and compare that data to our network access for those services. For example, we determined that BH, particularly psychiatry, is a high demand specialty for our members, and that asthma is the most common chronic condition of our child members. We also identified a high volume of ER visits for non-emergent issues and analyzed the historical utilization of hospital and out-of-state services to identify anticipated service use and health needs. We are contracted with all acute care hospitals in West Virginia, including tertiary and children's hospitals, and our network access for hospital services in both urban and rural areas is 100%.
- **Assessing the numbers of network providers who are not accepting new patients (ND006).** We only include providers accepting new members in our accessibility analyses to make sure all new members will have access. Over 97% of our network providers are open to accept new members.

- **Assessing the geographic location of providers and members, considering travel time, distance and transportation needs (ND007).** As described in our response to ND001, we run Quest Analytics reports that map geographic access of our members to locations for each required provider type for both adult and pediatric members. We evaluate travel times and transportation options available, including availability of public transportation where available. Except for hospital and inpatient services, BMS' access standards do not distinguish between urban and rural areas.
- **UniCare considers the physical accessibility of our providers' locations to provide reasonable access for our members with disabilities to assure sufficient access in accordance with the Americans with Disabilities Act of 1990 (ADA) and BMS requirements (ND008).** We assess our providers' ADA accessibility during site visits. Our contracts require all providers to comply with all applicable federal and State laws in assuring accessibility to all services for members with disabilities, to meet federal and State accessibility standards and those standards defined in the ADA.

Additional strategies and approaches to network adequacy monitoring include:

- **Reviewing OON utilization patterns and SCAs.** We monitor OON and out-of-service area utilization to identify patterns that may indicate access gaps. We scrutinize those OON providers who serve our members and actively work to recruit them to join our network when appropriate. Our Provider Services department works one-on-one with our Care Management department to monitor and assess out-of-network referral patterns to inform our provider recruitment. In 2019, we completed 60 SCAs to assure care for our members. Most of the agreements were with John Hopkins University, Cincinnati Children's, and specialty durable medical equipment (DME) providers.
- **Evaluating the numbers and types of providers (in terms of training, experience, and specialization) needed to furnish covered services.** We analyze claims and other data to assess the

needs of our adult and pediatric Medicaid members as well as Children with Special Health Care Needs (CSHCN) members and the ability of our network to furnish covered services. To determine the number of providers required, we used the capacity ratios specified previously and applicable time and distance standards to assess access to providers with the specialization, training, and experience needed to serve our member populations. This includes providers with key specializations such as age-appropriate PCPs, internal medicine providers for adults, pediatricians and pediatric specialists for children, OB/GYN provides for female members, and specialists across all high-volume and other specialty types. We also evaluated outpatient BH services, hospitals, and ancillary providers, and pharmacies. We also considered the accessibility to essential community providers, including FQHCs and RHCs who predominantly serve low-income and underserved populations. For example, our network includes all West Virginia FQHCs and RHCs. Our network also includes over 100 participating PCP practices that are NCQA-recognized patient-centered medical homes (PCMHs). Sixty-eight of these providers currently participate in our Provider Quality Incentive Program (PQIP) alternative payment model (APM) program (described in detail in our response to PS007). To assure access in our network, UniCare is expanding provider capacity through our UniCare Training Academy (the Academy)'s enhanced educational tools and on-demand trainings in topics that build provider competency, such as Screening, Brief Intervention, and Referral to Treatment (SBIRT), and recognizing the impact of Adverse Childhood Experiences.

- **Evaluating provider and member input.** Our Provider Relations Director is responsible for analyzing information obtained through a variety of mechanisms, such as thorough analysis of satisfaction surveys, meetings with our Medical Advisory Committee, and input from staff who are actively involved in working with members and the provider community. Based on results, our

Provider Relations and Network Development Directors partner to identify, recruit, and contract additional providers to address any concerns from our members, the providers, or the community. For example, our Care Management department assisted a member in locating a pain management provider in the eastern panhandle. As the provider was not in our network, we arranged for care through an SCA, while our Network Relations Consultant worked to contract with the provider.

- **Reviewing Grievances and Appeals.** We continually monitor grievances and appeals to improve our network and address deficiencies. Our Provider Relations Director reviews member grievances regarding travel distance or time to develop contracting strategies. In 2019 we received 19 member grievances related to concerns about network access, equating to 0.474 grievances per 1,000 members, representing approximately 3.5% of our total number of grievances received for that time period. Each network access-related grievance is investigated by our Provider Services department leadership to identify root causes and remediation, which may include additional provider education regarding access requirements or additional contracting to expand access as applicable.
- **Monitoring Network Changes.** Our Provider Services department reviews network additions, deletions, and PCP capacity changes by type and location at the county and zip code level to identify impacts to provider-to-member ratios or on network accessibility for time and distance standards, and deploys provider recruitment contracting strategies to address gaps and increase provider capacity.
- **Evaluating Member Satisfaction Survey Results.** Our Quality Management (QM) department engages a qualified vendor to administer the most current version of the CAHPS® survey. We review results to identify areas where members indicate gaps may be preventing full satisfaction. During our most recent assessment of member satisfaction, we met our goals related to getting care quickly (95th Quality Compass Percentile) and getting needed care (90th Quality Compass Percentile). We deploy

targeted provider recruitment and contracting strategies to mitigate gaps, and additional provider training through our Network Relations Consultants. For example, we issue provider bulletins to remind providers about our requirements for providing timely access to care.

- **Evaluating Provider Feedback.** We consider the feedback from our providers, particularly our PCPs, to identify opportunities to expand access. We then deploy strategies designed to increase retention and provider satisfaction. One way we gather provider input is through our Medical Advisory Committee and then act to address the provider issues.
- **Continuous Employee Feedback.** Our Network Relations Consultants, Care Management team, UM Clinicians, QM team, and Enrollee (Member) Services Representatives provide feedback on the quality, access, and availability of our provider network. They are in the community daily working with stakeholders — members, caregivers, providers, and community-based organizations. These stakeholders are best poised to provide feedback concerning needs and opportunities, help us solve challenges, and assure we are delivering high-quality services to meet member needs.

ND009 1 The Vendor should describe how they ensure its provider network will provide culturally competent care to members.

Assuring Our Network Provides Culturally Competent Care (ND009)

UniCare assures our provider network can meet the multilingual, multicultural, social, and disability needs of the individuals and families through established processes and standards promoting culturally competent care. In 2017, we received NCQA's Multicultural Health Care Distinction, which is awarded to organizations that engage in efforts to improve Culturally and Linguistically Appropriate Services (CLAS) and reduce health care disparities. The Multicultural Health Care Distinction recognizes UniCare's commitment to quality and adherence to collection standards for race/ethnicity and language

data, facilitating language assistance, cultural responsiveness, quality improvement of CLAS, and reducing health care disparities. We monitor and investigate all member complaints and grievances. In 2019, UniCare received no CLAS complaints related to language access, race, ethnicity, or culture.



During our initial credentialing and contracting process, prospective providers are required to complete our provider application, which captures the completion status of cultural competency training. Member and other stakeholders can identify providers trained on cultural competency on UniCare's Find A Doctor online provider directory, which displays whether a provider has completed cultural competency training.

We work to build competency in providers by offering cultural competency training and toolkits through our Academy. We educate providers about the availability of these trainings and encourage providers to complete them during our initial and ongoing site visits and during any targeted educational outreach. UniCare's *Caring for Diverse*



Populations Toolkit is a comprehensive resource designed by and for health care professionals offering resources to help providers and their staff enhance care for their diverse patient panel. The toolkit offers providers and their staff educational materials and resources covering a range of topics including, but not limited to, communication strategies with a diverse population, strategies to overcome language barriers, the role of culture on health and health care delivery, regulations and standards regarding culture and language services. A full discussion of our Academy and cultural competency training resources can be found in Attachment 6, Section 8, Provider Services.

Yearly we analyze HEDIS[®] measures to detect racial and ethnic disparities in key indicators. We contracted network providers that speak 59 different languages in addition to English — 686 providers speak one other language and 242 providers speak two other languages in addition. The top three non-

English languages spoken by providers are Spanish, Hindi, and Arabic.

- ND010 1 The Vendor should describe how they will develop and maintain a directory of providers that includes provider names, locations with street address, website URLs (as appropriate), and telephone numbers of current contracted providers in the member's service area.

Developing and Maintaining a Provider Directory (ND010)

Accurate and easy-to-use provider directories help members find in-network providers. Our provider directory, accessible on our website and in paper form, meets all State required informational elements. Provider demographic information is captured during our initial credentialing in the application process. Once a provider is enrolled all the collected information is uploaded to our Provider Data Maintenance System. After initial loading, providers can make changes to any of the information elements using our secure, online provider maintenance form (PMF), which is available on our secure provider portal,

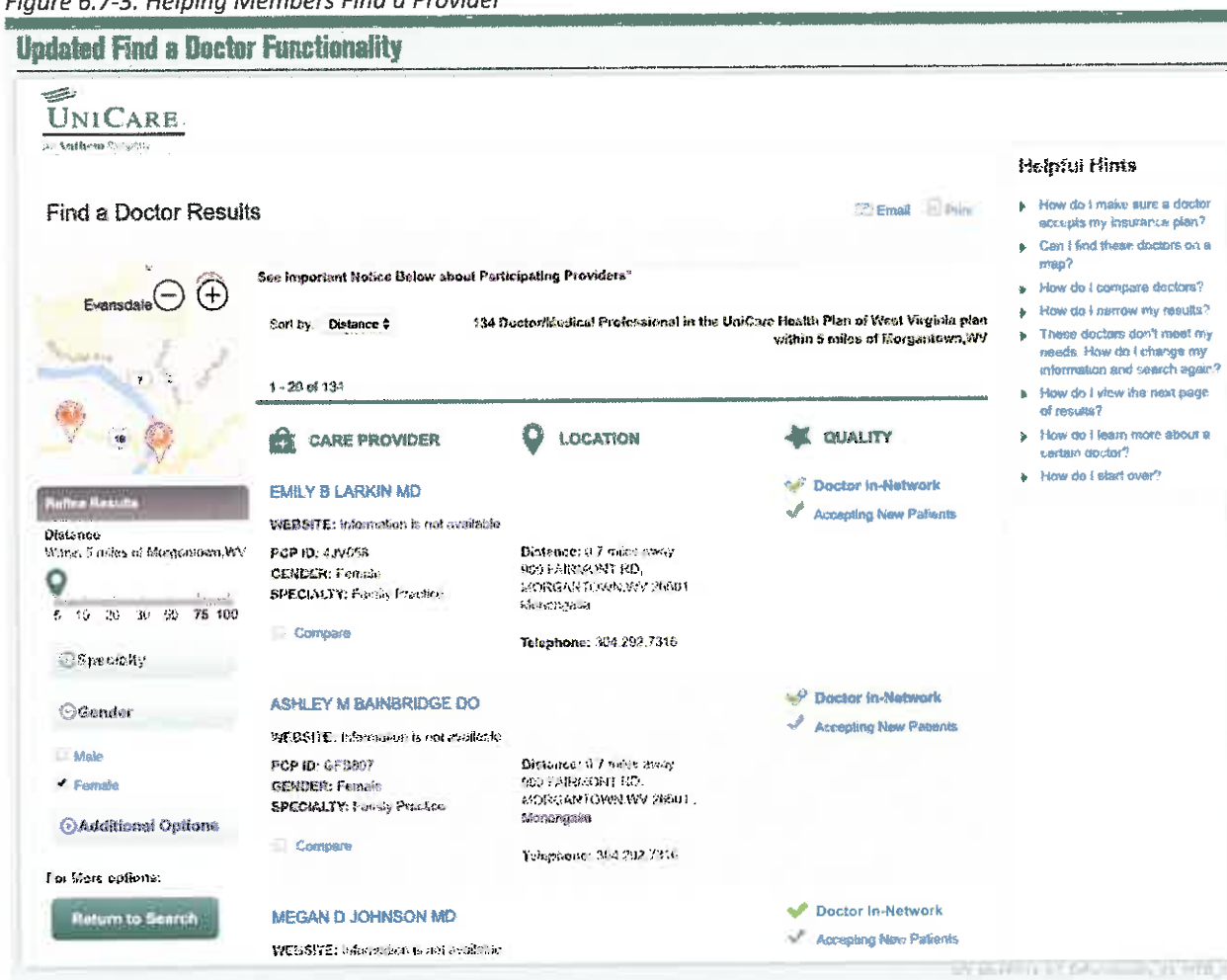


Availability. Our field-based Provider Services department staff confirm and update information during outreach and all provider sites visits. This information is routinely confirmed and updated during provider recredentialing. ***We update our Find a Doctor tool weekly.*** In addition, we update our printable PDF and paper provider directory monthly, with new information received from providers within the previous 30 days. Monthly, UniCare submits an updated provider directory file to the enrollment broker.

Our ***Find a Doctor tool***, available on the member and provider websites, is searchable by provider name, specialty, place, and type (for example, hospital, BH, or urgent care). Members can enter their location information (address, zip code, city, or county) and view a list of providers that meets their needs. The tool, shown in Figure 6.7-3, includes a map option that allows the user to see where the provider is located. It also provides directions and information about public transportation options. Users can refine results by specialty, location, providers accepting new patients, group affiliation, hospital

affiliation, and languages spoken. Results include the provider's gender and ethnicity, languages spoken, medical education and licensure, Medicaid and National Practitioner Identifier (NPI) numbers. The results also show cultural competency training completion, whether the provider is wheelchair-accessible and ADA-accessible, and special areas of services or expertise, such as CSHCN or if a provider has EPSDT services for WVCHIP members upon implementation of the new contract.

Figure 6.7-3. Helping Members Find a Provider



Updated Find a Doctor Functionality

Find a Doctor Results

See Important Notice Below about Participating Providers*

Sort by: Distance ↑ 134 Doctor/Medical Professional in the UniCare Health Plan of West Virginia plan within 5 miles of Morgantown, WV

1 - 20 of 134

CARE PROVIDER

LOCATION

QUALITY

Emily B Larkin MD
WEBSITE: Information is not available
PCP ID: 4JY058
GENDER: Female
SPECIALTY: Family Practice
Distance: 0.7 miles away
909 FAIRMONT RD,
MORGANTOWN WV 26601
Monongalia
Telephone: 304.292.7316

Ashley M Bainbridge DO
WEBSITE: Information is not available
PCP ID: GF5807
GENDER: Female
SPECIALTY: Family Practice
Distance: 0.7 miles away
909 FAIRMONT RD,
MORGANTOWN WV 26601
Monongalia
Telephone: 304.292.7316

Megan D Johnson MD
WEBSITE: Information is not available

Helpful Hints

- How do I make sure a doctor accepts my insurance plan?
- Can I find these doctors on a map?
- How do I compare doctors?
- How do I narrow my results?
- These doctors don't meet my needs. How do I change my information and search again?
- How do I view the next page of results?
- How do I learn more about a certain doctor?
- How do I start over?

Paper (printable) directories are available on our website. These PDF directories, which can be printed from a remote user location, are sorted by county and are available in English or can be translated into other languages, upon request. Members can always obtain more hands-on assistance identifying a

provider, including providers who speaks their language, by calling our Enrollee (Member) Call Center or by speaking with their Care Manager. UniCare's Member Services department provides directories to potential members upon request and to members requesting a paper copy within five days.

- ND011 1 The Vendor should describe its process to ensure its provider network adheres to geographical access standards for all adult and pediatric members.

Assuring Our Provider Network Adheres to Access Standards for Adult and Pediatric Members (ND011)

UniCare is committed to making sure our adult and pediatric members have access to a network of providers able to meet their health care needs. We capture data on any age-restrictions indicated by providers for consideration in our accessibility analyses. In accordance with State accessibility standards, we evaluate our network accessibility for adult and pediatric members separately using Quest Analytics and member-to-provider ratio reports to assure access for our adult and pediatric members. For example, in evaluating pediatric accessibility, we only consider providers that are appropriately credentialed to serve pediatric populations.

Additionally, we display any provider age-restrictions and other relevant information, such as on our online tool and in paper provider directories. Our provider contracting strategies are aligned to assure we have an appropriate network in place for members of all ages. Our detailed network development and monitoring processes and strategies for making sure our network contains an appropriate quantity and mix of types of providers needed to provide the necessary services are described in our responses to ND001–ND008.

- ND012 1 The Vendor should describe how they will establish provider contracts and include in its provider network all identified comprehensive behavioral health and Psychiatric Residential Treatment Facilities (PRTF), as defined within the Service Provider Agreement (SPA), for both pediatric and adult Mountain Health Trust (MHT) members.

Establishing Contracts with Comprehensive Behavioral Health and Psychiatric Residential Treatment Facility Providers (ND012)

UniCare offers members geographically accessible BH and SUD services on both the provider and facility levels of care. Our network includes all three in-state West Virginia PRTF providers and all 18 State-approved residential SUD providers. We currently contract with 12 of the 13 West Virginia COMPs. The only non-participating COMP, Northwood, accepts our members as an OON provider, and we are in discussions with them regarding network participation. In addition, our network supports co-location and integration of physical health (PH) and BH services, with more than 85 provider groups providing both primary care and BH specialties. This is especially important in rural areas where integrated care providers help us meet the needs of our members. UniCare contracts with all West Virginia FQHCs and RHCs. Our telehealth and telemedicine solutions, described in our response to ND014, will bring BH services to hard-to-reach areas and members with limited ability to travel.

Over the past 17 years, we have continually proven our commitment to integrating and coordinating care for West Virginians. For example, after BH services were carved into our current MCO contract, UniCare focused on bringing members placed in out-of-state PRTFs back to West Virginia. As of December 2019, we had four members in a PRTF and two of those were out-of-state. Our focus on quality services and strong outcomes also includes a

Reducing Out-of-State Placements

Between July 2015 and June 2017, we reduced the number of youths in out-of-state placements from 22 youths to three, an 86% reduction, by working directly with residential providers to improve quality of services and securing local, community-based alternative placements.

focus on reducing the length of stay and readmission. To address this challenge, we redesigned our PRTF

placement coordination process to include bi-monthly integrated team calls with each PRTF facility, active monitoring of progress towards treatment goals, and bi-monthly medical necessity review. All PRTF admissions require Medical Director authorization and Care Managers review progress toward treatment goals, family visits, and home visits weekly with guardians. We also developed a comprehensive geographic list of alternative in-home providers and intensive in-state programs to assist the team during discussions with providers to assure members were accessing the least restrictive level of care, inclusive of community options while supporting transitions and reducing readmissions.

- ND013 1 The Vendor should describe how its network development and adequacy processes include and assess provider hours of operations, convenience to members, and parity to commercial or Fee-for-Service (FFS) populations.
- ND014 1 The Vendor should describe its guidelines and monitoring processes that ensure members have timely access to care per contractual requirements.

Network Development and Processes Related to Access and Availability (ND013–ND014)

UniCare has comprehensive policies, contracting and monitoring strategies, and processes to measure provider compliance with the hours of operation, after-hours accessibility, office wait times, and timely access to care State standards. We require our network providers adhere to strict access to care standards and take corrective action when non-compliance is identified. Network providers are contractually obligated to make sure covered services are as accessible to members in terms of timeliness, amount, duration, and scope as those services that are available to non-Medicaid persons within the same service area. We educate our providers about our timeliness of access to care standards through our provider manual, provider orientation and ongoing Academy trainings. We will update our provider manual, provider training and monitoring processes to reflect changes in BMS's timeliness standards, including the changes specified in SPA Section 2.1.2.4, as they occur.

Our Provider Services department and QM oversight processes monitor provider and network-wide compliance. We use a variety of means to monitor provider and network access to these standards, as shown in Figure 6.7-4.

Figure 6.7-4. UniCare's Mechanisms to Monitor Compliance with Timely Access to Care

UniCare's Mechanisms to Monitor Timely Access to Care	
Source	Activities
Provider Interactions	We check network PCPs to confirm they maintain an open panel and can schedule member appointments within established access standards. We do this during face-to-face visits and telephone calls.
Concierge Services Data	We analyze call center data to identify potential compliance issues. For example, if we receive feedback regarding a provider's inaccessibility, we contact the provider, determine the cause, and work with the provider to correct the situation.
Complaint and Appeals Data	We analyze complaint and appeals data to monitor provider adherence to access standards at an individual provider level.
Secret Shopper Phone Calls	We use Secret Shopper calls to confirm compliance with appointment availability and access to care, including hours of operation and after-hours availability, for those providers who perform poorly on the annual After-hours and Appointment Availability Survey. We do this to assure performance has improved after our Network Relations Consultants meet with these providers to discuss their performance and develop a plan to mitigate issues. We also use Secret Shopper calls to follow up on complaints we receive from members or stakeholders.
Provider Appointment Availability and After-hours Survey	We survey providers annually to monitor access, asking them to respond to a series of related questions. We outreach to non-compliant providers by phone or in person to provide re-education. We develop corrective action plans for deficiencies, which ultimately may lead to committee review for possible termination if the issue is not corrected.
Member Satisfaction Surveys	Each year, our QM department engages an NCQA-approved organization to administer the most current version of the CAHPS survey that queries members on access to care, among other key questions.

We communicate these standards via face-to-face meetings, provider training, policies and procedures, our provider agreement, and the provider manual. If deficiencies are identified, we will develop action plans for improving timely access to care, including:

- Sharing results with non-compliant providers and implementing corrective action plans (CAPs)
- Meeting with compliant providers to identify best practices
- Developing customer service seminars for physicians' office staff to discuss scheduling protocols and best practices to manage challenges and improve efficiency within the office

Assessing Provider Hours of Operation, Convenience, and Parity to Commercial or FFS Populations (ND013)

UniCare requires all network provider hours of operation are convenient, do not discriminate against members, and are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid Fee-for-Service (FFS). We will also continue to assure that office waiting times are kept to a minimum and that the waiting time standard for Medicaid members is the same standard used for commercial enrollees. Providers are not permitted to discriminate against Medicaid enrollees in the order patients are seen or in the order that appointments are given. Providers are not permitted to schedule Medicaid-only days. Additionally, to provide access to primary care services for routine, urgent, and emergency PH and BH needs, we require all PCPs be accessible 24/7, either personally or through covered arrangements with designated network PCPs. Member can access information on provider hours through our provider directory, available online or in print, or by calling our Member Call Center.

The standards for office hours, office wait times, and 24/7 coverage (PCPs only) are included in our provider contracts, provider manual, website, and provider bulletins as needed. We monitor our network and respond if we identify non-compliance. For example, in July 2019, we issued a PCP provider bulletin outlining standards related to the access and coverage requirements.

We initially capture provider hours of operation at each provider location as part of their provider application information. We monitor provider office hours, after-hours accessibility, telephone accessibility, and office wait times to assure members have timely access and that our providers respond promptly to after-hour requests for care. Our Network Relations Consultants and PC3s verify provider hours of operation during ongoing site visits to provider offices. Providers are required to provide ongoing updates regarding changes in office hours to UniCare through our secure PMF on our provider portal.

We monitor provider compliance with the wait standards through member complaints and our annual After-hours and Appointment Availability Survey. Our 2019 survey results demonstrated 90% of all PCP providers met the 30-minute office wait time standard. We follow up with all providers not meeting our established standard through direct outreach and re-check compliance using Secret Shopper calls.

Our members can access quality health care 24/7. PCPs are informed of this 24/7 coverage standard in their contract, provider manual, and our website. We require PCPs have a system to field member after-hour calls related to medical questions or concerns. UniCare prefers that PCPs use network providers for on-call services. When that is not possible, the PCP must make sure that the covering on-call physician or other provider abides by the terms of the UniCare provider contract. If the PCP's staff or answering service is unavailable, an answering machine may be used. The message must instruct members who have emergency health care needs to dial 911 or go to the nearest hospital ER. The message must give members an alternative contact number to reach the PCP or on-call provider.

We monitor provider access compliance through our annual survey and member complaints. An example of our quality improvement includes a 2018 training targeted to all PCPs who were unaware or failing to provide the required 24/7 coverage. We facilitated a provider training on the 24/7 standard, resulting in a 58% increase in provider standard compliance.

To assist members after-hours, but not replace provider 24/7 coverage, UniCare also offers members our Nurse Line, offering members 24/7 access to a registered nurse who can provide health information regarding illness and options for accessing care, including emergency services.

Monitoring Network Access

Our Quality Management Committee (QMC) reviews and analyzes data and assists with prioritization of opportunities to improve continuity and coordination of care. Our Provider Services department also

monitors and verifies office hours, wait times, and after-hour coverage and appointment availability during their in-person visits to provider offices and through our annual After-hours and Appointment Availability Survey. This is a random, statistically valid sample of PCPs and BH providers to assess their coverage. Additionally, we confirm provider access and availability compliance during face-to-face and telephonic provider contacts. Figure 6.7-5 summarizes our compliance monitoring approach.

We document provider responses, identify potential quality improvement opportunities, and respond by leveraging our Academy, provider newsletters, provider manual, and provider agreements. When necessary, we issue special provider bulletins to reaffirm our access standards.

Figure 6.7-5. UniCare Uses Several Methods to Monitor Provider Accessibility

Monitoring Provider Accessibility	
Monitoring Provider Access	
Access Standard	Monitoring Approach
Office Hours, Office Wait Times, and After Hours	Appointment availability audits
	Site Visits
	Member input and feedback
	Staff feedback
	Administrative data

Our Network Relations Consultants meet with under-performing providers identified in our annual After-hours and Appointment Availability Survey and in response to all member or stakeholder complaints. We discuss their performance issues and develop a plan to mitigate issues. We then use Secret Shopper calls to confirm improved compliance, including hours of operation and after-hours availability.

- ND014 1 The Vendor should describe its guidelines and monitoring processes that ensure members have timely access to care per contractual requirements.

Guidelines and Monitoring Processes to Assure Timely Access (ND014)

UniCare monitors appointment availability to assure our members have timely access to care. Providers are contractually obligated to abide by all required access standards. We educate providers about access requirements through our provider training, provider manual, newsletters, and website. Our strategy for monitoring provider appointment availability compliance is depicted in Figure 6.7-6.

Our 2019 After-hours and Appointment Availability Survey, which monitors provider compliance with appointment timeliness standards, showed a 90% compliance rate for PCP appointment timeliness. If we learn a member has difficulty obtaining an appointment with a specific provider, we immediately contact the provider to secure an appointment. If the provider cannot see the member within a reasonable time period, we identify another available provider within the area, with member consent. A Network Relations Consultant contacts the initial provider to discuss the scheduling issue, remind the provider of appointment and access standards, and create an action plan to assure access to care. We follow up with the provider within 120 days to confirm compliance. If we continue to see no improvement after repeated attempts, we may remove the provider from our network. These rare cases of provider terminations are often the result of continued non-compliance, failure to meet recredentialing requirements, fraud or abuse, quality of care issues (as determined by our QMC), or continued failure to adhere to authorization requirements. Over the past year, we have not had a network provider placed on a CAP.

Figure 6.7-6. Monitoring Appointment Access

Monitoring Appointment Availability	
Appointment Standard	Monitoring Approach
Appointment Availability	Site Visits
	Provider Access and Availability Survey
	CAHPS Survey
	Member grievances
	Secret shopper calls

Using Telemedicine to Expand Access and Network Capacity

Expanding the use of telemedicine offers the opportunity to expand access and to reduce unnecessary ER utilization for urgent, non-emergent care. Our telemedicine strategy focuses on expanding member access in rural and underserved geographic areas — in a member’s home, school, primary care clinic, BH or SUD provider office, or other location. We reimburse for telemedicine services provided in accordance with West Virginia Medicaid program telemedicine reimbursement policy at the West Virginia Medicaid fee schedule

rate. In 2019, we paid over \$509,000 to providers for services provided via telemedicine. We inform providers that we reimburse for telemedicine during provider site visits and inquire about the provider's telemedicine capabilities and interest in expanding the use of telemedicine in their practice through our LiveHealth Online (LHO) My Practice Edition telemedicine solution described in a following subsection.

UniCare's innovative telemedicine strategy focuses directly on using internet, video-conferencing, and other web-based services to expand access, support providers, improve quality, and accelerate technology adoption. Our telemedicine strategy goals are shown in Figure 6.7-7. Subject to BMS approval, we will offer telemedicine solutions for our Medicaid members, such as LHO, Bright Heart Health, and Project ECHO® (Extension for Community Healthcare Outcomes). Our telemedicine solutions, shown in Figure 6.7-8, will offer options that increase access to PH, BH, and SUD treatment services.

Figure 6.7-7. UniCare's Telemedicine Strategy Goals

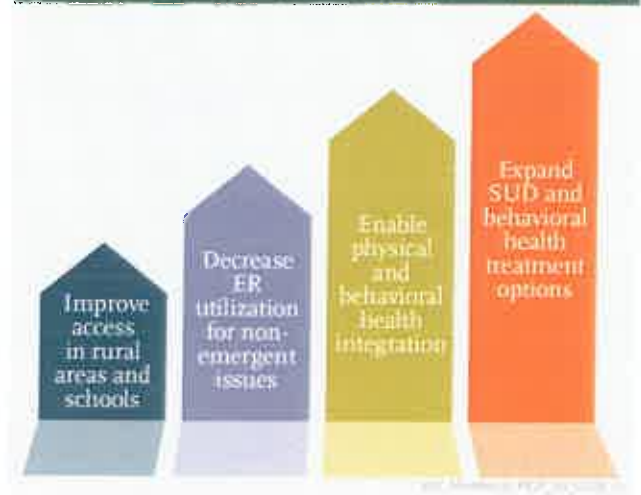


Figure 6.7-8. UniCare's Comprehensive Telemedicine Solutions

UniCare's Comprehensive Telemedicine Solutions			
MEMBER-FACING SOLUTIONS			
VENDOR/PARTNER	SPECIALTY/SERVICE	DEMOGRAPHIC	ACCESS POINT
PHYSICAL HEALTH			
LiveHealth Online	Urgent Care Physical Health	Adults and Children	Consumer on Demand
TytoCare	General Physical Health/ Preventable ER Visit(s)	Children	Schools
BEHAVIORAL HEALTH			
Bright Heart Health	Medication Assisted Treatment/Addiction Services	Adults and Children	Provider Offices
LiveHealth Online – Psychology & Psychiatry	Low-acuity Behavioral Health	Adults and Children	Consumer on Demand
FasPsych	High-acuity Behavioral Health	Adults and Children	Consumer on Demand
PROVIDER-FACING SOLUTIONS			
VENDOR/PARTNER	SPECIALTY/SERVICE	DEMOGRAPHIC	ACCESS POINT
FasPsych	Psychiatric Consultation	Adults and Children	Provider Offices/ Emergency Room
ConferMED	PCP-to-Specialist E-consults	Adults and Children	Provider Offices
Project ECHO	Provider Enablement	Adults and Children	Provider Offices
Practice Edition	Provider-owned/managed telehealth solutions	Adults and Children	Provider Offices

Member-facing Telemedicine Solutions

Expanding Access to Urgent Care: LiveHealth Online (LHO)

Our LHO solution provides members with real-time, online access to BMS-enrolled, West Virginia-licensed, board-certified physicians through HIPAA- and 508-compliant two-way audio/video technology. LHO offers urgent care consultations on clinically appropriate conditions such as cold, flu, allergies, and other non-emergent conditions. LHO providers can diagnose, offer medical recommendations, and prescribe medications when medically necessary, in accordance with DHHR requirements. Members can access services through a safe and secure internet connection or an application on any video-enabled computer, laptop, tablet, or smartphone. LHO is especially beneficial to members in rural areas where they may not have access to a provider due to distance or transportation constraints.

Examples of Successful Utilization of LiveHealth Online (LHO)

UniCare's affiliates in California, Florida, Iowa, Nevada, Texas, and Washington have implemented LHO for their Medicaid programs. As with all new technologies, member awareness and initial use was limited, but continues to grow. Since inception through September 2019, over 4,195 of our affiliate's Medicaid members have registered with LHO for a total of 2,338 LHO visits, including 1,557 urgent care and 781 BH visits. Based on LHO patient responses to post-visit surveys, *23% of LHO patients said they would have gone to the ER if LHO had not been available to them*, and 39% said they would have sought care at an urgent care center. Our Medicaid members are highly satisfied with LHO. Patient feedback survey information indicates *ratings 4.9 out of 5 points (with 5 points meaning extremely satisfied) for both LHO and the LHO provider*.

Expanding Access for Youth in School-based Settings: TytoCare

Schools and school-based clinics can serve as key access points to PH screenings and treatment visits for school-aged children. According to the National Education Association and the National Association of School Nurses, the ratio of full-time school nurses to students in West Virginia is approximately 1 to 1,159. In 2017, the West Virginia Legislature, recognizing that for some students the school nurse is the only health care professional they ever see, introduced Senate Bill 319 to adopt the Centers for Disease Control's recommended 1:750 nurse to student ratio.

Through our relationship with TytoCare, we offer an opportunity to significantly expand access to care in schools through telemedicine. TytoCare's Virtual Exam Platform and suite of medical-grade, FDA-cleared hand-held devices, the TytoPro™ Exam Kit, connect patients to their own clinician networks for a complete virtual office visit. Each TytoPro Exam Kit (see Figure 6.7-9) includes a hand-held modular examination tool for examining the heart, lungs, skin, throat, ears and body temperature; a complete

telehealth platform for sharing exam data, conducting live video exams and scheduling visits; a cloud-based data repository with analytics; and built-in guidance technology and machine learning algorithms to assure accuracy and ease of use. The TytoCare platform also allows for simple integration with electronic health record systems and other telehealth platforms.

Examples of Successful Uses of TytoCare

TytoPro was implemented in the Burke County, North Carolina school system in the fall of 2017 as part of a pilot between TytoCare and the school district. The most common reasons for using telehealth included acute conditions (85%), well-care (6%), follow-up (4%), and chronic conditions (2%). Since piloting the program, they have seen a significant improvement in the level of care that can be provided to students, as they can now cover all 26 schools with their telehealth program. Approximately 89% of students that completed a telehealth visit using TytoCare were able to return to class, thus reducing absenteeism.

Figure 6.7-9. TytoPro Exam Kit



Expanding Access to Behavioral Health: LiveHealth Online and FasPsych

LiveHealth Online. In addition to providing on-demand urgent care visits, LHO provides our members with access to scheduled, low acuity BH consultations with BMS-enrolled, West Virginia-licensed psychiatrists and licensed mental health counselors for consistent in-home access, allowing members to pursue their own plan for management and recovery. In our six affiliate markets that have implemented LHO for their Medicaid members, 781 members have received BH counseling visits through LHO.

FasPsych. Through our relationship with FasPsych, we will offer our members who have more complex BH issues access to counseling services (including crisis assessments) in their home through FasPsych's

network of West Virginia-licensed, Medicaid-enrolled BH practitioners. FasPsych also helps support expansion of integrated PH and BH care in PCP offices.

Expanding Access for SUD and Opioid Use Disorder (OUD): Bright Heart Health

UniCare is working with Bright Heart Health to offer members with SUD/OUD Medication Assisted Treatment (MAT) and mental health treatment via telemedicine. Bright Heart Health, the first nationwide telemedicine OUD treatment program, is available through a smart phone, tablet, or computer. Bright Heart Health's West Virginia-licensed, BMS-enrolled counselors "meet" with individuals online, and help identify and develop strategies to deal with issues and disorders that may have contributed to or been impacted by opioid misuse. At designated primary care locations across the state, members will be able to access MAT provided by Bright Heart Health providers who will oversee telemedicine treatment and delivery of care by PCPs. Bright Heart Health also offers an OB/GYN program focused on pregnancy-related MAT and pain management. Bright Heart Health is a comprehensive, multi-modal program that provides chronic pain management using medication and non-medication therapies to address chronic pain issues and opioid dependency. Each patient is assigned a multidisciplinary care team, and the Bright Heart Health clinicians can prescribe and monitor medications that allow individuals to stop misusing opioids without experiencing powerful drug cravings or severe withdrawal symptoms. All patients are evaluated for the safe use of medications to address pain issues. In addition, Bright Heart Health uses non-medication therapies including operant therapy, mindfulness, CBT, and acceptance and commitment therapy.

Examples of Use of Bright Heart Health

Our affiliates in California and Washington recently implemented Bright Heart Health for statewide access to their nationwide OUD treatment program. Each program is in the early stages of operation, but early data show based on Bright Heart Health's all-patient outcomes reporting for 2019, over 90% of

patients remained in the program after 30 days in treatment (significantly above the retention rates reported in all major published studies of opioid treatment programs), and 52% remained in the program after one year. In addition, 97% of patients tested negative for opioids at 90 days from initiation of treatment and 85% were negative for opioid, stimulants and sedatives as well.

Provider-facing Telemedicine Solutions

FasPsych. UniCare will collaborate with targeted our West Virginia network primary care clinics, FQHCs, and ERs to establish relationships with FasPsych to offer virtual integrated co-located PH and BH services to our members through tele-behavioral health counseling visits provided to its more than 4,000 qualified West Virginia-licensed, BMS-enrolled psychiatrists and psychiatric advanced practice registered nurses. FasPsych is a pioneer in telepsychiatry, with approximately 12,000 virtual visits per month, and currently operating in 15 states.

ConferMED. UniCare will collaborate with ConferMED and targeted West Virginia network PCPs to provide PCP-to-specialist eConsults, which are asynchronous telehealth consultations between a PCP and a specialist. eConsults increase access to specialty care by making it possible for the PCP to confer with a specialist after clinical information sent by the PCP is reviewed and returned with recommendations. PCPs benefit by being able to provide efficient and effective care to members with timely guidance and answers to questions. They also benefit from increased knowledge and confidence gained from consultations with trusted specialists.

Project ECHO. We promote the use of Project ECHO as a collaborative model of medical education and care coordination that supports clinicians with evidence-based guidelines and tools. The ECHO model increases access to specialty treatment in rural and underserved areas. UniCare, in conjunction with our parent company, implemented an initiative to train primary care and rural clinicians to treat members with

OUD through collaborations with three academic medical centers, including West Virginia University School of Medicine. UniCare is providing no-cost training for identification and treatment of opioid addiction to providers and their primary care teams. The training covers management of naloxone, buprenorphine (such as Suboxone), and injectable naltrexone (such as Vivitrol), as well as access to a virtual learning community for treatment guidelines, tools, and member resources.

Examples of Successful Use of Project ECHO

In June of 2017, we launched Project ECHO as part of UniCare's solutions to address the ongoing opioid epidemic in West Virginia. Project ECHO MAT facilitates the expansion of scope of PCPs' knowledge through distance learning. This innovative hub-and-spoke knowledge-sharing network allows rural physicians to connect with

Project ECHO® Educates Members

- 46 one-hour sessions held
- A total of 656 attendees included 124 individuals with an average of 14.3 providers per session
- 38 de-identified case presentations
- Hub members presented 32 didactic presentations
- 40 organizations have participated, including Charleston Area Medical Center, Marshall University, and other providers in and outside of West Virginia

SUD specialists at West Virginia University in order to present patient cases and participate in didactic presentations covering a variety of MAT topics. During sessions, providers from across West Virginia are instructed on the benefits of MAT and learn how to implement a group-based recovery model in various practice settings.

Our West Virginia Project ECHO MAT is supported by our ultimate parent company, Anthem, Inc., West Virginia's Clinical and Translational Science Institute, and the West Virginia University School of Medicine.

Since Project ECHO MAT started in West Virginia, it has significantly contributed to increasing the percentage of our members experiencing opioid use disorder who received MAT (including MAT with recommended counseling) from 57.4% in January 2018 to 62.4% in June 2019, and a corresponding decrease in opioid overdose claims of more than 53% over the same time period.

LHO My Practice Edition

We are identifying current opportunities to enhance the telemedicine capacity of our existing network by identifying West Virginia PCPs and COMPs that are interested in expanding access for their patients by adopting telemedicine in their practices. LHO's My Practice Edition allows physicians to see and treat their own patients through private and secure two-way video. Patients enjoy the convenience video visits offer as they visit a health care provider from the comfort of their home using a smartphone, tablet, or computer. My Practice Edition offers providers the technology to establish telemedicine capabilities for their patients for after-hours access and follow-up care during non-office hours.

\$100 Gas Card

As a new Value-Added Service, all members enrolled in care management are eligible to receive a \$100 gas card to help them more easily access resources and supports in their communities.

Supporting Member Transportation Needs

UniCare's commitment to health equity focuses on reducing the role of social determinants of health, including transportation barriers. The lack of available transportation often leads to barriers for members making healthy living choices and fully accessing their communities. UniCare works to assure any members facing transportation challenges do not miss appointments or become disconnected from care.

We will continue to educate our members and providers on how to access non-emergency transportation in our handbooks and website. Additionally, our Member Services Representatives are trained to assist members needing transportation who call our Member Call Center and will refer these members to the State's Non-Emergency Medical Transportation (NEMT) broker for transportation services.

As a VAS, UniCare will provide a \$100 gas card to help with transportation needs for members residing in rural locations without access to Uber, Lyft, taxi, or other public transportation options, pending BMS approval. This benefit will help members access extracurricular activities, self-help meetings, educational programs, grocery stores, etc., and is available only through care management referral.

- ND015 1 The Vendor should describe its process for the selection, credentialing, retention, and maintaining of qualified providers.

Selection, Credentialing, Retention, and Maintenance of Qualified Providers (ND015)

UniCare's network development, network maintenance, provider credentialing, and recredentialing processes are designed to assure members have a selection of providers that meet BMS standards and are qualified to meet the needs of all our members. UniCare understands and will comply with all BMS requirements, including the requirement that all network providers ordering, referring or rendering covered services are enrolled with the State (ND016) as a Medicaid provider, per 42 CFR 438.602(b).

Provider Selection

Recognizing our responsibility to provide members with accessible services and a choice of providers, we proactively develop and manage our provider network, carefully identifying and planning for potential network gaps before they become an issue. Our approach to building a strong provider network is based on collaboration, mutual respect, and trust. We regularly review our provider network design and distribution for improvement opportunities. We strive to include all eligible providers in our network to maximize member choice and access. Our network reflects the uniqueness of our members and provider selection considers:

- Review of our expected membership in relation to the overall population distribution of West Virginia
- Finalization of the number of providers, by type and location, to support the benefits we will administer with a focus on preventive and primary care services
- Refinement of the number of providers based on access standards and travel distances
- Review and engagement with providers currently serving members to understand their referral and care use patterns
- Outreach to potential providers regarding our strengths and experience in all aspects of Medicaid, including our hands-on approach to provider services

- Identification of PCPs identifying, treating, and referring members with BH disorders (for example, providers using SBIRT, an evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs)
- Contract terms that clearly define our performance expectations and hold all parties accountable for the success of the program

Provider Credentialing and Recredentialing

Our provider qualification process includes policies and procedures for initial credentialing, recredentialing, denials, suspensions, terminations and appeals, and reporting deficiencies to the State. Our credentialing process involves verifying licensure, board certification, education, and identification of adverse actions, including malpractice or negligence claims through the appropriate State licensing boards, including, but not limited to, the Board of Medicine, Chiropractic Board, Osteopathic Board, and the Dental Board. Our credentialing and recredentialing policies and processes are described in our response to ND017.

Provider Retention and Maintenance

UniCare's provider network retention strategy is grounded in a philosophy of partnership and bi-directional trust designed to develop and maintain lasting provider relationships. Our best-in-class network management and operational model includes comprehensive tools and education, meaningful engagement, and efficient processes to ease the administrative burden for network providers, and empowers them to deliver high-quality, culturally competent care to our members. We are proud that over the last two years, less than 1% of our PCP network providers have chosen to voluntarily terminate with UniCare due to dissatisfaction. UniCare offers a variety of strategies to enhance provider retention and network maintenance, including:

- Offering training and skill building through our Academy to increase provider competency
- Reducing administrative burden through our online provider portal functionality (such as our online claims disputes and authorization requests)

- Personalized one-on-one attention from our specialized Provider Concierge program
- Comprehensive Value-Based Payment strategies described in our response to PS007

We continuously monitor provider satisfaction through our Provider Services department, including the use of provider satisfaction surveys. We assess all survey findings to identify improvement opportunities, valuing provider satisfaction to assure our members are served by high-performing, engaged providers. According to the most recent measurement of provider satisfaction, 78% of providers say they are very or somewhat satisfied with UniCare overall.

- The Vendor should describe how they will ensure that its network providers have completed enrollment with the Department as required by Centers for Medicare & Medicaid Services (CMS)
- ND016 1 Medicaid and Children's Health Insurance Program Medicaid Managed Care Final Rule (<https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered>).

Assuring Network Providers Are Enrolled with DHHR (ND016)

UniCare will only contract with credentialed providers who are enrolled with the State as West Virginia Medicaid providers. Our provider application review process utilizes our Provider Contract Checklist to screen out provider applicants who are not currently enrolled with West Virginia Medicaid and assure all required information and supporting documentation is complete, correct, and included in the provider's application before it is routed for credentialing. We verify provider enrollment through the West Virginia Medicaid Management Information System (MMIS) and enrollments reports provided by the State. If we identify a provider for contracting who is not enrolled with West Virginia Medicaid, our Network Relations Consultants explain the provider enrollment process to the provider, and help the provider by directing the provider to the BMS provider enrollment website. Once providers are enrolled with West Virginia Medicaid, we proceed with contracting these providers to participate in our Medicaid network.

ND017 1 The Vendor should describe how they will establish credentialing and re-credentialing processes that fully comply with West Virginia C.S.R. §114-53-6 (https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/rule_053.pdf?ver=2004-09-14-092000-000) and 42 Code of Federal Regulations (CFR) 455, Subpart B (<https://www.govinfo.gov/app/details/CFR-2011-title42-vol4/CFR-2011-title42-vol4-part455-subpartB>).

Establishing a Compliant Provider Credentialing and Recredentialing Process (ND017)

UniCare's credentialing and recredentialing policies incorporate all aspects of the West Virginia C.S.R. §114-53-6 and all CMS regulations related to the credentialing and recredentialing process. Our credentialing and recredentialing policies have been reviewed multiple times by external auditors with no deficiencies identified related to either State or federal regulations. Our credentialing and recredentialing files have also been audited during these external surveys with no deficiencies identified.

On-time Credentialing

In 2019, UniCare processed 459 initial credentialing applications for practitioners and facilities with 93% completed within 90 days of receipt.

The credentialing and recredentialing policies are reviewed annually for any necessary changes from State, federal, or contractual requirements. We also make any necessary updates during the year as

needed. The annual review and off cycle updates are presented to the Credentials Committee for approval.

Each practitioner must complete the West Virginia mandated provider application form when applying for initial participation in UniCare's network. We have streamlined the credentialing process by teaming up with Council for Affordable Quality Healthcare (CAQH), the nationally recognized industry standard for collecting the provider data used in credentialing. UniCare verifies those elements related to an applicants' legal authority to practice, relevant training, experience, and competency from the primary source, where applicable, during the credentialing process. All verifications must be current as required by applicable accreditation standards.



We meet or exceed credentialing standards and protocols, including NCQA standards.

Our current provider site visit process also meets NCQA standards and West Virginia standards. Our provider manual, available to all providers on our website, provides details on our eligibility standards and rules. All providers seeking to join the UniCare network must meet all requirements, including eligibility, safety, medical record documentation, liability insurance, and all other standards, including handicap accessibility in accordance with the ADA. If we learn of any lapse or failures in any such eligibility standard or rule, UniCare works with the provider to address the issue and if needed, enters into a CAP. Termination is an option considered on the rare occasion a provider fails to remedy the issue, despite our corrective action process and support from UniCare.

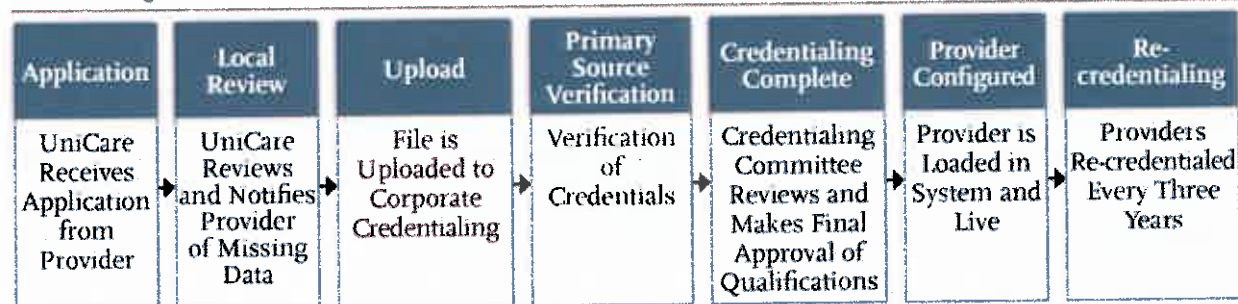
During the recredentialing process, UniCare reviews verification of the credentialing data captured during the initial credentialing process. The recredentialing process incorporates reverification and the identification of changes in the provider licensure, sanctions, certification, health status, and/or performance information (including, but not limited to, satisfaction survey results, UM information, complaints/grievances, malpractice experience, hospital privilege, or other actions) that may reflect on the provider's professional conduct and competence. This information is reviewed in order to assess whether providers continue to meet UniCare credentialing standards.

The Credentials Committee's objective is to maintain accreditation and regulatory compliance as it relates to credentialing functions. Our credentialing and recredentialing process assures providers enrolled in our network deliver quality services by conducting primary source provider verification and completing the credentialing process with a referral of the provider applications for review by the Credentials Committee. The Credentials Committee also conducts pre-contractual and recredentialing site visits, as discussed in ND018. An overview of this process is depicted on the following page (Figure 6.7-10).

Credentialing and Recredentialing Oversight Structure and Process

Figure 6.7-10. Overview of UniCare's Credentialing Process

Credentialing Process



We adhere to a formal structure to oversee credentialing activities (see Figure 6.7-11). Key credentialing steps include:

- The credentialing and recredentialing process, guided by our provider manual and credentialing policies, is executed by our Network Relations Consultants.
- The Credentials Committee oversees the credentialing process. If a provider does not meet UniCare credentialing criteria, the Credentials team refers the application to the Credentials Committee for review.
- The Credentials Committee will review the information and decide what action to take regarding the provider's participation in the UniCare network.
- A UniCare Medical Director is a part of the Credentials Committee. The Credentials Committee's Medical Director is accountable for convening meetings, signing off on the providers that meet UniCare credentialing criteria, and reviewing and acting on practitioner credentialing files that have potentially significant issues.

Figure 6.7-11. Credentialing Oversight Structure



- The Credentials Committee reports periodically to the QMC, which has oversight of UniCare's credentialing processes, including:
 - Annual credentialing evaluations
 - Semi-annual updates (high-level summary) of delegates reviewed for compliance with company, regulatory, and accreditation standards at the Accreditation Delegation Oversight Committee

Maximizing Provider Efficiency

We have structured our credentialing process for efficiency. UniCare strongly encourages West Virginia providers to use CAQH's ProView for initial credentialing and periodic recredentialing. CAQH is a not-for-profit alliance of the nation's leading health care plans and networks whose mission is to improve health care quality and access for more than 165 million Americans covered by these plans. The CAQH system collects data from over 1.3 million providers and allows administrative requirements to be streamlined. ProView is the industry standard for collecting the provider data used in credentialing. Providers in all 50 states and the District of Columbia use ProView free of charge and to reduce provider paperwork. ProView allows providers to fill out a single application to meet the credentialing data needs of multiple organizations. For both UniCare and providers, ProView is helpful because this process:

- Supports UniCare's administrative streamlining and paper reduction efforts
- Helps to assure the accuracy and integrity of the provider database
- Simplifies the credentialing application process, eliminating redundant application forms and streamlining paperwork for providers
- Enables providers to utilize the ProView database at no cost

Credentialing and Recredentialing Requirements

Our written policies and procedures support the identification, recruitment, and retention of participating providers, and include a uniform credentialing and recredentialing policies for PH and BH providers. Our process includes a statement by the provider regarding:

- Any physical or mental health problems that may affect current ability to provide health care
- Any history of chemical dependency or 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 health care programs
- An attestation to correctness/completeness of the application

Primary source verification is completed by UniCare, using the information and corresponding sources summarized in Figure 6.7-12.

Figure 6.7-12. Primary Source Verification Assures Providers Are Qualified to Serve Members

Primary Source Verification Assures Providers Are Qualified to Serve Members	
Information Category	Source
License to practice	Appropriate licensing agency
Hospital privileges	Hospital
DEA certificate	DEA online search via National Technical Information Service (NTIS)
Residency/education	Residency training program or state licensing agency
Board certification	American Board of Medical Specialties or acceptable specialty boards
Malpractice coverage	Copy of current malpractice coverage sheet or the completed malpractice coverage application item and a signed and dated attestation statement
Malpractice history	National Practitioners Data Bank (NPDB)
Sanction information (includes Medicare & Medicaid)	NPDB or state licensing boards
Work history	Application or curriculum vitae
Attestation to the correctness and completeness of information provided by the practitioner	Disclosure statement on the credentialing application attestation page
Reasons for inability to perform the essential functions of the position	Disclosure question on the credentialing application
Lack of present illegal drug use	Disclosure question on the credentialing application

We regularly review and update our comprehensive credentialing policies and procedures when NCQA, the federal government, or the State, including DHHR, issue new standards and requirements. We monitor credentialing and recredentialing activities to assure a smooth onboarding process for providers.

Types of Providers Credentialed and Recredentialed

UniCare credentials and recredentials all provider and facility types referenced in Figure 6.7-13.

Figure 6.7-13. UniCare Credentials and Recredentials the Full Spectrum of Providers

UniCare Credentials and Recredentials the Full Spectrum of Providers	
Medical Specialties That Require Credentialing: • Physician (MD, DO) • Podiatrist (DPM) • Chiropractor (DC) • Optometrist (OD) • Oral and Maxillofacial Surgeon (DDS, DMD, MD) • Certified Nurse Midwife (CNM) • Traditional Midwife (ITM or LM) • Registered Nurse Clinical Specialist (RNCS, CNS) • Registered Nurse Practitioner (RNP) • Physician Assistant (PA) • Licensed Acupuncturist (LAC) • Medical Therapists (for example, physical therapists, speech therapists, and occupational therapists) • Genetic Counselors • Audiologists • Registered Dietitians	Facilities That Require Credentialing: • Ambulatory Surgery Center (Free-standing Only) • Birth Centers (Free-standing Only) • Home Health Care Agency • Hospital (All types, including Psychiatric) • Skilled Nursing Facility/Nursing Home • Sleep Center (Free-standing Only) • Home Infusion Therapy when not associated with another currently credentialed HDO
Behavioral Health Specialties That Require Credentialing: • Psychologists who have doctoral or master's level training • Clinical Social Workers who have master's level training • Psychiatric or Behavioral Nurse Practitioners who have master's level training • Other Behavioral Health Care Specialists/Telemedicine Practitioners who provide treatment services under the health benefit plan	Behavioral Health Facilities That Require Credentialing: • Adult Family Care/Foster Care Homes • Ambulatory Detox • Community Mental Health Centers • Crisis Stabilization Units • Intensive Family Intervention Services • Intensive Outpatient — mental health or substance use • Methadone Maintenance Clinics • Outpatient Mental Health Clinics • Outpatient Substance Use Clinics • Partial hospitalization — mental health or substance use • Residential Treatment Centers — psychiatric or substance use

The following BH practitioners are not subject to professional conduct and competence review under UniCare's credentialing program, but are subject to a certification requirement process, including verification of licensure by the applicable State licensing board to independently provide BH services or compliance with regulatory or State or federal contract requirements for the provision of services: Certified Behavioral Analysts, Certified Addiction Counselors, and SUD Practitioners.

The following Health Delivery Organizations (HDOs) are not subject to professional conduct and competence review under our credentialing program, but are subject to a certification requirement process

including verification of licensure by the applicable State licensing agency or compliance with regulatory or State or federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End-stage renal disease service providers
- Dialysis facilities (CMS Certification)
- Portable X-ray suppliers (FDA Certification)
- Home infusion therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- FQHCs (CMS Certification)
- RHCs (CMS Certification)

All participating providers must meet initial and ongoing UniCare credentialing standards and network participation criteria. Figure 6.7-14 lists minimum credentialing requirements.

Figure 6.7-14. Requirements for Provider Credentialing and Recredentialing

Credentialing and Recredentialing Requirements

Credentialing and Recredentialing Requirements for Practitioners

- Graduation from medical school and completion of a residency, or other post-graduate training
- Board certification or eligibility, or specialized training as appropriate
- Current, unrestricted license to practice in West Virginia
- Valid Drug Enforcement Administration (DEA) or Controlled Dangerous Substance (CDS) certificate
- Hospital privileges, as applicable
- Current curriculum vitae or resume and work history (must show continuous five-year history)
- Signed attestation and release of information
- Absence of disciplinary action history, loss of clinical privileges, felony convictions, Medicare or Medicaid sanctions, exclusions, or debarments including 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

- Current, adequate malpractice insurance with minimum coverage requirements of \$1 million per individual episode and \$1 million in the aggregate
- Curtailment or suspension of medical staff privileges (other than for incomplete records)
- Any revocation or suspension of a state license or DEA/Bureau of Narcotics and Dangerous Drugs (BNDD) number
- Any censure by the State or County Medical Association
- Enrollee complaints

Credentialing and Recredentialing Requirements for Facilities and Organizational Providers

- Current and unrestricted licenses/accreditation for specified facility type
- Site Surveys for non-accredited providers (either State or CMS)
- Applicable general liability coverages
- Absence of Medicare, Medicaid, or Federal Employees Health Benefits Program sanctions, exclusions, or debarments
- Department of Health survey results, or recognized accrediting organization certification

UniCare will comply with the additional State credentialing and recredentialing requirements for dental providers and BH providers and agencies, including verification of:

- **Dental.** Anesthesia permits, and/or certificate from the West Virginia Board of Dental Examiners for those inducing central nervous system anesthesia.

- **BH Providers.** Licensure of COMPs or LBHCs with the West Virginia office Health Facility Licensure and Certification, independent psychologists, and practicing licensed social workers hold current license with their professional board.
- **Physician.** Requirements related to the provision of Suboxone.

Delegated Credentialing and Recredentialing

In certain instances, UniCare may delegate credentialing and recredentialing functions to a third party (delegate). Oversight of our delegated credentialing reduces the administrative burden for providers and, where feasible, is more efficient for all parties. Every delegate must perform credentialing and recredentialing functions according to our policies and procedures and the contract. UniCare retains final approval or denial for single provider participation within the delegated group. Our delegated credentialing and recredentialing processes meet or exceed NCQA accreditation requirements, as well as CMS and State guidelines. When considering potential credentialing and recredentialing delegates, we require the prospective delegate meet the following criteria:

- NCQA-accredited or certified or pursuing NCQA accreditation or certification
- Employ a minimum of 300 providers
- Meet or exceed all CMS regulations
- Comply with all applicable HIPAA requirements in accordance with business associate regulations
- Meet all UniCare credentialing requirements

Delegates may credential the following types of providers, including provider groups that meet specific eligibility requirements based on size, experience, infrastructure, and professional liability insurance: pharmacy providers, medical group practices, hospital-based physician groups, and physician and physician-hospital organizations.

- ND018 1 The Vendor should describe how they will establish site visit criteria and evaluation as part of its credentialing process for Primary Care Providers (PCPs), Obstetrics and Gynecologists (OB/GYNs), Durable Medical Equipment (DME) providers, behavioral health providers, other high risk providers, and other highly utilized specialists.

Establishing Site Visit Criteria as Part of Credentialing for Specified Provider Types (ND018)

UniCare's current site visit criteria is part of our provider credentialing and recredentialing policies, is in compliance with West Virginia C.S.R. §114-53-6, and have been approved by BMS. Our PC3s conduct site visits at the time of credentialing and every three years during recredentialing, in accordance with state regulations, for all PCPs and OB/GYNs, and more recently psychiatrists. Since 2016, over 75 site visits have been conducted with psychiatric providers. In addition, we currently perform site visits for other provider types, including, DME providers, non-psychiatrist BH providers, and other high-risk and/or highly utilized specialists, based on member complaints and quality of care concerns. Upon implementation of the new contract requirement in specified in SPA Section 2.1.6.1, we will revise our initial credentialing site visit criteria to include DME and BH providers.

UniCare's site visit policy, process, assessment criteria, and forms collectively inform our Network Relation Consultants' evaluation of provider compliance with federal, State, and local regulations and laws as well as conformance with our network credentialing standards. Our site visit evaluation form delivers a structured provider practice assessment of 71 elements across 13 domains including:

- **Office, ADA compliance, and provider accessibility (urgent and non-urgent).** Examples: adequate parking and handicap accessibility
- **Patient services and referrals.** Examples: Conduct all services behind closed doors and track all patient referrals
- **Provider policies, privacy, documentation and record keeping.** Examples: Authorization to treat forms, medical record availability upon member request
- **Physical plant safety and appearance.** Examples: Appropriate process and policy on waste disposal

- **Signage, informational, and educational materials.** Examples: Educational pamphlets or materials in various member languages

ND019 1 The Vendor should describe its process for reimbursement of services that occur during mid-transfer of a treatment, when a recoupment is not available through the original provider (for example, orthodontia).

Process for Reimbursement of Services During Transfer of Treatment When Recoupment Is Not Available (for Example, Orthodontia) (ND019)

UniCare has established continuity of care policies related to transfers of treatment and treating providers that assures our members, first and foremost, receive the care they need from the right provider to meet their needs.

When a member expresses the need or desire to transfer from one provider to another, we facilitate that transition. Our Care Management team assists the member in selecting an in-network provider in their service area that is the best fit for their health and social needs. We assure continuity of care by assisting with the transfer of records to the new provider and share the member's care plan, if applicable, as well as scheduling appointments as needed, and providing other necessary support services. UniCare works with both providers to coordinate care and payment.

We work with both providers to assure continuity of care for any member who transfers mid-treatment to make sure there is no disruption in care due to payment issues. Most commonly this scenario occurs related to inpatient services, where the member is admitted to one provider and transferred to another during the inpatient stay. We follow established coordination of benefits and inpatient reimbursement rules that generally provide payment to the admitting provider for the inpatient stay. Reimbursement for authorized outpatient, professional, and ancillary services are generally paid to the servicing provider. As

regards orthodontia, SKYGEN's mid-treatment transfer policy assures the original provider as well as the new provider are reimbursed appropriately.

As an example, orthodontia providers are reimbursed for some services in one lump sum payment at the start of the treatment process. If the member needs to continue their treatment with a different provider, the appropriate allocation of the lump sum payment is recouped from the original provider and paid to the new provider. To determine the appropriate allocation of funds, SKYGEN's orthodontist dental consultant for West Virginia works with both the original and new provider and reviews the treatment records. In addition to our dental consultant, SKYGEN's dedicated West Virginia Medicaid Provider Relations Field Representative as well as the designated Dental Reimbursement Analyst support any recoupment process and make sure that both providers are informed throughout the process.

Rarely, recoupment is unavailable through the original provider. When this occurs we work with SKYGEN to determine appropriate course of action. Importantly, if recoupment is not available through the original provider, SKYGEN does not reimburse the new provider without direction to do so from us.

- | | | |
|-------|---|---|
| ND020 | 1 | The Vendor should describe how they will establish notification processes related to provider network terminations including, but not limited to, the following: |
| ND021 | 2 | Notification to the Department and the enrollment broker with advanced written notice of any Primary Care Provider (PCP) network deletions within fourteen calendar days |
| ND022 | 2 | Written notification to members, at least thirty calendar days prior to the termination, to allow the opportunity to select a new Primary Care Provider (PCP) before being assigned one |
| ND023 | 2 | Immediate notification of a hospital termination to the Department |

Notification to Members, Enrollment Brokers, and DHHR of Provider

Network Terminations (ND020–ND023)

UniCare has established policies and procedures to ensure timely notification of provider network terminations to the Department, enrollment brokers and members (ND020). UniCare notifies BMS and the enrollment broker of provider terminations that materially affect our ability to deliver services within

14 calendar days. An individual physician or contracted medical group voluntarily terminating their UniCare contract must submit written notification to UniCare at least 90 days before the termination date. If a physician in a contracted medical group voluntarily terminates from that group, the group must submit written notification to UniCare 60 days before the termination date. Upon notification of a specialist termination, our system auto-generates letters to any member who has been treated by the terminating provider within the past six months. The letter instructs the member to contact their PCP as soon as possible for a new specialist if referral is required, including if the member has questions or needs further assistance; is undergoing an active course of treatment; is in the second or third trimester of pregnancy; is within six weeks postpartum.

Notification to BMS and Enrollment Brokers of PCP Deletions (ND021). UniCare provides BMS and the enrollment broker with advanced written notice of PCP terminations, both MCO initiated and voluntarily, within 14 calendar days.

Notification to Members and new PCP Assignment (ND022). Upon receiving a termination notification from a PCP, UniCare updates the provider record within our provider data management system, which auto-generates a letter to our members to advise them of the pending PCP termination. UniCare will make a good faith effort to notify members within fifteen (15) calendar days of the issuance of a termination notice, and no later than thirty (30) calendar days prior to the termination effective date. The member is instructed to contact the Member Call Center to select a new PCP. If the member has not selected a new PCP by the provider termination date, a new PCP is assigned to the member. When the PCP termination is immediate, the provider's members are reassigned to providers and sent new membership cards with their new PCPs. An automated letter is generated and sent to the member stating that the PCP is no longer available. If a member desires a different PCP than the one assigned, they are

instructed to contact the Member Call Center. Our auto-assignment process is based on the following criteria:

- Assign the member to the current or most recent valid PCP with whom the member has a relationship based on prior claims history or other available information
- Assign the member to an active family member's (closest in age) PCP
- Assign the member to the PCP of a family member found in the claims history file

In addition, we use our Member Default Optimization algorithm to assign members to PCPs who best meet their needs based on quality and efficiency ratings and participation in our value-based payment programs such as PQIP. Additional factors include proximity and languages spoken, specialty, and specialized training and expertise, such as assigning a child with special health care needs to health professionals with CSHCN training and experience.

Notification to BMS of Hospital Terminations (ND023). UniCare reports all hospital network disenrollment to BMS immediately.

8. PROVIDER SERVICES

PS001 1 The Vendor should provide a description of its Provider Services operating model.

UniCare's Provider Services Operating Model (PS001)

The UniCare Health Plan of West Virginia, Inc. (UniCare) approach to Provider Services is founded on 17 years of experience collaborating with providers in West Virginia to deliver medical services to West Virginia's Mountain Health Trust (MHT) program.



Our Provider Services operating model consists of our West Virginia Provider Services Department (Service Provider Agreement [SPA] 2.6.1.1) and our Toll-Free Provider Phone Line (SPA 2.6.1.2), and follows the principles of our ***Provider Pledge: to deliver a best-in-class experience by simplifying health care so our providers can focus on member health.***

Strong provider relationships and support increase provider satisfaction, retention, and willingness to collaborate on programs and initiatives to improve the health of our members. The complexity of members' needs continues to increase for various reasons — the worsening substance use disorder (SUD) epidemic and the increased awareness of the influence of social factors on health — to name a few. With this growing complexity comes an increase in demands on providers. As they work to connect the dots for members — integrating physical health (PH), behavioral health (BH), and coordinating with community resources — we support them through the tenants of our Provider Pledge: Engage, Incent, Empower.



Engage participating providers to support and collaborate on programs and initiatives that improve patient care. For example, our Provider Concierge program supports high-performing providers by streamlining their office processes to significantly reduce administrative burden.

Incent participating providers to drive improved member outcomes that are aligned with State goals. For example, we are expanding our array of Value-Based Payment (VBP) programs to increase focus on access and wellness, overall population health, BH and specialty services, and social factors influencing member health.

Empower network providers through education, training, performance support, and sharing of clinical quality data. For example, the UniCare Training Academy (the Academy) provides training that helps providers understand and simplify administrative processes and expands training on health factors and best practices to improve member health outcomes.

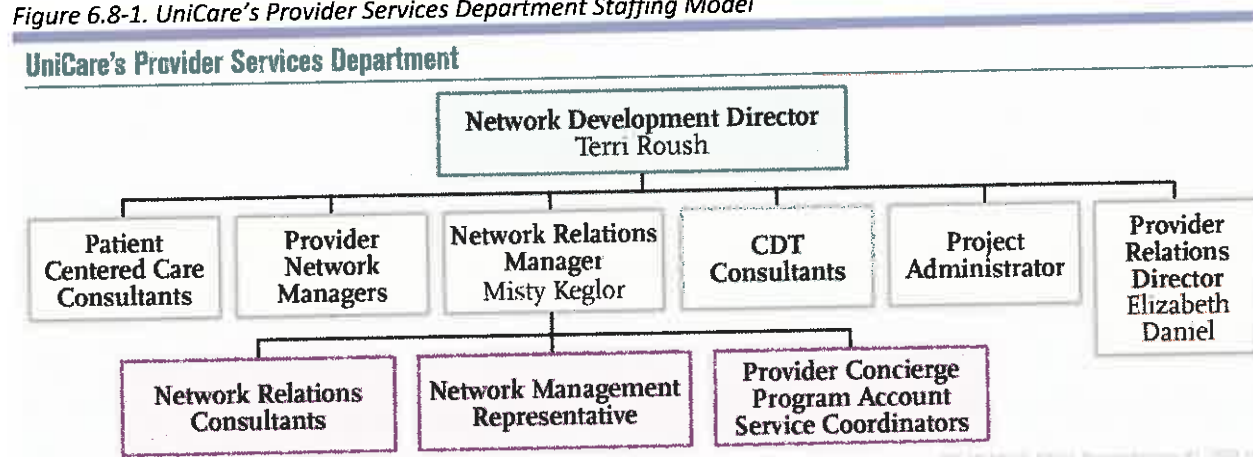
Through our Provider Services operating model, our Provider Services Department and Toll-Free Provider Phone Line support our participating providers so they can focus on and improve the health and lives of West Virginians.



Provider Services Department

Overall responsibility for our Provider Services Department is the duty of our Network Development Director, Terri Roush. Our integrated PH and BH Provider Services Department staffing model is shown in Figure 6.8-1.

Figure 6.8-1. UniCare's Provider Services Department Staffing Model



Reporting to our Network Development Director are four Patient Centered Care Consultants (PC3s), two Provider Network Managers, two Care Delivery Transformation (CDT) Consultants, one Project Administrator, and one Provider Relations Director. Reporting to our Network Relations Manager are seven Network Relations Consultants, three Provider Concierge program Account Services Coordinators, and one Network Management Representative. We detail the responsibilities of each of these positions below.

Network Development Director



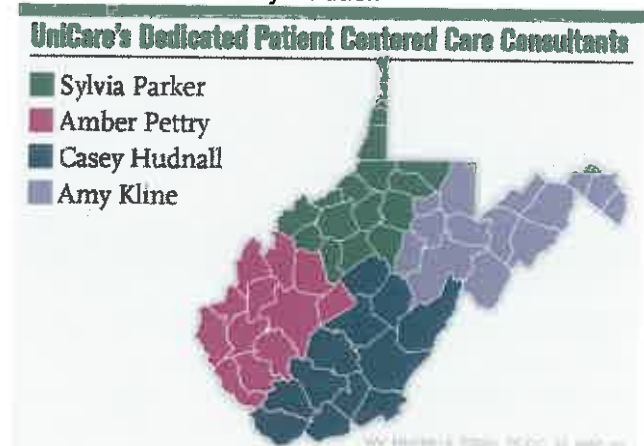
Our Network Development Director, Terri Roush, oversees all activities related to network development and contracting for PH and BH services. She is responsible for network development and provider reimbursement; establishing and maintaining a comprehensive, accessible, statewide provider network; making sure members have

access to the full range of provider types and specialties in accordance with covered benefits and Contract standards; and developing reports on provider network adequacy. She also oversees the contracting activities of valued-based arrangements, shared savings, and alternative payment models (APMs). She oversees the development of innovative ways to maintain a cost-effective network with adequate access and positive provider working relationships. She also supports credentialing activities and is responsible for reporting network adequacy.

Patient Centered Care Consultants

Our PC3s (Figure 6.8-2) report directly to our Network Development Director. They are integral to our Whole-person Health model and offer support to

Figure 6.8-2. Regionally Assigned PC3s Support Providers with Office-based Care Delivery Interventions and Promote Practice Transformation



providers to improve the effectiveness and efficiencies of provider practices. Their primary duties include analyzing quality metrics and reports for care opportunities and supporting practice implementation of care coordination and care management.

PC3s also conduct facility site reviews and provide education for practices to develop expertise with metrics and data review for quality improvement. They collaborate with the CDT team and actively support the efforts of providers and practice teams on office-based care delivery interventions resulting in cost of care savings and improved health outcomes for our members.

Provider Network Managers

Our Provider Network Managers are responsible for developing, maintaining, and enhancing our West Virginia MHT provider network, including assuring an appropriate distribution of provider specialties. They conduct effective contract negotiations, develop strategic relationships, and offer operational support. Our Provider Network Managers work with complex providers, including large institutional providers, large medical groups, and ancillary providers, to assure an understanding of and to support value-based concepts; to help providers in areas with strong competition; and to offer provider education around managed care concepts when in-depth information is required. They also continuously recruit new providers, conducting negotiations and leading contracting efforts to assure UniCare maintains a cost-effective, accessible provider network.

Care Delivery Transformation (CDT) Consultants

Our CDT Consultants manage the technical assistance program for our Provider Quality Incentive Program (PQIP), PQIP Essentials (PQIPE), and Negotiated Risk/Shared Savings (NRSS) program total population health-focused APM providers. CDT Consultants lead a team that includes our Network Relations Consultants, PC3s, Quality Management (QM) Practice Consultants, and Medical Directors.

Their primary duties include analyzing practice-specific cost and quality data and reports for cost of care and quality opportunities; helping practices target high-risk members and gaps in care based on reports provided; supporting practice implementation of population health, care coordination, and care management strategies; identifying action plans for providers to implement to improve cost, quality, and the member experience; and participating in design, development, and implementation of community learning forums.

Project Administrator

Our Project Administrator supports our Provider Services Department. Primary duties include managing cross functional projects and serving as a liaison with internal departments (for example, Claims, Information Technology/Management, Network Management, Utilization Management [UM], Care Management, and Operations). Our Project Administrator is also responsible for project support, including provider engagement, provider contracting, and departmental education activities; and critical business activities, such as out-of-network (OON) utilization education, OON cost of care analysis, reimbursement strategies, clinical connectivity, and provider contracting. The position manages provider contract files and prepares information for timely and accurate submission to the Provider Data Management area.

Provider Relations Director

Experience Matters

Elizabeth Daniel
 Provider Relations Director



Elizabeth is responsible for communicating with the provider community and supporting ongoing provider relationships.

Our Provider Relations Director, Elizabeth Daniel, is responsible for communicating with the provider community and supporting ongoing provider relationships. As a knowledge and resource expert, she handles escalated provider issues affecting provider satisfaction, and researches and resolves the most complex provider issues and appeals

for prompt resolution. She directs the communication and complaint resolution strategies between physicians, hospitals, members, and the public. She also develops provider training; oversees our provider satisfaction surveys; and fosters and supports the development, distribution, and maintenance of our provider manual.

Network Relations Manager

Experience Matters

Misty Kegl
Network Relations Manager



Misty oversees and supports the day-to-day activities of our Network Relations and Provider Concierge Program teams.

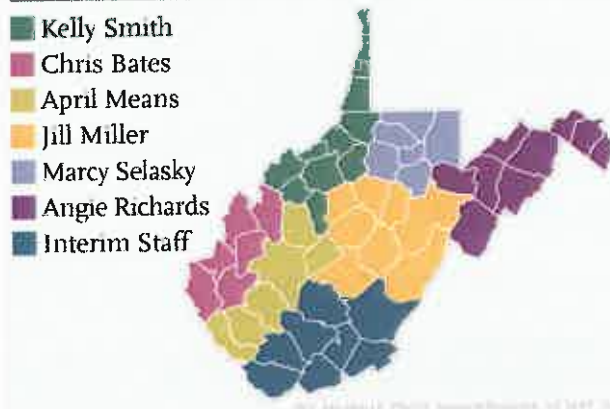
Our Network Relations Manager, Misty Kegl, oversees and supports the day-to-day activities of our team of seven Network Relations Consultants, three Provider Concierge program Account Service Coordinators, and one Network Management Representative. She also communicates with providers and supports ongoing provider relationships.

Network Relations Consultants

Our Network Relations Consultants (Figure 6.8-3) are the face of our Provider Services model. They conduct regular, on-site, face-to-face visits with our providers and their staff, communicate administrative and programmatic changes, facilitate and deliver provider education, and resolve any provider-related issues. They also assist providers and their staff with contracting questions, prior authorizations (PAs), claims submission, and processes related to credentialing, needs assessments, and electronic remittance advice/electronic funds transfer (ERA/EFT).

Figure 6.8-3. Regionally Assigned PH Network Relations Consultants Deliver High-touch, One-to-One Support

UniCare's Dedicated Network Relations Team



Assigned regionally, the majority of our Network Relations Consultants reside in the areas they serve to assure they understand the nuances of member and provider needs in those areas (for example, public transportation patterns, availability of specialists in rural areas, and OON alternatives). They assist at the point of care, providing member utilization data to identify gaps in care, and assuring our members have access to all appropriate services.

I can't say enough about how helpful our Network Relations Consultant has been and continues to be. She is knowledgeable, prompt, and efficient in the job that she does. She never makes me feel like any confusion that I may be having is unimportant. She is definitely an asset to the UniCare Operation, because she's most definitely an asset to me.

Sheila Long, Patient Accounts
Wheeling Hospital

Provider Concierge Program Account Services Coordinators

Beginning in 2020, UniCare is expanding its Provider Services operating model to include our Provider Concierge program. Under the oversight of our Network Relations Manager, our Provider Concierge program is designed to increase provider satisfaction by rewarding high-performing providers with differentiated concierge-type service, tailored to their practice. Three designated Account Services Coordinators will serve as single points of contact for their assigned provider groups for operational support functions and payment matters including onboarding, claims, data updates, and credentialing. They will be responsible for hosting planned, proactive, and regular communication between provider groups and the Provider Services team. They will also serve as a centralized navigator for expedited access to various shared services teams. Our Provider Concierge program is focused on continually making it easier for the provider to do business and is one of the ways we deliver on our Provider Pledge to simplify health care so providers can focus on health.

Network Management Representative

We strive to engage and support our providers to foster a mutually beneficial relationship and encourage interaction, communication, and collaboration at multiple touch points. To that end, our Network Management Representative provides comprehensive services to the provider community through

researching the most complex provider issues. The Network Management Representative is our knowledge and resource expert regarding provider issues that might affect provider satisfaction. The Network Management Representative is responsible for researching, analyzing, and recommending resolution of provider disputes; as well as issues related to billing and claims. The position facilitates prompt resolution through direct contact with providers and internal departments; and works on special projects, supports developing policies and practices, and audits work.

Toll-Free Provider Phone Line



Also part of our Provider Services operating model is our Toll-Free Provider Phone Line. Our Toll-Free Provider Phone Line offers all providers in our West Virginia MHT network a dedicated phone line for access to live Provider Services Representatives between the hours of 8:00 a.m. and 6:00 p.m. ET, Monday through Friday, ***exceeding the SPA requirement by 25%***. Our Toll-Free Provider Phone Line complies with Mandatory Requirement MD009 and meets all requirements outlined in SPA 2.6.1.2.

In 2019, our Toll-Free Provider Phone Line received 64,183 calls with an abandonment rate of less than 5%. We answered more than 90% of the calls received within 10 seconds.

Our Provider Services Representatives operating our Toll-Free Provider Phone Line receive focused training to support the unique needs of providers serving West Virginia MHT members, including claims and invoice status and information specific to provider specialties (PH, BH, specialists, dental, vision), member eligibility, general program information, and guidance and education specific to individual provider types. Our Provider Services Department and QM staff monitor our call metrics.

In 2020, we are establishing a West Virginia-based call center staffed with experienced representatives who have the skill set and local knowledge to address the more complex needs of our

providers. Our call center will be comprised of 12 employees located in our Charleston, West Virginia office, alongside the rest of our health plan staff. This co-location enables our CEO, Tadd Haynes, to be directly connected to the service level and supports that this team provides. Additionally, the team will have immediate access to the health plan staff most appropriate to address the needs of our providers, such as our Operations department, Clinical staff, and Provider Services team. As West Virginians serving West Virginians, this local knowledge will help make sure our providers receive the highest level of service and embrace our philosophy that health care is local.

We will continue draw on the strength of our national resources to help callers with more administrative tasks, such as confirming Member eligibility, which will allow our local West Virginia call center to focus on providing more high-touch and specialized service to our providers that need it most. Should these administrative calls become more complex at any point, our national resources will be trained to quickly warm transfer callers to the local West Virginia team. These national resources will also provide our providers critical support during business continuity events, such as the tornado that left our office without power in June 2019.

PS002 1 The Vendor should describe how its Provider Services Department will provide initial provider orientation, annual training, and support to its provider network.

Initial Provider Orientation, Annual Training, and Support to Providers (PS002)

We provide education and training to our providers through the Academy, a dynamic, multi-modality system that encompasses all UniCare provider training, including provider orientation, annual refresher training, and ongoing training.



As shown in Figure 6.8-4, the Academy incorporates multi-modality delivery processes (in-person training, online courses, tailored webinars, and written materials), as well as mechanisms for tracking, monitoring, alerting, and reporting compliance and completion of training.

Through the Academy, we reinforce consistency across various formats and promote unified results. As a differentiator, the Academy provides a robust vehicle for training that is continuous, measurable, and customizable to regionally identified, member-specific requirements and provider needs. It is our comprehensive approach to assure initial, annual, and ongoing provider training for all West Virginia Department of Health and Human Resources (DHHR)-required and UniCare-offered provider training.

Figure 6.8-4. UniCare Training Academy Modalities Suit Provider Preferences for Training Delivery

UniCare Training Academy Modalities		
Provider Orientation	In-person, webinar, and recorded versions of provider orientation assure training is completed within 30 days of placing a newly contracted provider on active status.	  
Individual Training	All providers can request individual training as needed. In addition, Network Relations Consultants meet one-on-one quarterly with hospitals and at least annually with PCPs.	 
Group Training	Group training is offered in several settings including Town Halls, Lunch and Learns, and association meetings.	  
On-demand/Online Resources	We offer providers and their staff educational events in the comfort of their offices through our provider website, toolkits (including our cultural competency toolkit), and our provider manual, newsletters, online bulletins, and e-updates.	
Additional Provider Outreach	We reach out to our providers using various methods, including in-person outreach and fax blast notifications.	 
KEY  In-person  Webinar  Online		

Initial Provider Orientation

All newly contracted providers complete initial onboarding within 30 days of becoming an active UniCare participating provider. During initial onboarding, we require all providers to complete initial provider orientation training. UniCare’s initial provider training assures that new providers understand the

program, specific benefits, reimbursement requirements, and UniCare policies and procedures. It is offered to providers via recordings and webinars hosted by the Academy, or in person in the provider office or private facility settings by a Network Relations Consultant or PC3. Initial provider orientation topics include, but are not limited to the topics shown in Table 6.8-1.

Table 6.8-1. UniCare’s Initial Provider Orientation Assures Providers Understand the Program

UniCare’s Initial Provider Orientation Topics	
• Introduction to UniCare, our Provider Services Department, our marketing policies, working with an MCO • DHHR policies, priorities, and processes • Provider roles and responsibilities • MHT requirements, plan rules, benefits and benefit exclusions for all MHT programs • EPSDT and Health Check program requirements for WVCHIP • Verifying eligibility, referral and prior authorization of services • Utilization management, disease management, and care management • Gaps in care reporting and member outreach • Person-centered treatment (care) planning • Appointment access standards, timeframes, and after-hours care requirements • Telemedicine, telehealth, and telemonitoring • Provider manual, web portal, and other provider resources • Medical necessity criteria • QM program, HEDIS®, and the provider’s role in the program • Early Childhood Intervention • Diversity and delivering culturally competent care and culturally responsive treatment	• Reporting requirements: communicable disease; mandated reporter’s training; false claims act; fraud, waste, and abuse • Preventive health care guidelines • Privacy and confidentiality of protected health information • Use of evidence-based and clinical practice guidelines • APM training • Provider grievances and appeals, dispute resolution processes, helping members file grievances and appeals • Value-Added Services (VAS) and social supports • BH and SUD protocols and resources • Billing procedures, claims, required documentation, navigating Availity, and payment methods • Community outreach, member education, and compliance • Member and provider satisfaction surveys • The importance of encounter data • Integrating PH and BH • Postpartum outreach • Introduction to social determinants of health (SDOH)

During initial provider orientation, we distribute copies of our provider manual and member benefit collateral that also give detailed information related to the West Virginia MHT program. We monitor the effectiveness of our training by conducting post-training provider surveys to determine if training objectives were met and identify any needed adjustments.

Annual Provider Training

UniCare offers annual provider training that reinforces areas covered in initial provider orientation, covers up-to-date topics relevant to our members’ needs, provides updates related to changes in State and federal requirements and UniCare policies and procedures, and reviews program standards and contract

requirements. Annual provider training is offered via recordings and webinars hosted via the Academy, or in person in the provider office or private facility settings by a Network Relations Consultant or PC3.

In addition to reinforcing all of the topics covered in initial provider training, and focused training on cultural competency (detailed further in our response to PS004), our annual provider training includes, but is not limited to the topics in Table 6.8-2.

Table 6.8-2. Annual Provider Training Topics Relevant to West Virginia MHT Members

Topic Area	Subjects Covered
Integration of Physical and Behavioral Health and Substance Use	• Understanding BH and PH Conditions • Substance Use and Substance Exposure • Evidence-based Treatment Practices • Integrated Health Care Delivery • Behavior Management • Crisis and Crisis Support
Trauma and Trauma-informed Care	• Trauma-informed Care • Trauma and Adverse Childhood Experiences (ACEs) • Impact of Trauma and ACEs • Evidence-based Trauma Treatment
Approaches to Service Delivery	• Engagement, Collaboration • Confidentiality • Caregiver Support
Special Populations	• Understanding Special Health Care Needs and Disabilities • Autism Spectrum Disorder • Dual Diagnosis • Meeting the Needs of Children with Special Health Care Needs and Disabilities • Serving the Homeless • LGBTQ Considerations
Social Determinants of Health (SDOH)	• Employment Resources and Helping Members with Employment • Food Security • Housing Stability • SDOH Education • Social Cohesion • Resources that Connect Members to Social Supports and Health Care • Environmental Member Needs

As with initial provider orientation, we monitor the effectiveness of our annual training by conducting post-training provider surveys to determine if training objectives were met.

Ongoing Training to Support Network Providers

UniCare delivers ongoing training that supports annual training when we have new information that will improve member outcomes, help providers with common issues (for example, coding, billing, and appeals

of claims decisions), or impact performance goals. Training is delivered online via the Academy, and via webinars that are live with providers being able to interact and submit questions. Some of the webinars we conducted in 2019 include:

- The UM process, common errors, basic UM request instructions, and available resources (February 2019)
- Pediatric HEDIS training covering the HEDIS process, common errors, and resources available to PCPs, pediatricians, office managers, and billing staff (May 2019 and July 2019)
- General information for OB/GYNs, office managers, utilization staff, billing staff, and others who work in an OB/GYN setting (June 2019)
- After-hours and appointment availability standards (September 2019)
- General information related to serving members with diabetes, common reporting errors, HEDIS, and available resources (October 2019)
- BH HEDIS training, common errors, and available resources (November 2019)

In 2019, our Provider Services Department conducted 22 ongoing provider training webinars, 16 State workshops, and 16 SUD-specific trainings in addition to provider self-led trainings hosted by the Academy.

The Academy supports providers throughout their tenure, and assures focus on evidence-based best practices and supports for all stakeholders in all members' lives. Table 6.8-3 provides training events and materials UniCare offers our participating providers, including Provider Services resources involved, modalities, and frequencies.

Table 6.8-3. UniCare Training Events and Materials

Event/Material	Resources, Modalities, Frequency
Provider Orientation Training	Our Network Relations Consultants and PC3s conduct new provider orientation whenever a provider joins our network. Training is offered to providers via monthly webinars, and on demand in the provider office or in private facility settings. Frequency: Within 30 days of new provider enrollment
Online Training	Our provider website is a successful tool for offering our participating providers online, on-demand training. Frequency: 24/7, on-demand access
In-person Training	In-person provider training is conducted at the provider's convenience by our Network Relations Consultants and PC3s. Training is often tailored for a particular provider type; for example, OB-GYN, home health, and BH; to address issues that vary based on provider type; like billing procedures, claims, and incentive programs. If we identify an issue we think will help a provider improve quality of care or billing practices, we proactively outreach to affected providers with customized in-person training. Frequency: Ongoing, as needed or requested
Population-focused Training	Beginning in 2020, through our Elsevier training platform (see description below); the Academy will offer a wide array of expert-developed, customized trainings specific to the member population providers are serving. Topics will include autism spectrum disorder, trauma-informed care, ACEs evidence-based practices in children's mental health, and culturally responsive care. Elsevier offers a web-based educational tool allowing providers to self-select courses with specialized content that meet their needs and interests. Providers completing training will have the opportunity to earn continuing medical education and continuing education units. Frequency: Ongoing, as needed or requested
Targeted Trainings Developed in Partnership with Other Organizations	UniCare partners with outside organizations and stakeholders to deliver targeted trainings applicable to West Virginia MHT recipients. For example, in October 2019, we partnered with the Bureau for Medical Services (BMS) to provide training specific to the SUD waiver. Training was given during statewide workshops, and to BH associations. Frequency: As new trainings are developed
Provider Manual	Our provider manual is a comprehensive resource designed to inform providers of our program guidelines and requirements and to assist in caring for members. We review the manual with participating providers during orientation. An electronic copy of the manual is available on our website. Frequency: 24/7 access via our provider website
Provider Bulletins	Our Provider Services Department issues provider bulletins to communicate program updates, new State-initiated programs or updates, policy clarifications and updates, updates to our provider manual, and to reinforce current policies and procedures. We also use provider bulletins to distribute clinical protocols. Frequency: Ongoing, posted to our provider website as needed; 24/7 access via our provider website

Event/Material	Resources, Modalities, Frequency
Provider Newsletter	Our Provider Services Department issues provider newsletters for important provider information and topical updates. These newsletters include information on a variety of topics. Recently, newsletters included information related to ICD-10, claims submission processes, pharmacy, BH, chiropractic code set, and the PA process. Frequency: Quarterly
Blast Faxes	Our Provider Services Department issues blast faxes to assure our providers have immediate access to important program updates. We also use them to communicate and promote our educational events. Frequency: Ongoing, as needed
Webinars	Webinars allow our providers to participate in educational events from their office or home. Facilitated by our Network Relations Consultants and PC3s, recent topics have included access to care, PA, UM, BH, HEDIS. Frequency: At least monthly
BMS Workshops	Spring and Fall workshops are held encompassing all areas of West Virginia. We participate in the planning and development of the educational topics for the workshops. A total of 16 workshops were held in 2019. Frequency: Spring and Fall
Provider Association Meetings	Our Provider Services Department regularly participates in ongoing provider association meetings. Based on the agenda, they develop a presentation and educational materials to meet the needs of each particular association. In 2019, our Provider Services Department participated in 30 provider conferences, events, and workshops. Frequency: Ongoing, based on association schedule
BH Association Meetings and Events	Our Provider Services Department participates in revenue and billing meetings, which are specifically designed to meet the needs of Comprehensive Behavioral Health Centers (COMPs) and Licensed Behavioral Health Centers (LBHCs). Issues addressed are related to specific BH program updates, claims-related questions, changes to billing methodology, and PA requirements. In 2019, our Provider Services Department participated in eight BH-specific meetings and events. Frequency: Ongoing, based on request and association schedule
Third-party Payer Events	Our Provider Services Department participates in Third-party Payer events by staffing a booth and providing important program information. We also participate in panel discussions as requested. In 2019, our Provider Services Department participated in four third-party conferences. Frequency: Quarterly

Improving Outcomes for CHIP and Children with Special Health Care Needs (CSHCN) Members

UniCare is committed to improving outcomes for CHIP and CSHCN members. *Given the inclusion of CHIP and CSHCN members in the West Virginia MHT program and the prevalence of trauma among individuals in this population, we will provide ongoing training to our participating providers to enhance their ability to identify the effects of trauma and build resiliency, reduce the consequences of trauma, and address the challenges these children may face.* Through the Academy, our participating providers will receive specific training on trauma and trauma-informed care, ACEs, and evidence-based treatment practices, such as trauma-focused cognitive behavioral therapy and SDOH that are pertinent to the unique needs of these members. The Academy highlights the unique needs of this population, including effective needs assessment, treatment planning, and integration of PH and BH care and services. Topics will include, but not be limited to:



- Screening for, identifying, and coordinating BH disorders (including screening tools)
- Responding to members with co-occurring mental health and SUD
- Referring members to a BH specialist
- Collaborating with other providers involved in member care
- BH and SUD training, including provider skills trainings
- Supporting integrated care at the pediatric practice level

Tobacco Use Cessation Training



In recognition of the priority the State has placed on reducing the burden of tobacco use, in 2020 UniCare is expanding provider training related to tobacco use, smoking cessation, and referral to the UniCare Quitline. Adults with mental illness or SUD are

more than three times as likely to smoke as the rest of the population and consume approximately 40% of all cigarettes sold in the United States. In addition, smoking exacerbates the symptoms of BH conditions such as depression, suicidal behavior, and drug and alcohol use relapse. Although this training will be available to all providers, it will target BH clinicians. BH clinicians can be effective in reducing tobacco use for the following reasons:

- Tobacco users expect health professionals to encourage them to quit
- Screening for tobacco use and tobacco cessation counseling are positively associated with patient satisfaction
- Often, the BH clinician is the member's provider who communicates most frequently and knows them best
- They are trained in SUD treatment (tobacco use disorder is a DSM-V SUD)
- They are trained in motivational interviewing
- BH clinicians are able to combine psychopharmacological and behavioral counseling treatment

Additional Provider Support

In addition to initial, annual, and ongoing provider trainings, UniCare offers providers support and enhanced educational tools through the Academy that are available on demand, reinforce learning objectives, and facilitate adoption and application of principles and best practices presented during formal training. For example, the Academy hosts our provider toolkits. Toolkit topics that are currently offered or are planned include:

- Caring for Diverse Populations
- Screening and Identifying BH disorders
- Neonatal Abstinence Syndrome (NAS)

- ACEs
- Child and Adolescent Needs and Strengths (CANS)
- Family First Prevention Services Act
- Parent-Child Interaction Therapy
- Motivational Interviewing Techniques
- Multi-systemic Therapy
- Functional Family Therapy
- Trauma-focused Cognitive Behavioral Therapy
- SDOH

PS003	1	The Vendor should describe its process for specialists serving as Primary Care Providers (PCPs), and related monitoring activities.
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Processes and Monitoring for Specialists Serving as PCPs (PS003)

Process for a Specialist to Serve as a Member's PCP

When a request is received for a specialist to serve as a member's PCP (whether from the member, a provider, or through other means) the member is contacted by a UniCare Care Manager to evaluate the member's needs. To accomplish this, and as part of ongoing care management, the Care Manager will outreach to the caregiver or member to obtain information about specific services the member is receiving. The Care Manager will also review utilization records, claims data, EPSDT periodicity schedules, and gaps in care reports to make sure primary care services are being provided by the specialist on an ongoing basis.

Specialists can serve as a member's PCP in circumstances where the member has underlying health conditions that would be best managed by the specialist. These include members with a chronic or life-threatening illness or condition that requires multiple hospitalizations, members where the majority of

their care needs are given by a specialist, and members where the administrative requirements arranging for care exceed the capacity of the PCP (for example, members with complex neurological disabilities, chronic pulmonary disorders, HIV/AIDS, complex hematology and oncology conditions, cystic fibrosis, serious mental illness, serious emotional disturbance, etc.). Other examples include, but are not limited to a female member requesting an OB/GYN or a participating advanced registered nurse practitioner as their PCP or a member with SUD requesting a BH provider as their PCP.

The Care Manager has responsibility for assuring the member's primary care needs are met and any identified barriers to care are addressed and resolved.

Once determination is made that a specialist would be the best provider to meet the member's primary care needs, our Care Manager will collaborate with our Network Relations Consultants to further assure the specialist understands what is required to serve as a member's PCP, and if needed, provide targeted training.

Our Network Relations Consultants are responsible for making sure the specialist meets the requirements for PCP participation in our network. This includes making sure the provider meets contractual obligations and credentialing requirements, is able to provide access to care 24/7, and is willing to coordinate the member's health care, including preventive care. The specialist must also agree to assume all PCP responsibilities and have admitting privileges at a participating hospital.

Should we identify underlying circumstances whereby we determine the specialist cannot serve as a member's PCP, our Provider Services Department is responsible for providing written notification to the member and the specialist with the reason for denial. Our Care Manager then assists the member with selecting an alternate specialist or PCP.

Monitoring Specialists Serving as PCPs

Our Network Relations Consultants conduct ongoing monitoring of specialists serving as PCPs, including conducting regular site visits and reviewing feedback from care management staff, to assure the specialist is complying with requirements and providing adequate primary care for the member.

When monitoring, should a Network Relations Consultant identify a potential non-compliance, they notify our Provider Relations Director and our Medical Director who then conduct an internal review. Our Provider Relations Director and our Medical Director also conduct an in-person meeting with the specialist to review data and discuss whether there are any extenuating circumstances. If warranted, the specialist is notified in writing of the non-compliance concern and required to submit a corrective action plan (CAP) to UniCare within 30 days. Failure to submit a CAP within the required timeframe results in further analysis and development of interventions. For providers submitting a timely CAP, our Provider Relations Director and our Medical Director review and approve the CAP, as indicated, and continue to monitor progress on a quarterly basis for evidence the problem has been corrected.

PS004 1 The Vendor should describe how its Provider Services Department will provide training to its provider network regarding culturally competent care.

Provider Training on Culturally Competent Care (PS004)

Initial and Annual Cultural Competency Training

All UniCare participating providers receive cultural competency training during initial onboarding and annually thereafter. We are committed to making sure our providers are fully trained in the delivery of culturally appropriate services for our members, their caregivers, and their communities. Cultural competency training topics include, but are not limited to the following:

- Standards for Culturally and Linguistically Appropriate Services (CLAS)
- Title VI of the Civil Rights Act of 1964

- Executive Order 13166: improving access to services for persons with limited English proficiency
- Tips for successful encounters and enhanced communication with diverse patients
- Identifying and addressing health literacy issues
- Americans with Disabilities Act requirements
- Available resources

Our cultural competency training helps make certain our providers understand that delivering services to people of all cultures, races, ethnic backgrounds, sexual orientations, abilities, and beliefs must occur in a manner that recognizes, values, affirms, and respects the worth and dignity of all members.

Ongoing Cultural Competency Training and Resources

Through the Academy and our provider website, providers have on-demand access to a broad array of trainings and other resources related to cultural competency, such as:

- Our Cultural Competency Plan
- Examples of best practices
- A review of the 15 national CLAS standards with a link to the US Department of Health and Human Services website for more information
- My Diverse Patient Trainings, including Breast Cancer Screening for African-American Women, Creating an LGBTQ-friendly Practice, Moving Toward Equity in Asthma Care, and other person-centered topics that facilitate improved quality and health outcomes
- A new program created by the Industry Collaboration Effort Cultural and Linguistic workgroup regarding culture and the impact on health care
- A link offering providers no-cost medical education credits from Georgetown University for further study of cultural competency topics

We are further expanding our cultural competency training in 2020 to include understanding members experiencing homelessness.

Cultural Competency Toolkit

We are proud to offer a Cultural Competency Toolkit, Caring for Diverse Populations, which provides resources to help address the very specific operational needs that often arise in a busy practice because of the changing service requirements and legal mandates. This toolkit specifically helps providers assess their level of competency.



Determining the Effectiveness of our Cultural Competency Training

To determine the effectiveness and impact of our cultural competency training, we closely monitor member grievances and satisfaction surveys and encourage members to contact us to report all grievances, including the inability to obtain culturally competent care. UniCare received five CLAS-related complaints in 2018 from members: one based on ethnicity/culture, two based on insurance status, and two based on age/gender. No provider received more than one complaint. Each complaint was investigated and responses from the providers were requested and received.

UniCare is committed to assuring our provider network is able to meet the cultural competency requirements specified in SPA 2.1.2.3 and the multilingual, multicultural, and disability needs of our MHT members. As a testament of this commitment, UniCare is proud to have been awarded NCQA's Multicultural Health Care Distinction, which is awarded to organizations that engage in efforts to improve CLAS and reduce health care disparities.



The Multicultural Health Care Distinction recognizes how well UniCare is improving quality by adhering to collection standards for race, ethnicity, and language data, facilitating language assistance, cultural responsiveness, quality improvement of CLAS, and reducing health care disparities.

Cultural competence, multilingual support, accessibility to the provider's premises, and any special communication abilities are an integral part of our provider network development efforts. We include these requirements in the provider manual and online directory, as well as ongoing communications with participating providers. Additionally, in accordance with SPA 3.4.4 our online provider directory includes a field indicating whether the provider has completed cultural competency training.

- PS005 1 The Vendor should describe its annual review process of its provider manual, including thirty business days prior notice of any material changes to impacted providers.

Process for Annual Review and Update of UniCare's Provider Manual

(PS005)

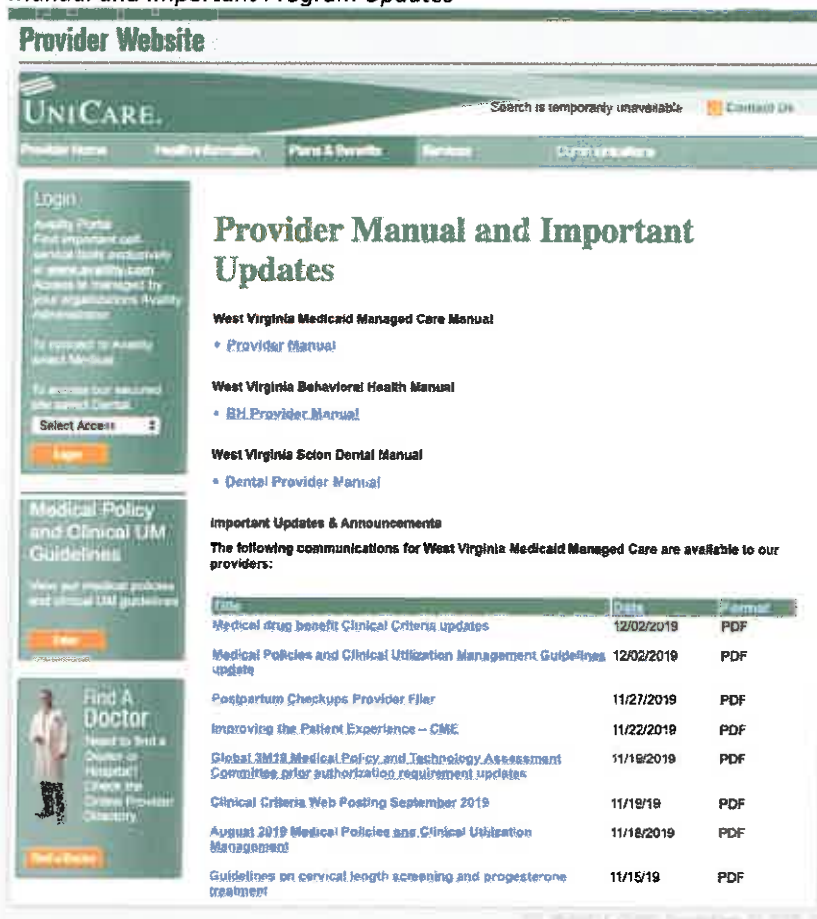
UniCare reviews the provider manual at least annually, in accordance with our policies and procedures, as well as mandates from the State. In addition to the annual review, the manual is also updated as necessary in response to policy or program changes that affect benefits, processes, or eligible populations; and changes to UniCare service sites or contractual requirements. Each review and update goes through a rigorous Collateral Material Approval Process (CMAP). Our CMAP includes a team of staff from the

health plan and subject matter experts from our parent company or affiliate health plans. Each member of the team completes a thorough review of the manual or update, adds comments, makes changes, and rejects or approves the content. In addition to the CMAP:

- Our Compliance Manager reviews and approves all updates for compliance with West Virginia MHT program requirements
- Our Legal department and business communication owner reviews and approves all updates related to our provider incentive programs or contractual-related items to make sure they meet legal, compliance, and national standards
- Our Chief Executive Officer (Program Administrator) and Medical Director provide final review and approval

We issue a printed copy of our provider manual to any provider that requests it and keep an updated version on our provider website (Figure 6.8-5). Information on how to access our provider manual online is included in our new provider welcome packets and new and annual provider training information.

Figure 6.8-5. UniCare's Provider Website Includes a Link to Our Provider Manual and Important Program Updates



Notifying Stakeholders of Updates

As program changes occur that affect the provider manual, the information is disseminated to our participating providers in the form of a provider bulletin by our Provider Services Department, and is included in plans for future insertion in manuals. Providers are notified at least 30 calendar days prior to the effective date of a change. Changes communicated in provider bulletins supersede information in our provider manual.

Our provider manual is updated at least annually and submitted to the State no later than July 1 of each contract year, in accordance with SPA 2.6.2.

Notification of changes and updates are also posted on our provider website and disseminated through fax blasts as appropriate, at least 30 business days prior to any changes taking effect, and during interactions with our Network Relations Consultants and other Provider Services staff.

UniCare will continue to maintain a provider manual that includes program information for PH and specialty service providers, BH providers, dental services providers, and vision providers.

- PS006 1 The Vendor should describe how members are held harmless and protected from balance billing for covered services.

Member Hold Harmless and Balanced Billing Protections (PS006)

UniCare's provider agreements and provider manual include provisions that specify the circumstances under which providers may and may not bill members for covered services. Providers contracted with UniCare may not balance bill our members or charge members for covered services above the amount UniCare pays to the provider. A provider may bill a member only when all the following conditions have been met:

- The service is not covered or the member has exceeded the program limitations.
- The member understands, before services are rendered, that the service is not covered and that the member is responsible for the charges associated with the service.

- The provider documents that the member voluntarily chose to receive the service and that the member was informed in advance that the service was not covered.

Providers may balance bill a member when PA of a covered service is denied; however, the provider must demonstrate compliance with all of the following:

- Establish that a PA was requested and denied before rendering service.
- Submit a request to review UniCare's authorization decision.
- Notify the member that the service requires PA and that UniCare has denied authorization. If OON, the provider must explain to the member that covered services may be available without cost when provided by a participating provider. In such cases, authorization of service is required.
- Inform the member of the right to file an appeal if the member disagrees with the decision to deny authorization.
- Inform the member of their responsibility for payment of non-authorized services.

If the provider chooses to use a waiver to establish member responsibility for payment, the waiver must meet the following requirements. The waiver:

- Was signed after the member received appropriate notification.
- Does not contain any language or condition specifying that the member is responsible for payment in the case of denial of authorization.
- Is specific to each member visit that falls under the scenario of the non-covered service; providers may not use non-specific waivers. The form must be obtained for each member visit.
- Specifies the services that fall under the waiver's application and the date the services will be provided.

We inform and educate providers regarding their rights and prohibitions regarding balance billing members for covered services in our provider contracts, provider manual, provider bulletins, initial provider orientation and ongoing training, and through interactions with Provider Services staff.

Working with Members to Help Resolve Billing Issues

We proactively monitor whether any of our members are being balance billed for covered services through a daily review of member grievances by our Grievances and Appeals Analysts. When our Provider Services Department is alerted by Enrollee (Member) Services a participating provider is engaging in balance billing that does not meet the criteria for allowable balance billing, a Network Relations Consultant notifies the provider they have balance billed a member in violation of their provider agreement and the billing must cease. If the provider continues to balance bill inappropriately, we conduct a formal on-site audit of the provider's practice and take appropriate action, which can include developing a CAP that specifies a timeline for compliance and possible termination in the event of continued non-compliance.

If the provider is OON, but is a West Virginia MHT enrolled provider, a Network Relations Consultant reaches out to the provider to notify them that, as a West Virginia MHT provider, they may not balance bill an MHT member for covered services. Our Network Relations Consultants also take that opportunity to encourage the provider to enroll in our network.

We recognize that receiving a bill from a provider is likely to be a highly stressful situation for our West Virginia MHT members. UniCare has detailed systematic instructions for Member Services Representatives to follow when they receive a call from a member about a provider bill. Member Services Representatives receive training at orientation on the prohibition against balance billing and how to respond when a member calls about a bill (or what looks like a bill) from a provider. They are trained to ask the member basic information such as the date of service, the amount being charged, and why the

member thinks they are being billed. The Member Services Representative confirms the member's eligibility on the date of the service and that the service for which the member was billed is a covered service. If the Member Services Representative determines from the member's responses that the member appears to have been incorrectly billed, they will tell the member not to pay the bill.

The Member Services Representative will then perform a warm transfer to a Member Services Representative who has received training on researching claims, member cost sharing, and communicating directly with providers who have balance billed a member. The claims-trained Member Services Representative will research the claim and reach out to the billing provider. UniCare provides scripts to claims-trained Member Services Representatives to use when talking to a provider about a bill. After the Member Services Representative has researched the claim and spoken with the provider, they will contact the member to advise them either that: 1) they do not have to pay the bill and the provider has been instructed that no payment is owed by the member, or 2) the bill is valid and the member is responsible for paying the bill. Member Services Representatives offer to file grievances on the member's behalf if an OON provider continues to bill. Our Member Services team alerts our Provider Services Department, who follows up with both participating and OON providers.

PS007 1 The Vendor should describe how they will develop comprehensive Value-Based Payment (VBP) strategies that link provider payment levels to quality of care outcomes.

UniCare's Comprehensive Value-Based Payment (VBP) Strategy (PS007)

Our VBP strategy includes innovative APMs and provider incentives that are integral to increasing provider satisfaction, retention, and willingness to collaborate on programs and initiatives to improve the health of our members. It is a key pillar of our Provider Pledge, to incent participating providers to drive improved member outcomes aligned with State goals.

When developing and implementing APM models, we consider various factors, including:

- The programs and needs of the member populations we are serving. Our APMs are designed to include all MHT program member populations as they become eligible, assuring seamless integration and implementation for new populations such as WVCHIP.
- BMS's MHT program goals and priorities for all member populations
- Provider interest and ability to participate in value-based reimbursement
- Current reimbursement structures and contract requirements
- Geographic and environmental factors effecting value-based reimbursement participation (such as rural geography and small panel sizes)

Following implementation, we monitor outcomes to determine the effectiveness of each APM and any future adjustments needed to meet the needs of the program. We work with providers to assess their comfort levels with APMs and their readiness to progress to higher levels within the value-based continuum, and encourage innovation and provider collaboration to increase quality and drive improvements in member outcomes.



Our strategy complies with MD006 and SPA 2.7.10, and is designed to advance DHHR's goals and objectives for improved coordination and access and improved health outcomes through provider collaboration and innovation to increase quality, efficiency, and access to comprehensive health care services.

UniCare's Comprehensive Array of APMs

In West Virginia, UniCare has used provider incentives and rewards to drive improvements in quality and access since 2015. *UniCare exceeds the SPA Section 2.7.10 requirement of 10% of members enrolled in APMs in SFY 2020. Currently, 35% of our members and 35% of*



our medical spending in Medicaid in West Virginia is with providers who participate in our PQIP. Our experience using APMs in West Virginia dates back over five years:

- In 2015, UniCare began providing incentives for school-based health centers (SBHCs) for improvements in the provision of well-child exams.
 - As a result, a total of 1,264 additional well-child exams were completed in 2015.
- In 2017, UniCare implemented our PQIP for high-volume PCPs. In West Virginia, 23 PCP groups with more than 49,800 assigned members currently participate in our PQIP.
- In 2019, UniCare further expanded the scope of our APMs to include BH services through implementation of our Behavioral Health Quality Incentive Program (BHQIP) and Women's Health Provider Incentive Program (WHPIP).
- In January 2020, we completed a Negotiated Shared Savings program arrangement with West Virginia Health Network (WVHN), a newly formed accountable care organization (ACO) that is currently comprised of 15 primary care practices.

UniCare's Provider Quality Incentive Program

For the 2018 performance period, UniCare providers that participated in our PQIP performed better than non-PQIP providers in 8 of 12 quality measures. PQIP providers also showed year-over-year improvement versus 2017 in 10 of 12 quality measures, three measures of which increased by more than 7.5%.

We are continuing to expand our array of APMs in West Virginia to include a larger segment of our PCP network through implementation of our PQIPE and Pay for Quality (P4Q) programs in 2020, which will make participation in APMs available to smaller volume and rural PCPs across West Virginia. Also in 2020, we will implement our new Social Determinants of Health Provider Incentive Program (SDOH PIP) for PCPs throughout West Virginia. We already offer an SDOH incentive program to Preferred Community Health Partners for completion of SDOH assessments for members in case management using a 10-question SDOH screening tool. Under our SDOH PIP, PCPs will also be eligible for additional incentives for assessment of their patient's SDOH needs and connecting them to community resources.

In 2021, we are further expanding our array of APMs to add an Obstetrical Care Quality Incentive Program (OBQIP), Behavioral Health Facility Incentive Program (BHFIP), and Integrated Care Quality Incentive Program (ICQIP).

UniCare's APMs increase the level of reward our providers can earn based on improvements in quality and member outcomes. They align with the Health Care Payment Learning and Action Network (HCP-LAN) APM categorization and framework. Our APM continuum is designed to incent, encourage, and support provider movement along the continuum, and increase the level of rewards for providers with the organizational and technical ability to assume greater responsibility and financial risk.

To support a population health focus, our APMs encompass all members attributed to the APM provider so as not to limit program participation based on diagnosis-driven eligibility. To ease provider administrative burden, we leverage industry-standard measure sets such as HEDIS, which can be assessed based on claims data (versus medical record audits) to measure quality performance in our APMs. As such, only members who meet the criteria for each specific measure (for example, age, gender, diagnosis, or other qualifying criteria) will be counted toward performance assessment of that measure.

Our continuum of APMs includes HCP-LAN Category 2 programs in which providers receive incentives for meeting specified quality, cost, or efficiency targets. In addition, we are able to offer Category 3 APMs in which providers can share in savings derived from improvements in quality and medical cost management (such as PQIP), as well as Category 4 programs in which providers assume financial risk for effective population health management. Our risk-based APMs require providers to meet specific financial solvency requirements in order to participate in our downside risk arrangements.

Table 6.8-4 lists each of the current and proposed APMs we offer or are prepared to offer, and includes descriptions of the incentive payment mechanism, the HCP/LAN category, and eligible provider types.

They are segmented into four strategic focus areas:

- **Access and Wellness.** APMs that enhance access, preventive care, and wellness, such as our School-based Well-visit Incentive Program (SBWIP), Women’s Health Provider Incentive Program (WHPIP) and Screening, Brief Intervention, and Referral to Treatment Provider Incentive Program (SBIRTPIP)
- **Total population Health Focus/Shared Savings.** APMs that enhance quality, efficiency, and total cost of care savings such as our Provider Quality Incentive Program (PQIP), PQIP Essentials (PQIPE), and Negotiated Risk/Shared Savings (NRSS)
- **Specialized Services.** APMs for specialty services and BH/PH integration, such as our Behavioral Health Quality Incentive Program (BHQIP), Integrated Care Quality Incentive Program (ICQIP) and Obstetrical Quality Incentive Program (OBQIP)
- **SDOH and Social Supports.** APMs for SDOH and socially necessary services and supports, such as our Social Determinants of Health Provider Incentive Program (SDOH PIP)

Table 6.8-4. UniCare’s Array of APMs for Our West Virginia MHT Members Link Provider Payment Levels to Quality of Care Outcomes

APM	Description	Implementation Status
Access and Wellness		
School-based Well-visit Incentive Program (SBWIP)	Developed in collaboration with the West Virginia School-based Health Assembly, SBWIP incentivizes SBHCs for completion of well-child and well-adolescent exams, and nutritional and physical activity assessment and counseling. SBHCs receive a \$25 incentive payment following timely submission for each completed medical record reflecting a well-visit for children in targeted age categories. They can also receive up to \$15 for nutrition counseling (\$5), physical activity counseling (\$5), and BMI percentile (\$5). HCP/LAN APM Category: 2C Provider Types: SBHCs	Active

APM	Description	Implementation Status
Women's Health Provider Incentive Program (WHPIP)	WHPIP incentivizes women's health providers to increase well-women and cervical cancer screening exams. Providers receive a \$50 incentive payment for each member identified as needing such screening via a list provided by UniCare. In addition, providers can earn up to \$2,000 for meeting UniCare's specified thresholds for the percentage of exams completed during the prescribed time period. HCP/LAN APM Category: 2C Provider Types: OB/GYNs, Federally Qualified Health Centers (FQHCs)	Active
Screening, Brief Intervention, and Referral to Treatment Provider Incentive Program (SBIRTPIP)	SBIRTPIP reimburses providers for SBIRT codes 99408 and 99409, which are not currently reimbursable under the program, to incentivize them for performing SBIRT screenings for our members. HCP/LAN APM Category: 2C Provider Types: PCPs, patient-centered medical homes (PCMHs)	Active
Tobacco Cessation Provider Incentive Program (TCPIP)	TCPIP incentivizes physicians to expand provision of tobacco dependence counseling. PCPs, OB/GYNs, and BH providers who provide intensive smoking cessation counseling and submit a corresponding claim will be eligible for an enhanced fee per claim beyond the Medicaid fee schedule rate. HCP/LAN APM Category: 2C Provider Types: PCPs, OB/GYNs, BH providers	Proposed for implementation in 2020
Pay for Quality (P4Q)	P4Q incentivizes providers for closing HEDIS care gaps. Providers receive monthly care gap reports that identify members needing specified preventive or chronic condition interventions. Related education encourages participation in improving quality metrics and health outcomes. HCP/LAN APM Category: 2C Provider Types: PCPs, PCMHs, and other rendering providers	Proposed for implementation in 2021
Total Population Health Focus/Shared Savings		
Provider Quality Incentive Program (PQIP)	PQIP incentivizes select PCP practices to undertake systematic improvements that affect health care outcomes and cost trends. Practices must participate with us for at least one year and have at least 1,000 assigned members to participate. HCP/LAN APM Category: 3A Provider Types: PCPs, PCMHs, Hospitals with PCP, ACOs, Independent Practice Associations (IPAs)	Active
Negotiated Risk/Shared Savings (NRSS)	NRSS uses quality metrics as a gateway to shared savings eligibility to encourage efficient, preventive, and cost-effective health care practices. Providers with 500 or more attributed members can accept upside-only risk or both upside and downside exposure. HCP/LAN APM Category: 3A/3B Provider Types: PCPs, PCMHs, Hospitals with PCP, ACOs, IPAs	Active

APM	Description	Implementation Status
PQIP Essentials (PQIPE)	PQIPE incents smaller practices, focusing on PCP with at least 250 attributed members. Providers receive quarterly and year-end scorecard reports. Earned incentive payments are made annually. HCP/LAN APM Category: 3A Provider Types: PCPs, PCMHs	Proposed for implementation in 2020
Specialized Services		
Behavioral Health Quality Incentive Program (BHQIP)	Our BHQIP incents COMPs and LBHCs to improve coordination of members' PH and BH needs and the quality of care provided to those with BH conditions. Providers receive incentive payments for achieving performance targets on specific measures important to members' health (for example, reduction in BH inpatient readmission rates, decrease in emergency room [ER] visits, increased PCP visits, and follow-up after discharge for treatment of a mental health disorder). We make earned payments annually. HCP/LAN APM Category: 2C Provider Types: COMPs, LBHCs	Active
Obstetrical Quality Incentive Program (OBQIP)	OBQIP incents OB providers with at least 10 attributed members for improving access, quality of care, and outcomes for members with OB needs throughout all phases of their pregnancy. OBQIP providers receive periodic reports indicating interim performance throughout the year, and an annual performance scorecard. We make earned incentive payments annually. HCP/LAN APM Category: 2C Provider Types: OB Providers	Proposed for implementation in 2021
Behavioral Health Facility Incentive Program (BHFIP)	Our BHFIP incents BH inpatient facilities for providing quality care and service to our members with long-term service and support needs. Facilities participating in the program that meet quality, service, and utilization goals will be eligible to receive incentive payments for improvements in indicators related to clinical quality, patient outcomes, patient satisfaction, cost management, and integration with PH (such as 30-day readmission rates, seven-day follow-up rates, and admission screening for violence, SUD, and psychological trauma risk). HCP/LAN APM Category: 2C Provider Types: BH Facilities	Proposed for implementation in 2021
Integrated Care Quality Incentive Program (ICQIP)	Under ICQIP, BH providers will be incented to enter into care compacts with PCPs who participate in PQIP or other incentive programs. BH providers will have an increased ability to earn an incentive the more integrated they become with PH providers, as the incentive measures are focused on both BH and PH. PH providers will have an increased ability to earn increased incremental incentives in their existing arrangements. HCP/LAN APM Category: 2C	Proposed for implementation in 2021

APM	Description	Implementation Status
	Provider Types: COMP, LBHCs PQIP, PQIPE, NRSS-participating PCP, PCMH	
SDOH and Social Supports		
Social Determinants of Health Provider Incentive Program (SDOH PIP)	SDOH PIP offers incentives to PCPs and other eligible providers for completion of SDOH assessments using an SDOH screening tool and referral of member to community resources. HCP/LAN APM Category: 2C Provider Types: PCPs, PCMH	Proposed for implementation in 2020

APMs for Small-volume and Rural Area Providers

Small-volume providers and providers in rural areas that may lack sufficient panel size are often not eligible for participation in APM programs; however, UniCare’s array of APMs encompasses programs for providers of all sizes, in both urban and rural settings. For example, our SBWIP, P4Q, TCPIP, WHPIP, SBIRTPIP, and SDOH PIP are available to providers located anywhere in the state regardless of their panel size. Our PQIPE program is available to PCPs with as few as 250 assigned members.

Empowering Providers Participating in Our Provider Incentive Programs

UniCare is committed to collaborating with and empowering providers participating in our APM programs to help them improve outcomes. We use a multi-faceted approach to providing technical assistance and data analytics to our incentive program providers.

Our CDT Consultants manage the technical assistance program for our PQIP, PQIPE, and NRSS program total population health-focused APM providers. CDT Consultants lead a team that includes our Network Relations Consultants, PC3s, Clinical Quality Program Consultants, and Medical Directors. Their primary duties include analyzing practice-specific cost and quality data and reports for cost of care and quality opportunities; helping practices to target high-risk members and gaps in care based on reports provided; supporting practice implementation of population health management, care coordination, and care

management strategies; identifying action plans for providers to implement to improve cost, quality, and the patient experience; and participating in design, development, and implementation of community learning forums.

Through our Academy, we provide comprehensive training to all providers on APM reimbursement principles and our APM programs. Our locally based Network Relations Consultants are in the field meeting face-to-face with providers and offering ongoing services and support, training and education, and information sharing.

Performance Data Sharing

In keeping with our Provider Pledge to empower providers, we offer our providers enrolled in our incentive programs performance scorecards, dashboard reports, and custom data analyses through our reporting platforms. These data tools enable providers to examine their current performance, identify opportunities for improvement, and develop action plans, processes, and workflows to improve quality and cost outcomes. Our quality and performance data sharing platforms, provider profile reports, and performance management tools are described in Table 6.8-5.

Table 6.8-5. UniCare's Solutions for Sharing Performance Data

Method	Description	Frequency
Quality and Performance Data Sharing Platforms		
Integrated Member Dashboard	This tool is available to all providers through our secure portal. It gives electronic access to member data and enables provider access to a single view that displays data in an easy-to-navigate dashboard. The dashboard includes HEDIS care alerts, authorizations, prescriptions, and claims; and is organized by type such as inpatient, ER, and office visits. It is also our primary method for sharing member care management information, including health risk assessments and the care plan.	Updated daily; real-time provider availability on demand
Provider Profile Reports		
Opioid Prescribing Summary	Providers receive a report detailing their opioid prescribing patterns against evidence-based quality standards and peer comparisons. Providers can use this data to target opportunities to improve their prescribing practices.	Updated and distributed monthly <i>(report will be implemented summer 2020)</i>
OB Profile	Enables OB providers to compare their key clinical metrics (such as preterm birth rate, C-section rate, and timeliness of prenatal care and	Updated annually; distributed to OB providers by PC3 Consultants

Method	Description	Frequency
	postpartum care) to benchmarks and performance of all providers in-state and nationally within their specialty and panel peer groups.	
Provider Incentive Program Performance Management Tools		
APM Provider Scorecards and Reconciliations	Our scorecards provide performance profiles aligned with program measures for providers participating in each of our provider incentive programs. Based on quality indicator scores and care opportunities, reports detail members who need services. Our PQIP, PQIPE, and NRSS providers also receive scorecards that detail scores for each quality measure and performance reconciliations against medical cost and quality threshold targets.	Updated and available monthly, quarterly, and annually
Provider Care Management System (PCMS) Portal	For our PQIP, PQIPE, and NRSS providers, PCMS delivers actionable data to identify members needing outreach and engagement, such as those in need of preventive health services. Provides real-time information, including: • Care Opportunities. Alerts on attributed members with gaps in care. • Hot Spotter. Identifies high-risk members' clinical opportunities, as well as members who are at increased risk for hospital readmission. • Inpatient Census. Information about members who are in the hospital to facilitate early and active involvement in the discharge planning process. • ER Visits. Alerts about members using the ER, including avoidable visits. Includes information based on Admission, Discharge, and Transfer (ADT) data received. • Medical Cost Performance. Identifies opportunities to more efficiently manage the total cost of care for the provider's assigned members by displaying historical and current unit cost and utilization data across the full spectrum of medical costs. • Performance Score Card. Provides a summary of physician performance against quality targets. • Pharmacy Reports. Information about members who are not adherent to medications and patient-specific alerts, such as controlled substance prescription drug use.	Updated daily; real-time provider availability on demand
Financial Recovery Group's (FRG's) Medical Economics Platform (MEP)	For our PQIP and NRSS providers, FRG's Medical Economics Platform reflects dynamic performance such as claims process and data cuts on a monthly basis that enables providers to trend present performance to historical, month-to-month, and year-over-year data, in advance of official reconciliations. MEP's AccuReports® present information from multiple sources in a crisp, drillable format, with customizable dashboard graphs and comparison to peers and benchmarks, enabling users to quickly spot trends, understand the drivers, and act on opportunities to improve financial performance.	Updated monthly; real-time provider availability on demand
Tableau Provider Insights	For our PQIP and NRSS providers, Tableau Provider Insights offers a suite of reports including population health management, utilization, benchmarking, HEDIS results, and total cost analysis, among other things. The reporting in these tools includes comparisons to peers and benchmarks.	Updated monthly

Goals and Outcome Measures

UniCare's APM approach considers the needs of our West Virginia member populations and BMS goals and priorities to implement leading-edge VBP programs that bend the cost curve and increase quality. Our innovative APM portfolio is based on our experience serving our West Virginia MHT members and our affiliates' experience with Medicaid programs across the nation. We design our APMs to align with BMS' Performance Improvement Project (PIP) focus areas and priorities, including enhancing coordination and access to PH and BH, dental and vision care; enhancing quality of care; improving health outcomes; and delivering a comprehensive quality approach across the continuum of care.



Our APMs help ease provider administrative burden by using industry-standard measure sets such as HEDIS, which can be assessed based on claims data. Table 6.8-6 describes measures applicable to all members in each active and proposed APM for 2020.

Table 6.8-6. UniCare 2020 APM Quality Measures

West Virginia MHT Program-related Quality Measures	UniCare APMs
Adolescent Well-Care Visits (Ages 12–21)	PQIP
Adult Access to Preventive/Ambulatory Services	PQIP
Adolescent Immunization Combination 2	PQIPE
Antidepressant Medication — Initiation and Continuation	BHQIP, ICQIP
Appropriate Testing of Children with Pharyngitis	PQIP
Appropriate Treatment for Children with Upper Respiratory Infection	PQIP
Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	PQIPE
Breast Cancer Screening	PQIPE
Cervical Cancer Screenings	PQIP, WHPIP
Childhood Immunization Status-COMBO10	PQIPE
Comprehensive Diabetes Care/CDC Eye Exam	PQIPE
Diabetic Screening for People with Schizophrenia and Bipolar on Antipsychotics (SSD)	BHQIP, ICQIP
Follow-up After Hospitalization for Mental Illness (FUH7)	BHQIP, ICQIP
Follow-up After ER Visit for Mental Illness (FUM)	BHQIP, ICQIP
Medication Management for People with Asthma	PQIP
Nutritional and Physical Activity Assessment and Counseling	SBWIP
Percentage of Members Who Are Readmitted to BH Inpatient Facilities	BHQIP, ICQIP
Primary Care Visits	BHQIP, ICQIP
SBIRT Screening	SBIRTPIP
Tobacco Cessation Counseling	TCPIP
Well-child Visits — First 15 Months of Life	PQIP, PQIPE, SBWIP

West Virginia MHT Program-related Quality Measures	UniCare APMs
Well-child Visits — Third Through Sixth Years Of Life	PQIP, PQIPE, SBWIP
Well-women Exams	WHPIP

All our APMs drive cost savings through incenting providers to improve access and quality and reduce inefficiencies in utilization; however, our population health-focused programs, which include shared savings arrangements, are particularly effective in driving cost savings. For example, *for the 2017 and 2018 performance years, our PQIP participating providers achieved costs savings from reductions in medical loss ratio (MLR) by more than 6% annually compared to target MLR, and as a result earned more than \$2 million in incentives derived from shared savings and quality performance.*

Our experience in West Virginia shows our APMs help drive improvements in quality, produce savings, and reduce avoidable ER visits — and most notably the measures shown in Table 6.8-7.

Table 6.8-7. 2018 Results Indicate That PQIP Providers' Performance Exceeds Non-PQIP Providers

Measure	PQIP vs. Non-PQIP
Adolescent Well-care Visits (AWC)	5.4%
Breast Cancer Screening (BCS)	1.4%
Medication Management for People with Asthma (MMA)	4.5%
Well-Child Age 0–15 Months (W15)	4.6%
Well-Child Age 3–6 Years (W34)	3.4%

Other UniCare Provider Incentive and Recognition Programs

In addition to our APMs, we are also implementing opportunities for providers to earn recognition for demonstrating innovation, best practices, and expertise in areas of importance to our West Virginia MHT members. Our array of provider recognition programs includes:

- Physician Champion Award.** UniCare will launch an annual Physician Champion Award in 2020 to recognize providers who demonstrate innovations or significant improvements in quality and service to our members. We will present our Physician Champions with a plaque to celebrate their contributions to a healthier West Virginia. We will communicate information about the Physician

Champion Award to providers in our network via upcoming newsletters and in bulletins on our provider website. Criteria for the award will include effective use of electronic health records, smoking cessation and reduction in tobacco use, and other topics aligned with West Virginia MHT program goals and objectives.

- **Premier Provider Recognition.** UniCare's Premier Provider Recognition program will recognize providers who complete a specified series of the Academy Trauma-informed Care and System of Care trainings with a small financial stipend. By obtaining Premier Provider status, providers are able to demonstrate a greater comprehension of the effects of trauma, approaches for treatment and services, and meeting the complex needs of West Virginia MHT members who have experienced a traumatic event. Premier Providers will also be highlighted on our Trained Provider List available to members, staff, stakeholders, and families.
- **ACEs Provider Champion.** UniCare will partner with leading West Virginia providers to implement our ACEs Provider Champion program. The goal of this program is to identify and work with designated organizations in West Virginia to implement innovative programming to increase the resiliency of our communities, address ACEs, and serve as role models and mentors for other providers. Each Provider Champion partner will receive funding to accelerate and expand the reach and impact of their innovative programming. The amount of funding will be determined based on the anticipated scale of the project, is intended to expand the scale and reach of innovative strategies, and are not meant to replace existing Medicaid-reimbursable services or activities.

UniCare will continue to comply with SPA Section 2.7.10 requirements. We will provide annual, and as required, APM Activities Reports to DHHR on our alternative payment models and activities. Our most

recent report was submitted August 2019. When we submit our annual APM reports to DHHR, and on request, we provide the following information related to our incentives:

- Types of incentive arrangements and services covered
- Percent of any bonus plans UniCare uses
- Amount and type of stop-loss protection each provider or provider group has, with assurance that the stop-loss protection is adequate
- Panel sizes for incentives that use pooling calculations

Complying with Physician Incentive Program Requirements

All of our currently active Physician Incentive Plans in West Virginia have been approved by BMS. UniCare has processes in place to assure all our physician incentive programs comply with all federal and BMS requirements regarding Physician Incentive Plans, including the requirements of Section 1876(i)(8) of the Social Security Act and federal regulations (42 CFR § 438.3(i), 42 CFR § 422.208 and 42 CFR § 422.210). UniCare currently does not operate any physician incentive programs in West Virginia that place physicians at significant financial risk. Any Physician Incentive Plans that involve shared savings or financial risk are subject to prior and ongoing review and approval by our Risk and Shared Savings Oversight Committee (RSOC). Our RSOC confirms the programs and the contractual terms of those programs meet all applicable federal and State compliance requirements, including member survey requirements as applicable, as well as our financial solvency and administrative standards. For our Physician Incentive Plans that do not involve shared savings or financial risk, we use our CMAP, which includes reviews by our Legal and Compliance departments, to make sure these programs are compliant with federal and State contract Physician Incentive Plan requirements and receive BMS approval.

We will submit our new proposed Physician Incentive Plans for BMS approval prior to implementing them with providers.

- PS008 1 The Vendor should describe its process to conduct annual provider satisfaction surveys to evaluate the overall satisfaction of its network providers, including the evaluation of results of satisfaction surveys on an annual basis, and how the Vendor will utilize data to inform quality improvement activities to enhance network satisfaction and availability of services to members.

Process for Conducting Provider Satisfaction Surveys (PS008)

Our annual provider satisfaction survey process complies with SPA 2.6.5, and includes an objective, systematic review of activities and systems that assesses quality of care and service that meets or exceeds all acceptable prevailing standards. This NCQA-approved survey is conducted annually and is jointly managed by the QM and Provider Services departments. Our provider satisfaction survey targets a randomized sample of provider types (PCPs, specialists, BH specialists, OBs), prioritizing high-volume providers. Providers may complete the survey online or on paper. Our Network Relations Consultants encourage non-responders in person or via telephone to complete the survey to reach an appropriate sample size for analysis. All completed surveys are processed to produce detailed summaries of results, and results are compared to prior years' metrics to identify upward and downward trends. We evaluate provider satisfaction with our communications, services, and procedures, then use the results as part of our continuous quality improvement efforts to provide strategic direction for efforts to strengthen provider engagement and relationships. We gauge satisfaction with UniCare in the following areas:

- Overall satisfaction and loyalty
- Local health plan provider services
- Claims processing and provider reimbursement
- Provider training and education
- Utilization management
- Communication and technology
- Disease management
- Continuity and coordination of care
- Cultural competency

Provider satisfaction survey information helps us better understand our provider network, its needs, challenges, and opportunities for member-focused, cost-saving innovations. Survey feedback also enables us to identify training needs by asking providers what information they would like from our offerings. Training topics may include chronic care management programs, HEDIS measures, participation in a quality incentive program, innovative programs to implement, after-hours care, electronic claims processing, and any other subjects they specify.

Annually, no later than June 30, we submit the results of our provider satisfaction surveys to the State. We also submit results to our internal Quality team and during Medical Advisory Committee meetings.

In addition to our annual provider satisfaction survey, we conduct ongoing quality assurance by offering providers the opportunity to fill out a provider satisfaction survey after each web-based, Provider Phone Line, or in-person interaction with one of our Network Relations Consultants and monitoring our operational performance to make sure we meet our service commitments. Our ongoing operational monitoring will yield the reports we use to identify individual providers experiencing problems with claims submission or other needs.

Evaluation of Results

Our annual QM Program Evaluation process is our formal mechanism for evaluating results of our network management, provider accessibility, and provider satisfaction activities. Upon completion of our annual surveys, our Provider Services Department reviews the results with our Quality Management Committee to identify and prioritize strategies as part of our coming year's QM Work Plan to address areas for improvement.

Based on our most recent survey dated November 2019, 78% of responding providers indicated overall they were somewhat or very satisfied with UniCare. To improve overall provider satisfaction, in 2020 we will focus on improving items that have the largest impact on overall provider satisfaction, such as:

- **Continuity of Care.** Seventy-six percent of providers were somewhat or very satisfied with timeliness, 79% with accuracy, 79% with clarity of information exchange, and 78% with sufficiency of information to coordinate care.
- **Utilization Management.** Seventy-six percent of providers were somewhat or very satisfied with the timeliness of the Medical Director's response to concerns, 77% with the process for obtaining precertification and authorization, and 79% with efficiency of the UM process.
- **Communication and Technology.** Eighty-four percent of providers indicated they were somewhat or very satisfied with the UniCare provider website.
- **Claims Processing and Provider Reimbursement.** Eighty-five percent of providers indicated they were somewhat or very satisfied with the accuracy of claims payment — up from 76% in 2018.

Using Provider Survey Data to Inform Quality Improvement Activities

We are focusing our resources on improving processes that underlie these items and continue to look for a significant improvement in our overall satisfaction score. For example, based on our 2018 survey results and other provider feedback, in 2019 our Provider Services Department implemented several activities to improve provider satisfaction.

- **Goal.** Increase focused educational webinars on the UniCare authorization and claims dispute processes.
 - **Action Taken/Result.** Our Provider Relations Director delivered additional internal training to Provider Services Department to improve their ability to address potential claims issues with providers in person.

- **Action Taken/Result.** Our Provider Services Department continues to review claims reports to proactively identify potential issues and tailor provider webinars to effectively address solutions.
- **Goal.** Develop and distribute a provider newsletter article specifically designed to inform providers of the importance of coordination of care.
- **Action Taken/Result.** Interactive coordination of care form and cover letter created and disseminated to providers.
- **Action Taken/Result.** Focused educational presentations related to coordination of care developed for PCPs and BH providers with training delivered during facility site reviews and medical record reviews.

Provider Concierge Program

To further improve provider satisfaction, we are expanding in 2020 our Provider Services operating model to include our Provider Concierge program to reward high-performing providers with differentiated concierge-type service, tailored to their practice. Our Provider Concierge program includes three designated Provider Concierge Program Account Services Coordinators who will serve as single points of contact for their assigned provider groups in order to support operational functions and payment matters including onboarding, claims, data updates, and credentialing. Our Provider Concierge program is focused on continually making it easier for the provider to do business and is one of the ways we deliver on our Provider Pledge to simplify health care so providers can focus on health.

9. QUALITY

- QU001 1 The Vendor should describe its Quality Assessment and Performance Improvement (QAPI) Program.

Quality Assessment and Performance Improvement Program (QU001)

As a current West Virginia Medicaid Managed Care Organization (MCO) and collaborative State partner, we are focused on supporting the West Virginia Department of Health and Human Resources' (DHHR's) goals for this procurement, including to enhance the quality of care for West Virginia Medicaid and CHIP beneficiaries. Our



Quality Assessment and Performance Improvement (QAPI) program, led by an experienced local team, encompasses the full spectrum of physical health (PH), behavioral health (BH), and social supports available to our members. Our quality program is embedded across, and integrates data from, all functions of our organization operations to reflect our holistic approach to member health and well-being.

Consistent with our culture of quality, we continually direct our staff and resources toward managing high-quality care to improve our members' health outcomes, access to care and services, quality of life, and satisfaction with their health coverage while delivering value to DHHR.

Achievements in NCQA Accreditation and Related Programs

UniCare's QAPI program is tailored to West Virginia's needs, fully integrated, aligned to NCQA requirements, includes clinical and non-clinical areas, and addresses both health outcomes and member satisfaction. We diligently work to sustain our NCQA accreditation, achieving Commendable status in 2019, as part of our commitment to adhering to industry best practices and document our progress in an annual QAPI Program Description, Work Plan,



and Evaluation. UniCare will routinely update DHHR regarding sustained accreditation status by the beginning of each Contract year and upon completion of each survey conducted.

Our ultimate parent organization's adoption of best practices and adherence to NCQA standards is evident in our affiliates' widespread accreditations, with affiliates in 22 states currently accredited by NCQA. In 2017, UniCare received NCQA's Multicultural Health Care Distinction, which is awarded to organizations engaged in efforts to improve quality by adhering to a collection standard for race, ethnicity, and language data; facilitating language assistance, cultural responsiveness, and quality improvement of Culturally and Linguistically Appropriate Services (CLAS); and reducing health care disparities. Figure 6.9-1 depicts UniCare's track record of quality achievements.

Figure 6.9-1. UniCare Demonstrates Quality in All We Do

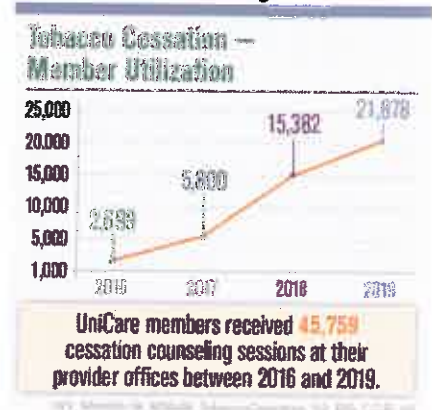
UniCare's West Virginia Medicaid Quality Successes				
				
Commendable level NCQA Health Plan Accreditation Accreditation held continuously for more than a decade	4.0/5.0 Health Plan Quality Rating by NCQA for 2019-2020 UniCare's rating is in the top 23% of all Medicaid health plans	Highest score for Consumer Satisfaction in West Virginia Scored 4.5/5.0 in CAHPS component of NCQA Health Plan Rating for 2019-2020	Only health plan in West Virginia to achieve NCQA's Multicultural Healthcare Distinction	Award-winning School-based Well-Visit Incentive Program Supports double-digit improvements in HEDIS scores and boosts EPSDT

We have the organizational support of our ultimate parent company, Anthem Inc.'s (Anthem's) BH program, which is **accredited nationally as a Managed Behavioral Healthcare Organization (MBHO) by NCQA**, demonstrating a commitment to following evidence-based practices for providing high-quality care, access, and member protections for BH. **Anthem's MBHO scored 100% on the associated five standards used to demonstrate proficiency: Quality Management and Improvement, Care Coordination, Utilization Management (UM), Credentialing, and Members' Rights and Responsibilities.** The UniCare BH Medical Director is chair of the Anthem MBHO Quality Management Committee.

UniCare will continue to maintain NCQA accreditation and receive support from a seasoned team that includes multiple senior staff who each have more than a decade of NCQA experience. We have formalized our approach to prepare for each NCQA survey and continually evaluate compliance with current and new requirements. We document our approach in an Accreditation Playbook for easy reference by our staff. Our internal experts educate staff on best practices through ongoing educational summits, quarterly meetings, and multi-level review of UniCare's applicable documentation. *Where State and federal regulations or accreditation standards are not consistent, we adopt the most rigorous requirements to assure the best possible outcomes for our members.*

Quality Assessment and Performance Improvement Program Strategies

Figure 6.9-2. Success of Evidence-based Tobacco Cessation Program



UniCare's QAPI program is responsive to our members' unique needs, and PH and BH conditions. We implement evidence-based quality improvement strategies and incorporate health promotion as well as performance monitoring to positively impact the quality of care and services delivered to members. For example, in 2016, UniCare removed the benefit limit for tobacco cessation support services and began to allow members unlimited access to these services. This policy is built upon a recognized best practice from the American Heart and Stroke Association. We were the first, and are currently the only, West Virginia MCO to do this. *The effort has resulted in an eight-fold increase in utilization of this helpful service between 2016 and 2019.* Our CAHPS® scores affirm more members are receiving advice from their providers about how to quit, as illustrated in Table 6.9-1 and Figure 6.9-2.

Table 6.9-1. Significant Improvements in CAHPS Adult Survey Measures Related to Tobacco Use and Cessation Efforts

Adult CAHPS Survey Measure	2015	2019	Percentage Change
Advising Tobacco Users to Quit	69.64	75.12	7.9% increase
Discussing Cessation Medication	36.94	47.80	29.4% increase
Discussing Cessation Strategies	31.53	44.57	41.4% increase

Our work reflects a Continuous Quality Improvement (CQI) philosophy, enterprise-wide Culture of Quality, and a mode of action that goes beyond established regulatory and accreditation standards by *engaging all UniCare staff as quality champions*. CQI is woven throughout our health plan and delivery



system; consequently, our QAPI program incorporates the most current health care quality management and quality improvement (QM/QI) methodology and techniques, including hot-spotting of areas with concentrated needs. In full alignment with DHHR's quality strategies and objectives, we conduct recurring quantitative and qualitative data collection that informs data-driven quality initiatives and activities, as detailed throughout this response. The design, planning, and implementation of QAPI activities is grounded in evidence-based practices and feedback provided by members, providers, and community stakeholders.

We are proud to have nine disease management programs with NCQA

UniCare understands the importance of early detection and prevention by engaging evidenced-based strategies. Patient and Practitioner Oriented accreditation, including for conditions like diabetes, asthma, and child and adolescent depression to help members and their caregivers. *Our DM programs are accredited through 2021, and we are working with NCQA to transition to the Population Health Program Accreditation, scheduled for review in 2020, making us one of the first organizations to commit to seeking PHP accreditation and one of the first to go through the review process.*

Evidence-based Clinical Guideline Conditions

Our current comprehensive portfolio of evidence-based clinical guidelines spans more than 43 conditions and diseases including:

- Autism
- Hypertension in adults, children, and adolescents
- Celiac disease
- Obesity
- ADHD
- Depression
- Substance use disorder
- Coronary artery disease (CAD)
- Chronic kidney disease (CKD)
- Diabetes
- Smoking cessation during pregnancy

Annual Measurement of Performance

QAPI strategies incorporate the annual measurement of performance in specified areas (for example, wellness visits and immunization rates). We use this data to inform the interventions and activities deployed, using a CQI approach, to achieve continuous measurable improvements. Table 6.9-2 illustrates UniCare's success in employing annual measurement of performance and trending over time to improve health outcomes for members, with many measures charting double-digit improvements over three years.

Table 6.9-2. UniCare's HEDIS® Scores Demonstrate Substantial Improvements

Measure Name	Improvement HEDIS 2017–2019	Current Quality Compass Percentile
Child and Adolescent Measures		
Metabolic Monitoring for Children and Adolescents on Antipsychotics	28.03% ↑	90 th
Adolescent Well Care Visits	14.98% ↑	90 th
Medication Management for People with Asthma — MMA Total 75%	14.68% ↑	90 th
Weight Assessment and Counseling for Nutrition and Physical Activity — Activity	11.30% ↑	50 th
Weight Assessment and Counseling for Nutrition and Physical Activity — Body Mass Index (BMI)	8.78% ↑	75 th
Annual Dental Visit	2.43% ↑	75 th
Childhood Immunization Status — HEP A	2.24% ↑	75 th
Adult Measures		
Medication Management for People with Asthma — MMA Total 75%	14.68% ↑	90 th
Controlling High Blood Pressure	12.12% ↑	75 th
Antidepressant Medication Management — Acute Phase	13.35% ↑	75 th
Antidepressant Medication Management — Continuation Phase	13.34% ↑	75 th
Postpartum Care Rate	6.82% ↑	50 th
Comprehensive Diabetes Care — Nephropathy Screening	4.77% ↑	90 th
Adult BMI Assessment	4.50% ↑	90 th

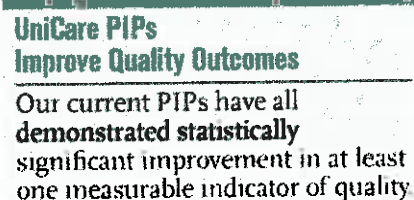
We further attribute our quality and outcomes successes to our commitment to continuously:

- Coordinate, monitor, and report QM activities
- Monitor and improve accessibility to seamless and appropriate care and services
- Assess improvements, and modify interventions as necessary, to sustain quality over time

These efforts are memorialized through our Annual Evaluation (detailed later in this section), itemizing measures of performance achieved against targets we set each year.

Performance Improvement Projects

UniCare's QAPI strategies include implementation of multi-year Performance Improvement Projects (PIPs) that address both clinical and non-clinical areas. Our approach, historic successes, and planned PIPs are detailed in our response to QU012. We structure and implement PIPs to improve members' outcomes through education regarding appropriate preventive services and healthy lifestyles. We further use PIPs to measure member satisfaction and implement effective interventions to address areas of dissatisfaction. UniCare will continue to work with DHHR and its External Quality Review Organization (EQRO) to identify clinical and non-clinical PIPs that target areas for program improvement. *Aligned with DHHR priorities and member needs, Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) will be the focus of one of our PIPs to begin in July 2020.*



**UniCare PIPs
Improve Quality Outcomes**

Our current PIPs have all demonstrated statistically significant improvement in at least one measurable indicator of quality.

Addressing Systemic Problems and Critical Incidents

Our QAPI strategies also focus on monitoring, identifying, investigating, reporting, and preventing systemic problems and critical incidents, as detailed in our response to QU015. We are enhancing our current approach to system improvements by formalizing the work of *UniCare's President's Panel*. This group is responsible for identifying and mitigating complex challenges. Under leadership of the CEO, Tadd Haynes, the President's Panel prioritizes issues that have an impact on members and providers to find cross-functional solutions. We handle critical quality of care incidents with urgency and great care. All are identified, investigated, tracked, and reported. Using this information, we implement and monitor programs designed to improve the safety of our members in health care environments.

Information System Support

Our data-driven QAPI program capitalizes on a technology infrastructure that supports capture and evaluation of performance measurement data across all functional areas. *We systematically and objectively collect, integrate, and measure access to care, demand for services, and quality of care to improve member outcomes.* Our fully established health information system supports our QAPI and:

- Leverages a NCQA-certified HEDIS engine to facilitate HEDIS, CMS Child and Adult Core Set, and State-specific measure reporting for Medicaid and CHIP
- Incorporates data on member and provider characteristics and services delivered, including utilization, claims, the grievances system, and disenrollment for reasons other than the loss of Medicaid eligibility
- Facilitates quick identification of negative performance trends so we can address them early
- Guides the selection, design, and implementation of PIPs
- Assures the confidentiality of our members' health and personal information is always maintained
- Monitors provider medical record-keeping, including compliance with medical record documentation, storage, handling, and retention guidelines
- Accepts the Medical Assistance ID (MAID) generated by Bureau for Medical Service (BMS) for all members
- Facilitates timely and accurate data exchange with providers



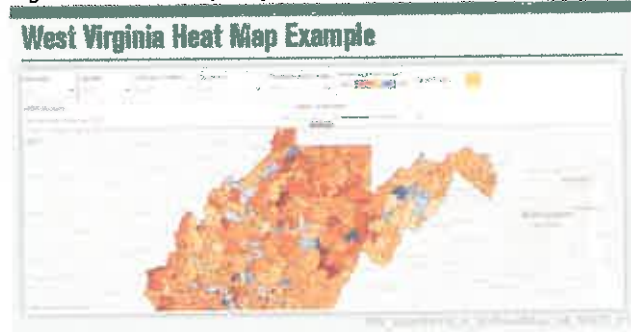
Our robust quality infrastructure, including our Interactive Analytic Insights tool and HEDIS Data Warehouse, captures and evaluates performance measures across our membership to improve delivery of care and services. The proprietary Interactive Analytic Insights tool is a dynamic, responsive, and scalable platform that provides comprehensive information about our quality performance. It displays quality

measure performance trended over time with performance benchmarks and comparable data from across the industry. The tool's analytics capabilities allow our Quality team to drill down to very specific geographic detail by zooming in on particular areas.

Our team can also select from a variety of HEDIS

measures and examine variables of interest to our health plan and the State such as member age, gender, race, and ethnicity. Based on identified gaps in care, we are able to create 'heat maps' that display concentrated gaps within identified zip codes, as illustrated in Figure 6.9-3. Using heat maps similar to this example, we are targeting interventions to increase cervical cancer screening for 2020.

Figure 6.9-3. Example of UniCare's Heat Map Capabilities



Administration of QAPI Activities

UniCare's robust QM/QI program includes experienced, local staff and quality-related committees with responsibility for QAPI program administration, oversight, and improvement, further detailed in our response to QU004. To assure proper administration of QAPI activities, we:

- Collaborate with the State in the administration and coordination of care and services, the development of policy and procedures, and the process of oversight
- Operate effective credentialing and recredentialing processes for providers that comply with State, federal, and accreditation requirements
- Coordinate and communicate QM/QI activities with all appropriate functional areas, including but not limited to UM, Enrollee (Member) Services, and Provider Relations
- Assure full compliance with all applicable State, federal, and accreditation requirements; provide delegation oversight

Skilled and Experienced Quality Staff

Our Quality Director, Victoria Warner, is a lifelong West Virginia resident and a strong leader of UniCare's Quality team. Victoria has a Master of Public Health degree with a specialization in Social and Behavioral Sciences and nine years' experience with the West Virginia Medicaid program — dedicated to Quality, HEDIS, and EPSDT programs. This experience includes monitoring the Medicaid EPSDT program and working with the Vaccines for Children program.

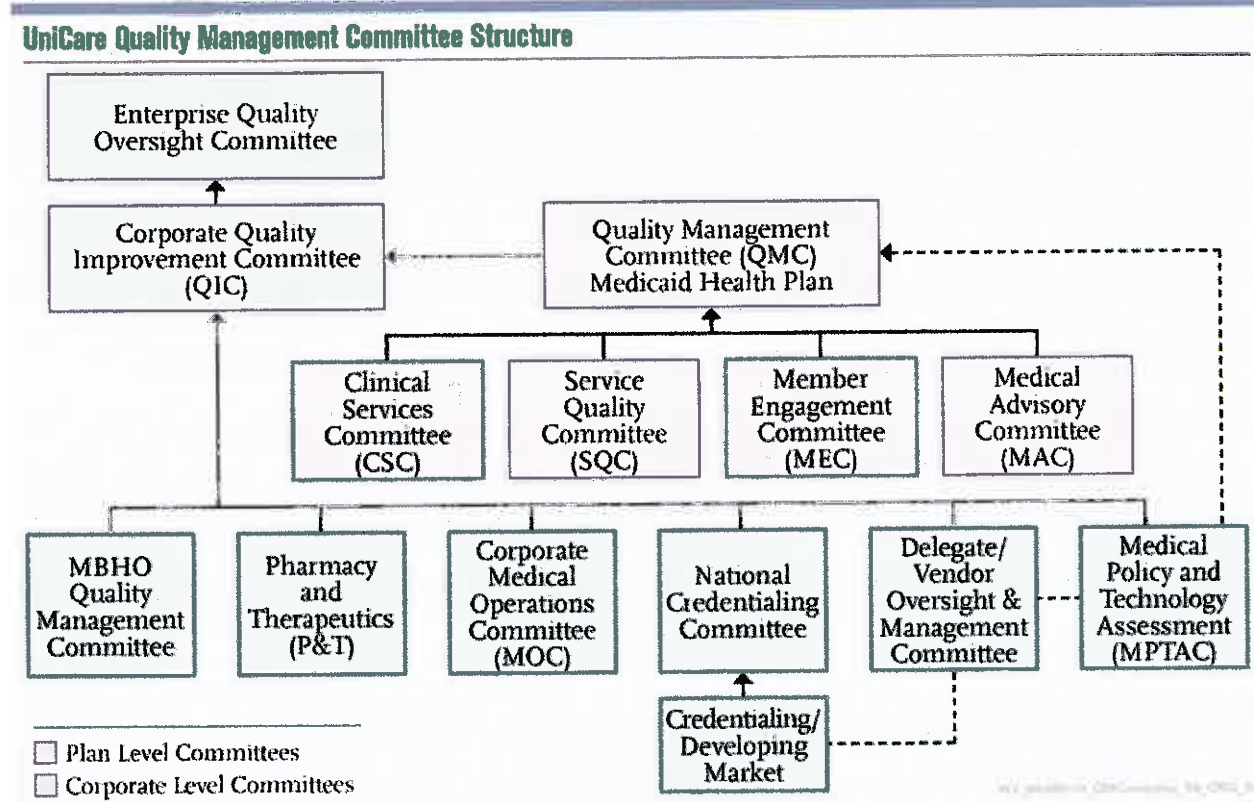
Our other skilled Quality team members have more than 138 years of collective managed care experience and have earned certifications including: Six Sigma Black Belt, Certified Professional in Healthcare Quality (CPHQ), managed care nursing, Project Management Professional (PMP), Person Centered Thinking® by the Learning Community for Person Centered Practices, and the Diabetes Empowerment Education Program (DEEP). The team brings a high-level of expertise in nursing, program management, end-to-end process improvement, HEDIS, and other types of performance measurement. In her role as a leader, Victoria collaborates closely with Tadd Haynes, UniCare's Chief Executive Officer, and receives direction and support from Sanjoydeb Mukherjee, MD, our Medical Director, and Jorge Cortina, MD, our BH Medical Director.

UniCare's and NCQA-compliant Committees and Structure

UniCare's robust QAPI program includes quality-related committees with responsibility for program oversight and improvement. Our culture of quality is present throughout our committees, with leaders from functional areas across the health plan participating to present issues for discussion and action plan development. We structure our quality committees to serve as working groups to be sure all health plan decisions consider whole-person, integrated care and include meaningful participation from providers and community representatives. For example, Medical Advisory Committee (MAC) participants recently

advised on strategies to improve cervical cancer screening rates that we will implement in 2020. Figure 6.9-4 reflects our Quality Management Committee (QMC) structure.

Figure 6.9-4. UniCare's Quality Management Committee Structure



The QMC functions as UniCare's QAPI Committee (per Service Provider Agreement [SPA] 6.5.3) and is the most senior quality-focused committee. The QMC provides oversight and direction to the Clinical Services Committee (CSC), Member Engagement Committee (MEC), Service Quality Committee (SQC), and our MAC. The MAC currently includes participation from providers from the following specialties: OB/GYN, General Pediatrics, Pediatric Hematology/Oncology, Internal Medicine, Psychiatry, Family Medicine, and Family Medicine/Nurse Practitioner. The QMC leads all UniCare quality activities, detects and addresses problematic issues, and assures compliance with the QAPI Program Description and annual

Work Plan. The Corporate Medicaid Quality Improvement Committee (QIC) acts as our policymaking body (per SPA 6.5.2). Additional information on our quality committees is detailed in our response to QU004.

Monitoring and Reporting Performance Measurement Data

Our goal is to make sure each member receives the most appropriate services tailored to their needs to achieve health and wellness goals. UniCare's leaders routinely monitor performance measurement data including medical trends, grievances, and appeals; the management of chronic and acute care diseases and conditions, and additional data points for emerging or persistent areas for improvement. We analyze public health data, statewide and community trends, impacts to core critical functions, social determinants of health (SDOH), disparities, and demographic data of all our members to understand key drivers that may affect their ability to achieve improved health outcomes. This data drives our organization's focus and strategies for program enhancement. We also prioritize our initiatives based on the volumes and types of care gaps present among the membership. Where gaps exist, we review the impact for both short-term and long-term sustainable health outcomes before implementing any new or modified programs.



Monitoring Service Utilization

UniCare strives to assure members receive the right care, in the right place, at the right time. We regularly monitor for utilization outliers, including appeals and overturn rates, which could indicate that a member is not receiving the appropriate care. As described in our responses to BA006 through BA010, we also view detailed utilization trend data, look for patterns, and detect potential access barriers. Performance reports identify both providers and members with utilization patterns that fall outside of the expected range. We use these results to modify our prior authorization processes and benefit limits if we determine it will advance member health outcomes and reduce provider administrative burden. For

example, *based on data showing low utilization and high approval rates, we removed the prior authorization requirement from tonsillectomies, electroconvulsive therapy, and pacemakers.*

Our quality committees serve as a collaborative and cross-departmental forum to review these data and reports, as well as our population health management evaluation and population analysis. Equipped with this information, our Quality Director, Mountain Health Trust (MHT) Member Advocate, and other UniCare leaders are constantly collaborating to identify trends that indicate opportunities for improvement and to enact both broad-based and targeted changes to improve quality outcomes.

Assessing Quality of Care for Members with Special Health Care Needs



UniCare uses systematic processes to assess and monitor the quality of care for members identified with special health care needs (SHCN) to confirm the quality and appropriateness of care provided.

KCEAA is proud of the extraordinary work we have done with UniCare that allows us to improve health outcomes for the UniCare members in the Kanawha Valley.

Joe Lynch, Executive Director,
Kanawha County Emergency
Ambulance Authority

Specifically, for members with SHCN, we are highly attuned to care opportunities, grievances, PCP change requests, out-of-network (OON) referrals, and frequent emergency room (ER) usage tools as potential flags for intervention. We continuously assess quality of care for members with SHCN through our care management program. Each year, we carefully evaluate the performance of member and provider satisfaction with our care management, utilization management, and disease management programs. Our Population Health Management Impact Report monitors outcomes such as ER and inpatient utilization, all-cause readmission rate, and use of opioids at high dosage. Our response to QU003 details how we use data to identify barriers to care for members with SHCN — including our Whole Person Health model — through which we provide community-based, individualized face-to-face support for members.

Annual Evaluation

UniCare evaluates the effectiveness of our QAPI program throughout the year, including through a formal Annual Evaluation of all Work Plan activities to measure their effectiveness at driving quality gains. We will continue to submit a written evaluation of its QAPI program strategy to BMS by June 15th of each year. Our annual QAPI Work Plans define specific goals for Medicaid and CHIP and cross-departmental collaborative activities to drive results over each 12-month period. The Work Plan represents our road map for the upcoming year's priorities and performance targets and guides our team in measuring success in achieving established improvement goals. As we do for the current SPA, we will continue to build our Work Plan and Annual Evaluation to confirm we are appropriately and promptly addressing the needs of our members, and the priorities and goals of DHHR.

The Annual Evaluation assesses all aspects of our Work Plan, which describes how we achieve full compliance with program requirements, including processes for all health plan initiatives to monitor and improve quality and timeframes for achievement, and:

- | | |
|---|---|
| ▪ Data collection processes, including HEDIS and SPA-specific metrics | ▪ Care management programs |
| ▪ Evaluation of PIPs | ▪ Provider satisfaction surveys |
| ▪ Measuring quality with objective indicators, benchmarks, and goals | ▪ CAHPS surveys of member experience |
| ▪ Patient safety | ▪ Cultural competency programs and training |
| ▪ Schedule for DHHR reporting requirements | ▪ Schedule for reporting updates and outcomes to the governing body |
| ▪ Monitoring training program effectiveness | ▪ Incorporating member and community stakeholder input |

Because of the importance of this issue, quality measures of access can be found in nearly all our QAPI documentation. UniCare will report to DHHR all measures as detailed in Table 6.9-3.

Table 6.9-3. Schedule of Quality Reporting to DHHR

Measure	Frequency
HEDIS	Annually
Written Description of PIPs and Results	Annually
PIP Progress Report	Quarterly
QAPI Annual Evaluation Report Including Status and Results	Annually
PIP Progress Report	Quarterly
HEDIS	Annually
QAPI Annual Evaluation Report Including Status and Results	Annually
QAPI Corrective Action Plan	Within 30 days of identification of systemic issue
CAHPS Member Survey Analysis, Action Plan, and Evaluation	Analysis Annually, Updates Quarterly
Accreditation Review Report	Upon completion or change in status
Encounter Data	Monthly
Adult and Child Core Quality Measures	Annually

Cooperation with the Bureau for Medical Services and EQRO

The success of our QAPI program is a result of extensive collaboration with providers, our State partners including the BMS, and the EQRO — all with the goal of improving members' well-being. Victoria Warner, our Quality Director, will continue to act as the EQRO's point of contact. In addition to recurring, timely, and accurate reporting to the State, we also have historically and consistently participated in annual on-site audits. We also virtually collaborate with the EQRO on performance measure validation, the process used to confirm we have calculated our performance accurately. We look forward to continued work with the EQRO to validate that our methodologies are sound, so we can confidently report our results to DHHR.



- QU002 1 The Vendor should describe how they will coordinate Quality Assessment and Performance Improvement (QAPI) activities with other performance monitoring activities.

Coordinating QAPI Activities with Performance Monitoring (QU002)

UniCare's QAPI activities and approach permeate every department and guide our day-to-day business.

Quality goes beyond HEDIS and CAHPS scores; it is how we work every day, with the goal of improving the health care, service quality, and stability for our members.

Cross-departmental QAPI and Performance Monitoring Coordination

UniCare coordinates QAPI activities with other performance monitoring activities through the efforts of our QM Committees, with ultimate oversight from the QMC and QIC — as detailed in our response to QU003. Our QAPI Work Plan and Annual Evaluation serve as our roadmap for upcoming priorities and performance targets — facilitating effective coordination with other performance monitoring activities including UM, risk management, and resolution of complaints and grievances.

The QAPI program continuously coordinates its activities and monitoring efforts across all health plan departments to make enhancements to better meet member needs. We also analyze quality and performance data across the health plan. This includes measures related to access to care, demand for services, quality of care, utilization, health outcomes, and member satisfaction to drive quality improvement strategies. We use multiple data types and the strategies detailed throughout this section, including PIPs, to inform and link QAPI activities to other management functions such as network changes, benefits redesign, Value-Added Services (VAS), health education, medical management systems, provider relations, and member education and outreach.

Integrating QAPI Across UniCare Operations

UniCare actively includes providers and members in our QAPI program. Provider contracts require their participation in QAPI activities, including provision of access to medical records, and cooperation with data collection activities. Further, providers voluntarily participate in our MAC. The MAC is dedicated to improving provider and member satisfaction, improving the health status and quality of care for our members and the community, informing VAS, improving member safety, assuring member access to medical services, and supporting UniCare's image as a highly respected and trusted organization. It convenes at least four times a year; additional ad hoc meetings and electronic voting occur when

necessary. UniCare elicits member perspectives through partnerships with local and national advocacy groups and community organizations including Family Resource Network; Recovery Point; Mission WV; West Virginia Coalition to End Homelessness; the Women, Infants, and Children (WIC) program; and universities including Marshall University.

We also seek and encourage member involvement through participation in recurring MEC meetings, ongoing member experience and satisfaction surveys, and by eliciting member feedback at every contact (such as through calls to our Enrollee [Member] Services Call Center and during meetings with Care Managers). To encourage participation, we will host MEC meetings throughout the state, offer members an option to participate virtually, and provide food.

We have a long history in West Virginia of implementing member- and provider-focused interventions to improve our performance; for example:



- Our award-winning *School-based Well-child Incentive Program* detailed in our response to QU009.
- We adjusted the HEDIS measures included in the Provider Quality Incentive Program (PQIP) provider alternative payment model (APM) program to better meet the needs of West Virginia providers and align to local quality improvement priorities.
- We are expanding our existing SDOH incentive program: PCPs will be eligible for additional incentives for assessment of patients' SDOH needs and connecting them to community resources.

QAPI and Member Engagement

UniCare monitors member data to determine if a member is experiencing negative outcomes, gaps in care, or low satisfaction. We use this information to outreach to and engage the member, caregiver, and PCP to determine the level of support the member needs to achieve their health and wellness goals. We

also evaluate our effectiveness in supporting members through recurring assessment of member satisfaction:

- We conduct annual Adult and Child CAHPS member satisfaction surveys, as further detailed in our responses to QU007 and QU008.
- In 2020, we are enhancing our approach by using tablets to collect a “mini-CAHPS” member experience survey from members at clinic days and community engagement events.

We are committed to refining the approach we use to improve State priority measures that do not meet performance goals. For example, we are tackling the significant barriers that exist to improving population health outcomes, EPSDT compliance, and chronic disease by introducing an enhanced Healthy Rewards Member Incentive program (offered as a VAS with new earning opportunities related to these measures, such as completion of the health risk assessment [HRA], annual child and adolescent dental visit, and HPV immunization). Our Healthy Rewards Member Incentive program is detailed in our response to QU009.

Member and Provider Engagement: Whole Person Health Approach

UniCare’s Whole Person Health model is designed to transform member engagement, which has historically presented a significant and persistent barrier to sustainable quality improvement. It is informed by analytics that look at the needs of the UniCare population as a whole (health and well-being, as well as disease prevention) and identifies the distribution of health needs across sub-populations — those who may need additional supports both through medical intervention and care management supports. Our Whole Person Health model deploys both member and provider-facing teams in our *Prevent, Engage, Care program*, illustrated in Figure 6.9-5.

These teams develop and implement both community and population level strategies, using analytics to identify opportunities and incorporating feedback from key stakeholders, to design interventions for clinical, QAPI, and SDOH initiatives. Quality and Provider Outreach teams assist providers to engage members in their health:

- **QM Member Liaisons** handle issues causing member dissatisfaction and disengagement from care, in collaboration with the MHT Member Advocate and our QAPI teams. Introduction of a

similar model in our Wisconsin affiliate paralleled a steady increase in the CAHPS measure *Overall Rating of Health Plan* over three years (6% Adult version, 7% Child version). The Wisconsin team directly assisted 300 members in the second half of 2019 alone.

- **Clinical Quality Program Consultants** support providers to manage and improve quality performance. Their primary duties include conveying Care Opportunity reports, providing training for and education of HEDIS and CAHPS strategies, and reviewing medical records for QI purposes. They collaborate with the Patient Centered Care Consultants (PC3s) and actively support the efforts of providers on interventions designed for improved health outcomes and cost savings.
- **Patient Centered Care Consultants (PC3s)** support providers through regular on-site visits to improve the effectiveness and efficiencies of provider practices by managing and overseeing Value-

Figure 6.9-5. Whole Person Prevent, Engage, Care Program



Based Payment (VBP) programs, facilitating education and the resolution of provider issues, and researching and resolving provider panel concerns.

UniCare QM Member Liaisons, Clinical Quality Program

Consultants and PC3s partner with our Population Health, Community

Engagement, and Care Management teams to share key information on an individual and member level as well as from a provider perspective, with a goal to develop targeted initiatives that improve clinical outcomes, quality performance, and member experience.

QAPI and Provider Performance Monitoring

Our Whole-person Health Model Achieved Results in Indiana Affiliate

- Achieved **49.78%** member engagement and participation rate (January through November 2019)
- Realized a **7.7%** cost reduction in targeted services
- Per member per month savings of **15%** (2018)

The UniCare QAPI program incorporates provider performance monitoring activities including annual HEDIS measures; member complaints, grievances, and appeals; critical incidents and potential quality of care concerns, provider access and availability assessments; provider profiling; and provider report cards related to APM arrangements. NCQA standards for network management underpin UniCare's approach to supporting providers so they can effectively treat members.

UniCare offers extensive data sharing and performance reporting to support providers' ability to monitor and improve their results. In profiling provider quality of care, our multifaceted approach recognizes the distinct roles different types of providers serve and the unique needs they have for profile information. Our strategy is designed to provide relevant, actionable information that can be used effectively to improve performance. For example, we recognize the importance of offering providers who participate in our APMs actionable member information as part of our population health management approach. We offer these providers an enhanced array of performance reporting, including APM scorecards, action plans, and interactive



enhanced array of performance reporting, including APM scorecards, action plans, and interactive management tools to drive performance improvement.

We monitor provider appointment wait times, after-hours accessibility, and telephone accessibility to assure members have timely access to their PH and BH providers and prompt response to telephonic inquiries. In accordance with our QM/QI policies and procedures, we conduct provider audits, using telephonic “secret shopper” surveys, to measure appointment wait times for specific types of visits and provider types against State-defined standards. We continually monitor member experience to identify

Supporting Providers’ Evidence-based Practices

In 2018, UniCare added Screening, Brief Intervention, and Referral to Treatment (SBIRT) codes to allow for reimbursement for this evidence-based screening practice. SBIRT is used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs. Although SBIRT is not a covered service, we offer this enhanced reimbursement to encourage use of SBIRT screenings and support integrated and coordinated care delivery.

evolving quality or access issues and trends. Annually, we will contract with an external vendor who performs independent appointment access and after-hours surveys.

We actively educate, counsel, and hold providers accountable for advancing quality of care. Our Clinical Quality Program Consultants, in collaboration with our Network Relations Consultants, share quality performance information, such as gap in care reports, data showing

their performance in relation to peers, and other profiling reports. They work one-to-one with PCPs, BH providers, and OB/GYNs to address deficiencies, and implement action plans to improve performance. When we determine a provider is not advancing toward suitable standards or higher performance levels consistent with program requirements, we first connect any affected members with the health services they need. Then we will address the provider’s non-compliance by employing various interventions, such as member reassignment or restricted member assignment to optimize our network composition and minimize the use of underperforming providers.

- QU003 1 The Vendor should describe how they will utilize data to identify barriers to care for individuals with special health care needs, and develop policies and procedures for methodologies for collecting and analyzing quality measures for different populations.

Utilizing Data to Identify and Address Barriers to Care (QU003)

UniCare recognizes there are unique challenges that complicate access to services for members with SHCN and Children with Special Health Care Needs (CSHCN). We have extensive experience implementing person-centered clinical programs, including intensive care management, designed to proactively identify and address barriers to care. We prioritize confirming that these members, including those with disabilities (or at risk of developing a disabling condition) or with a chronic or complex condition are identified, screened, and referred to providers for assessment and appropriate treatment. Once referred, we confirm they receive care in a timely and appropriate manner.

The goals of these programs are to improve member identification, engagement, quality, and scope of care management provided to our membership, improving health outcomes and patient safety, such as reduction in avoidable admissions, readmissions, and low-acuity ER visits. We monitor the impact of our clinical programs, and associated member outreach and engagement rates. For example, *members in our CSHCN Enteral Feeding program had engagement rates in 2019 ranging from 92-98% month by month.*

Identifying Members with Special Health Care Needs

We identify members with SHCN or with complex or serious medical conditions as follows:

- CSHCN are identified on the monthly enrollment file; we run predictive analytics to identify adults and other children who may not yet have been identified.
- Member referrals from the State, providers, members, or community and State agencies.
- Lists of members receiving Social Necessary Services, indicating there are medical and/or social complexities in the family warranting UniCare's monitoring.

- UM data mining for existing authorizations, including real-time member utilization data from PreManage.
- Data and claims mining activities, including predictive modeling. For adult members specifically, we focus on chronic disease management and overcoming HEDIS barriers.
- Initial health assessment (initial screening) results, and ongoing health screenings such as EPSDT screens.
- Comprehensive assessment tools, including over 200 tools, such as condition-specific assessments, integrated through branching logic.

PreManage Helps Identify Members for Care Management

Leveraging current and historical member utilization data available in PreManage, we can quickly identify:

- New members with high-risk factors
 - Members with current health care needs
 - Members who may be likely to develop chronic conditions
- PreManage is used in concert with other UniCare tools.

UniCare will enhance our current approach by running quarterly reports to track these data specifically for members identified as having SHCN and for CSHCN.

UniCare will identify members who are consistently using certain types of services, such as Private Duty Nursing or who have certain diagnoses such as cardiac conditions, epilepsy, or neurological disorders. Once a member has been identified as having SHCN and enrolled in this program, our Care Managers closely monitor and coordinate with the State and treating providers to solicit feedback regarding stabilizing members and overcoming access barriers that lead to poor outcomes, such as overutilization of ERs.

Health Insight

UniCare's integrated care management platform, Health Insight, provides a holistic view of the member's whole-person needs — supporting our staff with the tools and functionality to support the delivery of high-quality care and coordination of covered services. This allows for direct care of physical, behavioral, and social services and supports timely communication between all Care Management team members, as well as providers and the members.

Our Health Insight platform is our key information system for member care management, and this platform integrates seamlessly with our Core Services System and data warehouse. The Health Insight platform enables integration among all clinical staff and fosters a holistic view of the member by combining member data and information from various sources into a single record, facilitating the

early identification of members with SHCN. Health Insight aggregates information and stores the data in an actionable and accessible manner for clinical staff and provider use. This information is synthesized in our ongoing care management program to identify SHCN upon enrollment and continuously throughout our engagement with the member, to facilitate effective care coordination and management that prevents and reduces any barriers to care.

Identifying Barriers to Care for Members with Special Health Care Needs

The methods and tools described above proactively identify barriers to care for CSHCN and members with SHCN. To measure and address access barriers for members with SHCN, we will leverage both qualitative and quantitative data obtained through our suite of utilization reports, quality and outcome measures, advisory committees, and surveys. In addition, we will run dedicated reports that may indicate opportunities to better connect members with SHCN to needed care; examples of these reports are included in Table 6.9-4.

Table 6.9-4. Data Reviewed to Identify Barriers to Care for Members with Special Health Care Needs

Report or Data Reviewed	Purpose
Grievance Data	Reviewed on a quarterly basis to identify difficulty obtaining services for members with SHCN and to inform systematic interventions needed in response.
Authorizations for OON Referrals	Helps assess adequacy of provider network to meet the needs of members with SHCN. Provider Relations and UM teams meet regularly to review the reports and pursue the opportunities to add providers to our already robust network.
Potentially Preventable Event Reporting • PPE (ER) • PPA (Admission) • PPR (Readmission)	Indicates opportunities to better connect members with SHCN to appropriate preventive and specialist care to avoid potentially preventable events, such as avoidable ER usage, and inpatient admissions and readmissions. Predictive modeling tools for these PPEs result in risk scores and care opportunities that are integrated into the member's electronic health record and inform and prioritize members for outreach by Care Management staff.

We will monitor PCP change requests for indications our members with SHCN are dissatisfied with care and could be better served by a different medical home. Should we identify a trend with a specific provider, they will be referred through our MAC for evaluation and potential corrective action. We also

understand that members with complex or SHCN may benefit from having a specialist assume the role of their PCP, and we facilitate that process when desired.

Further, UniCare's QM/QI department will run recurring targeted HEDIS gap in care reports for individuals in the Supplemental Security Income (SSI) population so we may proactively identify members who may be experiencing barriers to care. These internal reports will provide our clinical teams a targeted analysis that allows them to drill down to specific issues and opportunities, detect disparities in care, and alert us to the need for enhanced or modified services.

Care Availability Surveys

We survey our members and inquire about satisfaction with access and provider availability through annual CAHPS metrics. Topics for member survey questions include:

- Difficulty setting up appointment
- Wait time between setting appointment and seeing doctor
- Receiving wellness and preventive care as soon as needed
- Having a good experience with doctor
- Doctor explaining things in a way that is easy to understand
- Doctor listening carefully
- Doctor spending enough time with member

2019 Child CAHPS

For UniCare's 2019 Child CAHPS Survey, the following composite measures exceeded the 90th percentile:

- Rating of Health Care
- Rating of Personal Doctor
- Getting Needed Care
- Getting Care Quickly
- Customer Service

UniCare monitors provider appointment accessibility, after-hour accessibility, and telephone accessibility annually. We use a vendor to audit provider availability through random calls to providers asking how soon a member would receive an appointment, assessment, or treatment. UniCare's Provider Relations team oversees this process and reports results through the annual QAPI evaluation, where data is trended and compared to annual targets.

Where an opportunity for improvement is indicated, we contact providers to address barriers to care related to appointment availability and capacity to meet timeframes for member assessment and treatment. Our root cause analyses often find that providers are not fully aware of appointment requirements, so we are increasing our efforts to educate our network on the importance of urgent and routine appointment availability. *In our most recent survey, high-impact specialists scored 100% in providing regular and routine care appointments.*

Proactively Preventing and Reducing Barriers to Care

Through our comprehensive community-based whole-person care strategy, we employ a variety of measurement and improvement techniques to prevent and decrease barriers to care. Care Managers, supported by community-based Care Management team members, such as our QM Member Liaisons, Community Paramedics (CPs), and Community Health Workers (CHWs), proactively address access barriers directly with members and providers. Community-based Care Managers also leverage our integrated Care Management team resources and collaborate cross-departmentally to link members to providers, services, community supports, and services — including through face-to-face, field-based member support. Interdisciplinary collaboration includes working with our UM and provider-facing teams to address barriers. Quality Management, through recurring data and outcomes review and formal collaboration, complements these efforts to assure members receive the holistic, integrated care they need to thrive.

Care Management Support

UniCare uses systematic processes to assess needs and monitor person-centered treatment plans (care plans) of members identified with SHCN, and we strive to eliminate barriers to care by providing direct access to experienced specialists within our network. For members actively engaged in care management, our Care Management team will also examine data regarding services that have been authorized but for

which we do not have an indication of utilization. When identified, we will conduct outreach to determine the reasoning or root cause and make sure the member is not missing needed care or supports.

Our integrated Care Management team works closely with UM staff to add vital details to the clinical information received from providers, as well as help incorporate a person-centered and trauma-informed approach to service level decisions. We examine data feeds for utilization that indicate potential for a SHCN to make referrals to the State's program for enhanced services and will continue this practice under this SPA. We collaborate to assure members receive needed services and seamless access to specialists in accordance with their care planning. For example, for members engaged in care management with an existing authorization that will soon expire, we will proactively coordinate with the treating provider(s) and our UM team to assure continuity of care, prevent service disruptions, and mitigate member and provider burden.

If appropriate based on the member's specific health condition, we will offer the opportunity to be assigned to a chronic condition Health Home that provides comprehensive services to facilitate coordination and management of their complex health condition. UniCare provides enhanced coordination of services to the chronic condition Health Home. This incorporates the provision of timely, actionable information to the Health Home, participation in interdisciplinary care planning, and support of the identification of current and emerging risks and care opportunities. We also make sure the Health Home is promptly notified of the member's use of emergency services, inpatient admission, or discharge.

Community Partnerships

UniCare values the partnerships we have established with community organizations and key stakeholders across West Virginia. These partnerships serve a key role in reducing existing barriers to care and assuring members receive appropriate and timely services and supports.

We seek community partners who already provide services to Medicaid beneficiaries and work with them to expand and enhance those services through a localized expression of a broader strategy to continuously improve the services and supports available to members. When these partnerships are demonstrated to be effective, we work to replicate the model across the state.

UniCare's Case Management team continues to work daily with KCEAA on our Community Paramedicine program and recently supported KCEAA's application to CMS for the Emergency Triage, Treat, and Transport (ET3) model.
Joe Lynch, Executive Director,
Kanawha County Emergency
Ambulance Authority

For example, in November 2018, UniCare launched our community-based paramedicine initiative: an outreach visitation program that engages hard-to-reach members experiencing disparities or poor health outcomes with care management. In this program, CPs outreach and engage hard-to-reach, high-cost, dual diagnosis members with Care Managers, after addressing urgent clinical and social needs. CPs meet with members where they are, going into their communities and knocking on their doors to perform assessments.

UniCare Care Managers partner with the CP telephonically, and as a team they coordinate the immediate health needs of the member including scheduling provider office visits, transportation, and medications. They also review the member's current condition and understanding of health care needs. CPs may also perform a high-level environmental assessment to confirm the safety of the member. Together, they educate the member regarding community resources, health education, and provide a safety check for smoke detectors, carbon monoxide detectors, and overloaded electrical circuits. Early results are promising: **53% of members outreached were enrolled in care management.** During this first phase of the initiative, we were able to identify 86 members without a PCP, 63 members unfamiliar with their PCP or with other PCP barriers, and 15 members who cited transportation as a barrier to care. Through interventions including linking members to our medical transport provider, and by assigning Care Managers, we have been able to help members address these issues. Due to the success experienced in our pilot county, Kanawha, we have

since expanded the program to Boone County and are currently expanding to Putnam County. We will be expanding this successful program to additional regions of the state.

Developing Quality Policies and Procedures for Different Populations

As described above, and throughout this section, data collection and analysis are central to our QM/QI approach. Data is continuously gathered — across all UniCare departments — through methods that include our enrollment process, care management approach, ongoing member and provider engagement, and claims and utilization review. These data and information are complemented by review and incorporation of local and national best practices and stakeholder feedback. We aggregate, analyze, and report on data through comprehensive information system tools and processes — including Health Insight. The resulting information is used by our Quality and Care Management teams to develop and implement relevant policies and procedures — which are reviewed and approved by our QIC and QMC.

To assure we are developing policies and procedures that adequately consider the needs of the different populations we serve, our approach to collecting and analyzing quality measures considers data at both the population and member levels. We capture and review multiple data elements from community health needs assessments, quantitative and qualitative data from primary and secondary sources about demographics, gap in care reports, and data elements captured via social mapping tools and predictive modeling. At the individual member level, we use multiple data elements including claims and encounter data, UM data, risk scoring, and provider referral and member self-referral.

Our approach balances multiple data sources to assure a comprehensive picture. *We routinely stratify more than 20 HEDIS clinical performance measures by race and ethnicity, allowing us to focus in on areas for improvement in health disparities and outcomes.* We base our annual analysis on measures identified as “disparities-sensitive” by the National Quality Forum; UniCare will incorporate the findings

into our CLAS and Health Disparities program plan in support of NCQA Population Health Program Accreditation annually. We then pinpoint the SDOH and clinical needs of our members to identify areas of greatest need for population-based interventions, as well as targeted programs to meet the needs of individuals. We are developing new reports for all of our populations, including CHIP, TANF, Expansion, and SSI populations to detect barriers to care and respond to any meaningful differences. This information is used to tailor policies and procedures, outreach, and interventions specific to the different populations we work with in West Virginia. We review policies and procedures on a recurring basis through venues including quarterly quality committee meetings, to confirm continued applicability and appropriateness.

- QU004 1 The Vendor should describe how they will establish procedures for formal and ongoing communication and collaboration among the Quality Assessment and Performance Improvement (QAPI) policymaking body and other functional areas of the Vendor (for example, health services management and enrollee services).

Collaboration Among QAPI and Functional Areas (QU004)

Accountability for UniCare's QAPI program is housed locally in our health plan QMC, which serves as our QAPI Committee. We also collaborate with our Medicaid affiliates across the country and receive support with NCQA accreditation requirements through our parent company's QIC, which meets monthly and acts as our policymaking body. Our QIC exercises general oversight over Medicaid health plan management, policies, and personnel and is inclusive of our West Virginia QAPI program. *NCQA accreditation standards form the backbone of UniCare-specific policies and procedures that govern communication among functional areas.*

Policymaking Body Collaboration with Other Functional Areas

UniCare fully integrates our QAPI governance model with other functional areas through responsibilities and accountabilities of top-level leadership. Our formal committee structure allows for oversight and the

flow of information to and from the QIC and QMC to and from other functional areas. QIC and QMC meeting agendas are formulated to include reports and discussion from many departments and teams, including Multicultural Health, EPSDT, Delegate/Vendor Oversight, Clinical Pharmacy, and Credentialing. Members of the QIC include health plan Quality leaders, UM leaders, Medical Directors, and senior corporate leaders of our Quality, Care Management, BH, Network Relations, and Pharmacy teams.

Locally, UniCare's committee members integrate medical management functions, operations, network management, and member services into our QAPI through their participation on one or more committees — overlapping membership and leadership responsibilities — and coordinating reporting requirements and analysis. UniCare quality committees that meet quarterly at a minimum and facilitate ongoing communication and collaboration between our QIC and other functional areas include:

- **Quality Management Committee.** Oversees QAPI activities and reports to QIC on a scheduled basis on activities, findings, recommendations, and actions. Our QMC is chaired by our Medical Director with cross-functional representation and participating provider involvement.
- **Medical Advisory Committee.** Assesses levels and quality of care provided to members and recommends, evaluates, and monitors minimum standards of care for members. Participants include our Medical Director, BH Medical Director, and six to ten fully credentialed West Virginia providers from specialty areas such as OB/GYN, general pediatrics, pediatric hematology/oncology, internal medicine, and psychiatry.
- **Clinical Services Committee.** Provides oversight and monitoring of all clinical operations functions assuring effectiveness of clinical programs and regulatory compliance. Chaired by our Medical Director, participants include our Compliance Officer, Quality Director, Care Management Managers, Utilization Management Managers.

- **Member Engagement Committee.** Provides advice to QMC and QIC and leadership regarding health education and outreach program development. Participants include our Health Promotion leader, Community Engagement leader, MHT Member Advocate, advocacy groups, community health educators, and members.
- **Service Quality Committee.** Oversees and monitors member services metrics and provides a forum to discuss and formulate recommendations for interventions to be implemented regarding member and provider services. Participants include UniCare’s directors of Quality Management, Operations, Network Relations, Provider Relations, Member Services, and our Medical Director.

UniCare’s cross-departmental collaboration is illustrated by our committee-driven approach to reviewing quality of care data and collaborating with providers to improve performance. For example, in 2019, a UniCare Care Manager referred a quality of care incident for peer review at the MAC. A member receiving inpatient treatment eloped from the facility with two of his peers while taking a walk. In line with our quality of care policy for investigation, medical records were obtained. QM reviewed historical data for any similar incidents with this provider, the facility provided their action plan to reduce the risk of future elopements, and the MAC closed the incident after reviewing the information and finding it satisfactory.

Table 6.9-5 highlights our quality committees’ key functions, as outlined in their current charters.

Table 6.9-5. Quality Committee Key Functions

Committee	Key Functions and Responsibilities	Cross-Functional Outcome
Quality Improvement Committee (QIC)	• Implements systems and processes for monitoring and evaluating member care and services • Receives and reviews periodic reports on QAPI activities including regarding UM, credentialing, care management, pharmacy, disease management, health care disparities, BH, population health, clinical practice and preventive health guidelines, and access and availability studies • Reviews and approves Quality Management Program Description, Work Plan, and Annual Evaluation • Implements recommendations and actions based on results of Annual Evaluation and periodic reports	• NCQA standards compliance • Sharing of best practices and lessons learned among affiliates

Committee	Key Functions and Responsibilities	Cross-Functional Outcome
Quality Management Committee (QMC)	- Reviews and approves Quality Management Program Description, Work Plan, and Annual QM Evaluation; as well as reports from other functional areas including member and provider satisfaction surveys - Recommends quality initiatives for implementation - Reviews and approves corporate QM/QI policies and procedures - Reviews and evaluates PIPs and provides feedback and suggestions - Reviews and evaluates the quality, safety, accessibility, and availability of care and services	Providing feedback to UniCare providers and staff regarding quality performance and member satisfaction surveys
Medical Advisory Committee (MAC)	- Provides applicable advice and input on the development and updating of clinical practice guidelines; identifies opportunities to improve quality by targeting high-volume, high-cost, high-risk, or problem prone conditions - Conducts a peer review process that provides a systematic approach for monitoring of quality and appropriateness of care; oversees drug utilization reviews - Gives advice to QIC regarding health plan policy or operation affecting participating providers or members	- Adoption of clinical practice guidelines relevant to West Virginia - Credentialing and recredentialing
Clinical Services Committee (CSC)	- Conducts annual review of UM and care management program descriptions and Evaluations. Reviews UM and care management policies and procedures assuring compliance with federal, State, and NCQA requirements and standards - Reviews health care management system (HCMS) workflow processes, assuring coordination with all HCMS functions - Establishes workgroups provide recommendations to improve effectiveness of clinical programs	Authorizing service for UniCare members
Member Engagement Committee (MEC)	- Assures materials and programs meet cultural competency requirements, are understandable to the membership, and address the health education needs of the membership - Assists in the review, development, implementation, and evaluation of member health education tools - Reviews the health education plan and make recommendations on health education strategies - Provides a forum for members to provide guidance and recommendations	Inclusion of member voice and perspective in QAPI
Service Quality Committee (SQC)	Reviews data and develops action plans for improvement as needed to address: CAHPS, CLAS, telephone access, first call resolution, new member welcome calls, provider satisfaction, complaints and grievances in relation to offered services, geographical access to providers, appointment availability survey and secret shopper activities, and claim processing and payment	- Resolving issues for UniCare members - Call center quality improvement

Procedures for Formal and Ongoing Communication and Collaboration

We have established procedures for formal and ongoing communication and collaboration between health plan functional areas and our QMC and QIC, grounded in NCQA standards. We memorialize these collaboration and communication expectations through our QAPI Work Plan and Program Description, which include protocols for quarterly formal collaboration with:

- Care Management and Disease Management departments to discuss data and trends related to enrollment, member needs, quality outcomes, and active and proposed interventions.
 - Member Services to discuss enrollment, call center metrics, satisfaction data, and initiatives.
 - Provider Services to discuss provider satisfaction survey results, action plans for improvement, PIPs, and access and availability data.
- QU005 1 The Vendor should describe its approach to having staff and providers receive initial and ongoing training on health equity and Social Determinants of Health (SDOH).

Initial and Ongoing Health Equity and SDOH Training (QU005)

As a West Virginia Medicaid health plan, UniCare understands and is working to address our state's unique health equity and SDOH

challenges. *In addition to UniCare's achievement of NCQA*

Multicultural Health Care Distinction, our parent company was

awarded the 2019 Innovation in Advancing Health Equity Award

from the National Business Group on Health. This award recognizes organizations committed to advancing health equity through innovative

initiatives and effective practices. As part of our commitment to health equity, UniCare offers staff, providers, and stakeholders comprehensive training on SDOH through the UniCare Training Academy (the Academy), including Appalachian Culture training and Disability Etiquette.

Cultural Competency and Diversity Recognition for Anthem, Inc. (2010-2018)

- Top 50 Companies for Diversity by Diversity Inc.
- Best Place to Work for Disability Inclusion by the US Business Leadership Network Disability Equality Index
- Best Place to Work for LGBT Equality on the 2018 Corporate Equality Index
- Top 100 Military Friendly Employers by MilitaryFriendly.com

Staff Training on Health Equity and Social Determinants of Health

By maintaining a deep understanding of the health and social factors present in the communities we serve, we can improve the health and quality of life of all West Virginians. In 2020, we will launch five SDOH-specific training modules, detailed in Table 6.9-6.

Table 6.9-6. Staff Training on Health Equity and Social Determinants of Health

Course Title	Learning Objectives	Length
Drivers of Health (DOH) 1: Introduction	Define social, economic, and environmental factors that make up health drivers. Learners will be able to illustrate impacts to health such as safe drinking water, accessible transportation, and healthy and nutritious foods, and relate ways to improve health outcomes. Learners will design pathways to improve health equity in their everyday activities and practice.	1 hour
DOH 2: Housing Stability	Connect primary ways that economic factors, such as access to affordable, stable housing, affect health outcomes. Learners will analyze pathways to stable housing from homelessness that include stability, quality, safety, affordability, and accessibility and their impact on health and well-being.	40 minutes
DOH 3: Food Security	Recognize how economic factors such as food insecurity affects health and well-being. Learners will articulate pathways to food security, impact on one's daily life and overall health, and some specific recommendations from our strategic partner, Feeding America.	40 minutes
DOH 4: Transportation	Explain key impacts of transportation on health and the health care system. Learners will evaluate public and private transportation in urban and rural settings to help improve health outcomes via regular access to daily living activities, wellness, and health care appointments.	20 minutes
DOH 5: Interpersonal Violence	Recognize key factors of interpersonal violence that impact health. Learners will learn about psycho-social models and how we collaborate with existing community support mechanisms to improve health outcomes via reductions in interpersonal violence.	30 minutes

This training series will be mandatory for all UniCare staff, available on our internal system for on-demand learning; our QM team will oversee initial staff completion of the training series. UniCare believes that thriving communities are the best medicine for SDOH challenges, and we have the resources in West Virginia to make a meaningful difference in people's lives. We will continue to tap into our established network of community partners to bring in experts for in-service trainings, as we have with faculty from West Virginia University. On an

SDOH Training

The needs of members with disabilities are often compounded by SDOH factors. We will offer staff recurring trainings that address these issues. Webinar topics planned for 2020 include

- Anthem Approaches to Employment for Members with Disabilities
- Hidden/Non-apparent Disabilities at Work
- Best Practices in Workplace Inclusion
- Future of Disability and the 30th Anniversary of the ADA
- Managing Good Mental Health in the Workplace

ongoing basis, the QM team will continue to develop and disseminate state-specific materials with data illustrating the prevalence of SDOH needs among Medicaid members and recommended actions our staff can take to address them. For example, in partnership with *Jobs and Hope and Workforce West Virginia* we will train all member-facing staff on how to assist members seeking information about employment

opportunities. We have a formalized referral process by which our Member Services Representatives and Care Managers refer inquiries to a local workforce office, so members may receive additional assistance in establishing employment and financial stability. Integrating SDOH and clinical data brings greater focus and personalization to member engagement efforts. For example, if a member's BH or PH need is a barrier to employment or housing (or vice versa), together we establish a care plan to address those barriers.

We also integrate SDOH and clinical data to measure our success in addressing SDOH in terms of impact to HEDIS quality measures. We are training QM/QI staff to use a new feature of our Interactive Analytic Insights quality tool, which

Figure 6.9-6. Innovative SDOH Dashboard Promotes Whole-person Care



houses a geospatial visualization of six SDOH categories and targeted measures within each, such as food insecurity, cultural barriers, income inequality, disconnected youth, and health outcomes. As shown in Figure 6.9-6, this tool provides a visualization of care gap compliance correlated to SDOH factors, sized and colored by magnitude. The information can be viewed for individual HEDIS measures or multiple measures in combination. With this holistic view, the Quality and Clinical teams can identify areas with the largest clinical and social needs and collaborate on resolving social and health-related barriers on behalf of members to improve outcomes.

Provider Training on Health Equity and SDOH

We recognize providers are key allies in reducing health disparities, so we offer cultural competency and SDOH training as part of our initial orientation. The Academy encompasses all provider trainings, including initial onboarding for new



providers, staff orientations, and ongoing training for all. It incorporates convenient, on-demand access and multi-modality delivery channels to maximize provider participation, increase efficiency, reduce administrative burden, and promote enhanced member service quality.

Modules include *Understanding SDOH Expectations*, incorporating our mandate to continually expand cultural competency knowledge and skills. We will continue to conduct this training for new providers at least monthly, and will also encourage existing providers to take it as a refresher course or as they hire new staff. We also include SDOH and cultural competency contractual expectations in our provider manual and provider portal.

We complement and reinforce this initial training through tools that include our ***Provider Cultural Competency Toolkit***, which contains information, tips, and resources regarding language, interpreter services, and cross-cultural issues. Providers will also be able to access the five SDOH training modules listed above under staff training resources. Moving forward, the Quality team will electronically survey providers to identify their education needs and will offer providers targeted resources, such as webinars, to address the identified education opportunities. ***One of our forthcoming offerings will be a brief guide to connecting members to employment resources — written in partnership with community experts — that will be distributed to our providers by Clinical Quality Program Consultants.***

We will also educate providers about health equity and SDOH issues through a suite of provider trainings on MyDiversePatients.com that are linked through our provider portal. The goal of MyDiversePatients.com is to offer educational resources to providers to help support the needs of diverse patients and address disparities, to help assure all people have the opportunity to lead healthy lives. This tool includes links to nationally recognized resources, tools, and podcasts, from sources like the Robert

Wood Johnson Foundation and Harvard School of Public Health. Course offerings with free continuing medical education (CME) credits for completion include:

- **Creating an LGBTQ-friendly Practice.** Connects health care providers and their staff with practical strategies for more welcoming practices and culturally responsive care to promote effective relationships with LGBTQ+ patients
- **Moving Toward Equity in Asthma Care.** Features a variety of scenarios that highlight racial and ethnic disparities and their effects on diverse populations' ability to successfully control their asthma
- **Health Care Stereotype Threat.** Gives providers an opportunity to recognize when patients may be experiencing a bias that can threaten the quality of care and explore how to foster a threat-free environment with practical changes
- **Medication Adherence: How to Navigate What You Can't See.** Enables providers to be more cognizant of barriers, use each appointment as an opportunity to build trust, and bring to light the concerns that may be occurring beneath the surface of their patient interactions

Reinforcing and Rewarding Provider Efforts to Address SDOH

UniCare currently offers an SDOH incentive program to Preferred Community Health Partners for completion of SDOH assessments for members in care management using a ten-question SDOH screening tool. For 2021, we will expand our SDOH incentive program to all PCPs to include an incentive tied to a provider's assessment of their patient's SDOH and connection to community resources.

Investing in West Virginia to Improve Health Equity and SDOH

UniCare's community giving supports our philosophy of the importance of SDOH to health, including:

- **Farmacy Market.** UniCare made a \$25,000 investment to address the food insecurities in the service areas of Roane General and Montgomery hospitals. Through a joint effort with West Virginia Health

Network, members enrolled in the program receive free or reduced-cost healthy foods and guidance on how to prepare them.

- **Mobile Grocery.** Our \$30,000 investment to United Way will reduce food insecurity in Clay County, where the last grocery store closed last year, resulting in a true food desert. This program will provide Clay and surrounding counties with fresh meats, products, and a few hygienic and household items.
- **Project THINK (Teaching Health Instead of Nagging Kids).** We invested \$34,000 to expand this program in Putnam County, which focuses on outreach and education to adolescents on teen pregnancy prevention, making healthy decisions, and positive relationship development.

We further confirm that we are effectively addressing health equity and SDOH challenges by conducting an annual analysis of HEDIS measures to detect inequitable outcomes among Black, Latino, and Asian members. Although we found the volume of disparities among our membership is currently small, we will continue to promote culturally tailored interventions such as *Take Action for Health* to Black communities. *Take Action for Health* features modules on topics where health outcomes are disparate nationally: heart health, prediabetes, emotional well-being, and cancer screenings.

- QU006 1 The Vendor should describe its policies and procedures regarding utilization of reports and data from subcontractors to ensure appropriate oversight and member access, satisfaction, and continuity of care.

Reports and Data Facilitate Subcontractor Oversight (QU006)

UniCare retains sole responsibility for fulfilling West Virginia SPA requirements. We are fully accountable for our subcontractors' performance through processes implemented to monitor, supervise, and enforce SPA compliance. We promote frequent, open, and effective communication that emphasizes delivery of quality services to members. *Additionally, UniCare will hire a West Virginia-based*

Subcontractor Oversight Manager who will lead our Subcontractor Oversight Committee and expand

its scope under the program. Our Subcontractor Oversight Manager will meet monthly with our Quality Director, to assure we receive accurate and thorough data from subcontractors, and contribute to QMC activities for cross-functional collaboration.

Utilization of Reports and Data to Assure Appropriate Oversight

UniCare analyzes a variety of quarterly and annual reports to assess subcontractor performance. These reports are reviewed at monthly Joint Operations Committee (JOC) meetings that are held for both delegated entries (who have direct contact with members) and ancillary providers (who may or may not have direct contact with members) to assure appropriate oversight and communication occur between the health plan, national teams, and UniCare Compliance Officers. The JOC meeting agenda can include corporate and health plan updates, delegate updates, a delegated function report overview, market-specific issues and collaborative project reports, annual audit results, corrective action plans, identification and follow-up on opportunities for improvement, review of sampling of denial and appeal letters (as applicable), and outreach efforts (where outreach is a subcontractor responsibility).

Table 6.9-7 lists vendor reporting requirements for UniCare’s vendors that manage provision of a benefit, SKYGEN USA, LLC (SKYGEN) and Vision Service Plan Insurance Company (VSP). We use these reports and data to help us track subcontractor performance including as it relates to access to care, member satisfaction, and continuity of care.



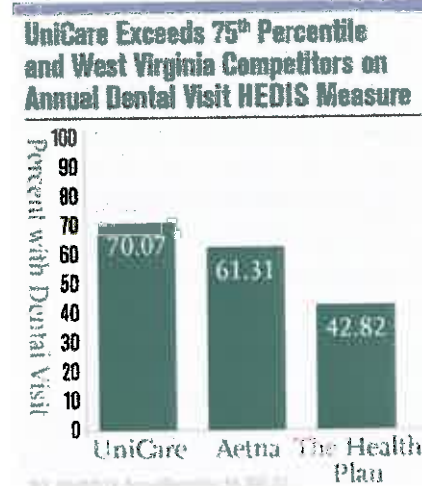
Table 6.9-7. Reports and Data Used to Assess Subcontractor Performance

Purpose	Report Title	Frequency
Assesses and Confirms Appropriate Access to Care	834 Vendor Load Report	Monthly
	Medicaid GeoAccess®	Quarterly
	Medicaid Network Validation	Quarterly
	Attestation	
	Provider Network Data	Monthly

Purpose	Report Title	Frequency
Assesses Member Satisfaction and Informs Interventions	Medicaid Member Complaint Report	Monthly
Tracks and Facilitates Continuity of Care	Appeal and Denial Letters	Quarterly
	Authorization Denial Report	Monthly
	Performance Indicator Report	Monthly
	Provider Demographic Change Report	Monthly

We also use data provided by benefit management subcontractors to enhance member care through UniCare's QAPI. For instance, in 2018, we sent more than 80,000 reminders to members to make dental appointments. We also use subcontractor supplied dental claims to monitor member adherence to annual dental visits. In 2018, UniCare representatives placed reminder calls to members who had missed an annual dental visit. This outreach, in combination with our comprehensive and ongoing quality improvement activities, has resulted in market-leading performance in the Annual Dental Visits (ADV) HEDIS measure as shown in Figure 6.9-6. We will continue to use claims and other subcontractor supplied data to drive member satisfaction and continuity of care.

Figure 6.9-6. Improved ADV HEDIS Performance



UniCare's Health Plan Level Oversight

UniCare benefits from a multi-level approach to subcontractor management that is overseen at the health plan level but supported by corporate departments focused on vendor management. Our West Virginia-based Subcontractor Oversight Manager will collaborate with our Quality Director, Subcontractor Oversight Managers, and local and national oversight committees to assure a successful oversight alliance between the local health plan, individual Subcontractor Oversight Managers, and national oversight committees. This individual will also participate in monthly meetings in partnership with the UniCare Subcontractor Oversight

Committee to discuss potential risk, compliance issues, changes to State or federal regulations, and auditing related to West Virginia Medicaid operations and functions.

Subcontractor Oversight Managers assigned to each subcontractor are responsible for focused day-to-day management, oversight, and ongoing communication with that subcontractor. Managers are assigned to subcontractors based on area of expertise, thereby maximizing their level of collaboration and effectiveness in monitoring performance. Subcontractor Oversight Managers keep the Subcontractor Oversight Committee and UniCare leadership apprised of concerns with, or significant changes at, the subcontractor. This approach places a subject matter expert as the first line of oversight while giving UniCare overall responsibility for overseeing subcontractor performance.

Members of the Subcontractor Oversight Committee meet monthly with vendor representatives and their Subcontractor Oversight Managers to review performance against standards. The meetings provide a forum to discuss issues and brainstorm potential solutions. During the meetings, the group discusses report submissions to determine whether all reports due were received promptly, accurately, and completely. In addition, the group reviews monthly Performance Indicator Reports with metrics on all contract requirements. The report contains a tab on which vendors must document any unmet service levels in the period. Corrective action plans (CAPs) are required for late or incomplete reports as well as instances of missed service level requirements. Responses to CAPs and the status of CAP remediation activities are also discussed during these meetings. The Subcontractor Oversight Committee monitors subcontractor performance and assures appropriate oversight through additional methods including:

- Ongoing communication with Subcontractor Oversight Managers
- Required, regular operational and regulatory subcontractor reports (as listed in Table 6.9-7)
- Annual audits

- Participation on national committees

National oversight committees provide an additional level of support to our program. Regular communication between these committees and our West Virginia Subcontractor Oversight Committee maintains focus on delivering high-quality services. National oversight functions include the Delegate/Vendor Oversight and Management Committee (DVOMC) that oversees subcontractors serving multiple health plans. It is responsible for compliance with State, federal, NCQA, CMS, and program requirements and standards, as well as other regulatory or accreditation standards. They report to the QIC quarterly.

QU007 1 The Vendor should describe how they will administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

Administering the CAHPS Survey (QU007)

UniCare engages a NCQA-certified organization to administer the CAHPS Member Experience survey annually. We strictly adhere to the protocol defined in the current NCQA specifications to produce a fair survey process that yields valid and reliable data, as described in the narrative that follows. Our performance with member experience has been strong: *UniCare is number one in the State on Consumer Satisfaction in the NCQA Health Plan Ratings, rated 4.5 out of 5.* Our locally-based Quality Director oversees the strategies in place to create a positive member experience. This includes the CAHPS survey administration process, grievance and appeal data analysis, and presentation of year-over-year results to discern trends and comparisons.



Annual Administration of Adult and Child CAHPS Surveys

We pride ourselves on working to improve the member experience and we issue the latest version of both Adult CAHPS and Child CAHPS surveys annually. Beginning with this contract, we will field CAHPS separately for Medicaid and CHIP members to generate two distinct data sets. UniCare believes

that using an external entity for survey administration offers members a sense of privacy that facilitates honest feedback. Each year, our survey organization follows a protocol to construct the annual survey sample based on eligibility and other criteria, prepares the sample files for data collection, fields the survey, tracks returned questionnaires, calculates response rates, and determines measured results. Our practice of administering the CAHPS surveys in the first half of each year assure that the data is received with sufficient time to process it fully and report to NCQA and DHHR.

We also augment our sample, by distributing 30% more surveys than required, to increase the likeliness of collecting an adequate sample size. In 2019, we mailed 1,755 Adult surveys and 2,145 Child surveys to a random sample of UniCare members. To reduce confusion and respondent burden, the sample was processed to remove duplicates so only one child per household was included in the sample. Surveys are accessible to respondents in both English and Spanish. To maximize response rate, we collaborate closely with the survey organization to issue multiple reminders via mail and telephone. *For the 2020 survey year, we are enhancing the process by sending a postcard in advance of the survey itself to notify members that it is coming and that we value their input.*

Data is reviewed locally, via our QMC and SQC, and together with other affiliates at the corporate level. Using our data, and aggregate data across affiliate plans, we determine what strategies are successful, identify areas for improvement, and design or modify our interventions, as detailed in our response to QU008. We will continue to supply our CAHPS survey results, action plan, and evaluation to DHHR annually on or before August 15th.

2019 West Virginia CAHPS Results

Our high CAHPS rates, with multiple measures scoring above the 90th percentile, demonstrate our experience and the success of our approach in West Virginia, as summarized in Table 6.9-8.

Table 6.9-8. UniCare's CAHPS Scores Demonstrate Our Commitment to the Member Experience

2019 Survey	Quality Compass Percentile	Measure Name
Child CAHPS	90 th Percentile and Above	• Rating of Health Care
		• Rating of Personal Doctor
		• Customer Service
		• Getting Needed Care
		• Getting Care Quickly
Adult CAHPS	75 th –90 th Percentile	• Rating of Health Plan
		• Rating of Specialist
		• Coordination of Care
		• Rating of Personal Doctor
		• Rating of Specialist
	50 th –75 th Percentile	• Getting Needed Care

Additionally, we observed a statistically significant increase from 2018 to 2019 in the following Child CAHPS items: Doctor Explains Things in a Way Their Child Can Understand (95.20% responded Always or Usually) and Rating of Personal Doctor (93.03% rated 8, 9, or 10).

- QU008 1 The Vendor should describe its process to administer and utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results to identify and investigate areas of member dissatisfaction, outline action steps to follow-up on survey findings, and disseminate findings with providers.

Using the CAHPS Survey (QU008)

UniCare offers DHHR considerable experience using the CAHPS surveys to assess member experience, incorporating them into our QAPI program, and regularly using results of the measures. Through collaboration with our Quality team, our full-time MHT Member Advocate will support our efforts to identify areas of member dissatisfaction and implement initiatives to increase member satisfaction. UniCare will be further supported by a new enterprise-wide CAHPS improvement strategy that includes:

- Staff training: *Quality Starts with Me*
- Provider training: *What Matters Most: Improving the Patient Experience*
- Post-visit experience text polls to members
- Member focus groups on provider-related experience measures

- Improved CAHPS data analytics

Using CAHPS to Identify and Investigate Areas of Dissatisfaction

As described in QU007, we conduct Adult and Child CAHPS surveys annually and submit results to NCQA in line with accreditation requirements. Our SQC will examine overall member satisfaction in Medicaid and CHIP on a quarterly basis, drawing from a variety of perspectives and data sources to detect patterns and devise solutions. Beyond CAHPS, we further assess member satisfaction with their health care experience by reviewing enrollment information, claims and encounter data, authorization data, grievances and appeals, adverse events, stakeholder feedback, Member Services performance reports, MAC recommendations, access and availability survey findings, surveys by external bodies such as accreditation entities or CMS, and QM/QI studies.

To evaluate and improve our care management program based on member input, we also conduct BH satisfaction surveys, care management surveys, and other ad-hoc satisfaction surveys. For example, we created a short “CAHPS-like” survey offered to members during clinic days and other community events to explore root causes of member satisfaction and to identify barriers to care.

All these sources provide us with actionable information about members’ satisfaction and opportunities for us to improve their experience with UniCare. We use this data and information to develop year-over-year comparisons to both internal and NCQA benchmarks. This assists our team’s efforts to investigate and understand root causes of low performance.

Taking Action on CAHPS Survey Findings

With local data and completed root cause analysis in hand, we collaborate internally and across affiliates to address member concerns proactively through the implementation of member experience action plans. UniCare designates our SQC, an interdisciplinary team of functional experts, to support the

member experience action plans. The SQC is tasked with bringing together Clinical, Member Services, and Operations team leads with network stakeholders to identify improvement opportunities and specific strategies for improvement. We work to simplify health care so members and providers can focus on health, thereby producing a better experience of care.

We incorporate member experience action plans into our annual QI Work Plan, setting quantitative goals for CAHPS measures aligned to State goals, national Quality Compass benchmarks, and any other elements specified by DHHR. We evaluate our member experience action plans as part of our QI Annual Evaluation, as detailed above in our response to QU001. This evaluation describes the effectiveness of the previous year's interventions. We will continue to remit quarterly updates to our Annual Evaluation and action plan to BMS within 45 days of end of quarter.

Per the 2018 QAPI Evaluation, there was *significant improvement seen in Adult CAHPS Rating of Health Plan and Child CAHPS Getting Care Quickly between 2016 and 2018*. We attribute this, in part, to efforts made to bring new providers into our network and to enhance and improve our Find a Doctor tool on the member website. UniCare's CAHPS quality improvement activities are provided in Table 6.9-9, and we will devise new strategies in response to trends.

Table 6.9-9. UniCare QM/QI Strategies Facilitate a Positive Member Experience in West Virginia

Program Type	Member Experience Improvement Strategies
Innovative and Convenient Digital Tools	• UniCare's mobile app (launching in 2020) will give members instant access to the most-used features of the member website, including a digital member ID card, secure messaging, tap-to-call functionality, our Find a Doctor tool, and the Healthwise A to Z Symptom Checker. • Member Engagement Platform will be offered to motivate healthy lifestyle choices and drive positive outcomes. It aggregates and analyzes data on personal activities such as sleeping, exercise, and eating from members' fitness applications or personal entries, then delivers insights and tools to help form and maintain healthy habits. • Longitudinal Patient Record (LPR) is a digital system that allows members to download their electronic medical record data to give them a holistic view of their health history, helping to increase engagement. LPR will allow members to share their health data with family, caregivers, providers, or anyone else they choose. • Telemedicine programs provide quick and easy access to clinicians outside of an office setting. • 24/7 Nurse Line connects members with nurses who assess clinical issues and provide members with guidance about the most appropriate point of care (ER, urgent care, or self-care) as well as answering general questions.

Program Type	Member Experience Improvement Strategies
Personalized and Responsive Health Plan Contact with Members	• Proactive member outreach will include welcome calls, mailers, and postcards with plan information and health reminders, as well as electronic HEDIS campaigns to close gaps in care. Some care gaps will qualify the member to earn incentives via Healthy Rewards. • QM Member Liaisons will handle issues causing member dissatisfaction and disengagement from care. This team will log member issues and complaints, find commonalities, and coordinate internally and externally to solve systemic problems at the root. The QM Member Liaisons will collaborate with the MHT Member Advocate and UniCare's QM/QI team. • Outreach during natural disasters will advise affected members on how they can access medication, telemedicine, BH supports, and other resources in an emergency. For example, our Texas affiliate mobilized after Hurricane Harvey to provide volunteers, social workers, translators, and member advocates at local shelters; contact members with high-risk health needs to check their well-being; and make the plan's 24/7 Nurse Line and telemedicine services available to anyone in Texas — not just their own members.
Provider Education and Training	• Our online course, <i>What Matters Most: Improving the Patient Experience</i>, is available on-demand via MyDiversePatients.com. The course guides providers in improving communication skills, building patient trust and commitment, and expanding provider knowledge of the CAHPS survey. Providers can earn free CME credit from the American Academy of Family Physicians. We advertise this course via the provider newsletter. • Clinical Quality Program Consultants will have face-to-face and telephonic contact with providers in our network and will deliver coaching and resource materials such as <i>Voice of the Member</i> feedback to support an improved in-office member experience.
Member Services Call Center Improvements	UniCare uses a brief satisfaction survey for callers to the Member Services Call Center. This automated survey (in English or Spanish) will gather feedback regarding ease of use and their ability to access needed information through the Member Services Call Center. We will then analyze and combine data with other Member Services Call Center metrics (for example, caller abandonment rate) to provide an all-inclusive picture of effectiveness, efficiency, and satisfaction. Customer Service training and call audits will be designed to increase accuracy and a positive member experience.

We also collaborate with affiliates that have contributed their local CAHPS improvement programs to a centralized inventory where we can draw from as potential best practices. For example, our Texas affiliate's work with Member Services Representatives yielded a 5.0% increase in positive responses to the *Customer Service Provided Needed Information* CAHPS rate from 2016 to 2018.

Disseminating CAHPS Findings with Providers

We currently discuss CAHPS findings with providers through regular meetings of our MAC. CAHPS results are also distributed to MAC participants via email and broadly to our network via the provider portal and provider newsletters. Through discussions related to member experience data, the MAC assesses levels and quality of care provided to members and identifies opportunities to improve services and clinical performance.



We also offer our *What Matters Most* provider training on CAHPS and *Improving Member Experience* as part of provider orientation. Field-based QM/QI staff and Network Relations Consultants promote this training during provider interactions and CMEs are available for completion. Moving forward, our QM/QI team will also develop an annual provider bulletin with CAHPS results highlighting the measures focused on providers and practical strategies to address any areas of low performance.

- QU009 1 The Vendor should describe how they will gather, report, and utilize audited Healthcare Effectiveness Data and Information Set (HEDIS) measures.

Using HEDIS Measures (QU009)

Our HEDIS data collection and validation processes are thoroughly grounded in NCQA requirements, and we carefully track and respond to edited measurement specifications released each year. We have over a decade of experience with annual HEDIS reporting in West Virginia, and our results are checked by an NCQA-approved auditor as part of our standard approach. Our high HEDIS rates demonstrate our experience and the success of our approach in West Virginia: for 2019, 25 measures scored at or above the 75th percentile; an additional 13 measures that achieved the 90th percentile are included in Table 6.9-10.



Table 6.9-10. HEDIS Measures Achieving 90th Percentile

Measure	Rate
Measures Achieving 90th Percentile; HEDIS 2019 (Measurement Year 2018)	
Adolescent Well Care Visits — AWC	70.07%
Adult BMI Assessment — ABA	96.84%
Childhood Immunization Status — IPV	93.67%
Children and Adolescents Access to PCP — AGE 12-24 M	97.89%
Comprehensive Diabetes Care — CDC NEPH	93.43%
Follow-up After Emergency Dep. Visit for Alcohol & Other Drug Dependence — FUA TOTAL 30 DAYS	36.12%
Follow-up After Emergency Dep. Visit for Alcohol & Other Drug Dependence — FUA TOTAL 7 DAYS	30.08%
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment — EN OPIOID TOTAL	49.06%
Initiation & Engagement of Alcohol & Other Drug Dependence Treatment — EN TOTAL	25.39%
Medication Management for People with Asthma — MMA Total 75%	49.05%
Metabolic Monitoring for Children & Adolescents on Antipsychotics — APM	62.28%

Measure	Rate
Persistence of Beta-Blocker Treatment After a Heart Attack — PBH	85.00%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents — APC	0.28% (reverse measure)

Gathering and Using HEDIS Data

Data collection, analysis, and reporting forms the backbone of our comprehensive approach to quality management and improvement. HEDIS data is gathered through claims monitoring and analysis, as well as through our medical record review process. We use our sophisticated quality infrastructure — including our proprietary internal Interactive Analytic Insights Platform and HEDIS Datamart — to systematically and objectively measure access to care, demand for services, and quality of care to improve member outcomes and efficiency through data collection and analysis.

UniCare uses Inovalon's QSI-XL™ NCQA-certified HEDIS software solution to facilitate HEDIS and State-specified measure reporting. This best-in-class measurement engine facilitates multi-dimensional reporting and reduced cycle times. Our QM/QI team tracks and trends HEDIS and other measures through bi-weekly reports for internal departments and our QMC. We will separately analyze Medicaid and CHIP members' HEDIS data to understand any meaningful differences in their clinical outcomes. With this data, we identify opportunities for performance improvement, assess the impact of interventions, and monitor our performance relative to DHHR's high-priority measures.

Our Clinical Quality Program Consultants help collect HEDIS data year-round from providers when they make office visits, enhancing completeness of our internal data and minimizing provider burden. These staff, together with the Patient Centered Care Consultants, also collaborate with providers to interpret their data and develop improvement initiatives.

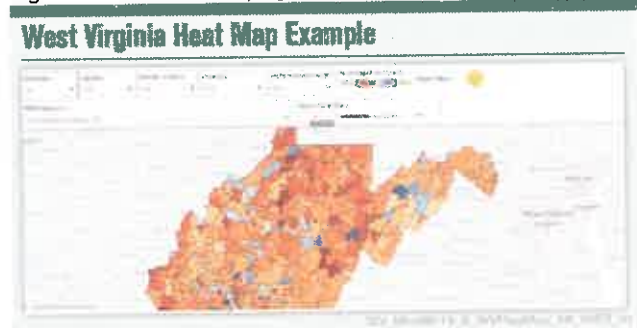
Reporting and Using HEDIS Measures

UniCare complies with all HEDIS reporting requirements. We use an NCQA-certified HEDIS engine to facilitate HEDIS and any State-specified, HEDIS-like measure reporting of other clinical quality metrics. Our Quality team tracks and trends our measures through bi-weekly and monthly reports, which we share with other departments and quality committees. Leveraging over a decade of experience with annual HEDIS reporting in West Virginia, we will continue to consistently and promptly submit finished HEDIS rates for Medicaid and CHIP to DHHR each year on or before June 15.

UniCare routinely stratifies more than 20 HEDIS clinical performance measures by race and ethnicity, shedding light on areas for improvement in health disparities. We base our annual analysis on measures identified as disparities-sensitive by the National Quality Forum and UniCare will incorporate the findings into our CLAS and Health Disparities program plan in support of NCQA Population Health Program Accreditation annually.

Our Interactive Analytic Insights platform is a dynamic, responsive, and scalable tool that provides comprehensive information about QM/QI programs and health plan quality performance across our Medicaid affiliates. The tool assists in monitoring and improving the effectiveness and efficiency of quality programs. Quality data experts continuously improve the tool with frequent updates, enhanced views, and visualization. We routinely analyze data by provider, geography, race, and ethnicity to identify intervention opportunities. We use this information to hot spot at the ZIP code level and tailor interventions to increase quality outcomes, as illustrated in Figure 6.9-7. This also allows us to drill down to determine if a specific member population,

Figure 6.9-7. Heat Map of West Virginia HEDIS Care Gaps



geography, or provider type requires enhanced education or specific interventions. The visualization technology is flexible and can be customized to respond to changing DHHR priorities.

Within the Interactive Analytic Insights platform, our ***SDOH Dashboard*** includes a combined view of clinical and social information for West Virginia. It tracks measures for food insecurity, cultural barriers, income inequality, disconnected youth, and health outcomes in a geospatial map format. The dashboard displays care gap compliance correlated to SDOH factors sized and colored by magnitude. The information can be viewed for individual or multiple HEDIS measures. With this holistic view, the Quality and Healthcare Management teams identify areas with the largest needs and collaborate on resolving social and health-related barriers on behalf of members to improve outcomes.

UniCare uses Interactive Analytic Insights to bring more precision and personalization to member engagement activities by reviewing HEDIS data in combination with individual-level data generated by member care patterns. We leverage predictive modeling, regression analysis, and decision trees to identify members who benefit from our prompting to seek care. Using this data, we target intensive interventions to areas of the state that are most in need. These may include clinic days, where we collaborate with a provider to set aside time for UniCare members to be seen for overdue services, potentially in the evening or over the weekend. Clinic days help support improvement on EPSDT targets; Adolescent Well-visit (AWC); Well-child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34); and Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC) measures.

Further, in response to ongoing analyses, we have also deployed member outreach programs, including our Healthy Rewards Member Incentive program, offered as a VAS, and Health Crowd text and phone campaigns. Based on identified opportunities to improve HEDIS performance, in 2019 *UniCare used our Health Crowd platform to launch 19 campaigns and outreach 300,000 times to members*. In 2020, we

are expanding our Health Crowd outreach to include medication refill reminders. We also use Health Crowd to support provider outreach to members. For example, when providers hosted a Diabetes Education class, we sent texts to members about the event, a reminder text, and information on how to contact UniCare for additional information.

HEDIS Data Promotes Provider Performance Improvement

We include HEDIS results in provider profiles to supports our providers' ability to monitor and improve their performance. We will construct quality profiles that offer PCPs with at least 100 attributed members a profile of their performance against key HEDIS measures, such as diabetes HbA1c testing. These profiles will be updated and distributed twice per year, by email, and reviewed during face-to-face meetings with our Network Relations Consultants.

To help providers improve their performance, we securely email monthly gap in care lists to all PCPs who have members with a gap in care. These lists detail the recommended care needed, such as upcoming or missed preventive health services, and member contact information. For providers participating in APMs, we offer the calculation of potential HEDIS incentive bonus payments for closing the gap on an annual basis. Lists are also reviewed during face-to-face meetings with Clinical Quality Program Consultants.

We incentivize providers for closing HEDIS care gaps through our Pay for Quality (P4Q) APM model. Related education encourages participation in improving quality metrics and health outcomes. Further, our APMs use a variety of HEDIS quality measures to advance member health outcomes, as shown in the Table 6.9-11 for our four signature APMs.

Table 6.9-11. APM Incentives Align with HEDIS Quality Measures for West Virginia Medicaid

APM Program	Provider Type	HEDIS Measures Included
Provider Quality Incentive Program (PQIP)	PCPs with large panels	Chronic Condition Management, Preventive Care, Immunizations
PQIP Essentials (PQIPE)	PCPs with smaller panels	Chronic Condition Management, Preventive Care, Immunizations

APM Program	Provider Type	HEDIS Measures Included
Obstetrical Quality Incentive Program (OBQIP)	Obstetricians	Prenatal Care, Postpartum Care, Birth Outcomes
Behavioral Health Quality Incentive Program (BHQIP)	Comprehensive Behavioral Health Centers (COMPs) and Licensed Behavioral Health Centers (LBHCs)	Inpatient BH, Outpatient BH

HEDIS Data Guides Member Outreach and Interventions

HEDIS data informs our member outreach, education, and incentive developments. For example, we deploy our Medicaid Outbound Call team to assist in contacting members and caregivers to support improvement in targeted HEDIS measures. This team is charged with handling campaigns for measures where our monthly analysis indicates a feasible opportunity for improvement. For example, one month in 2019, this team attempted to reach more than 3,300 Medicaid members in West Virginia about their care gaps. When calls were completed, *our team successfully closed more than 35% of the care gaps* by assisting with appointment scheduling or obtaining medical records to indicate the service was completed. Analysis indicates this is an effective strategy, and we continue phone campaigns. With our technology, we can identify how many members are tied to an individual phone number and have a single conversation with the parent or guardian about all children in the household.

The teamwork between UniCare and CCWV's school-based health center program staff has increased the wellness exam rate for West Virginia. These well-child exams are of the utmost importance annually for growing children. During these exams, areas of concern can be identified and actions can be quickly taken.

Yvonne Staschiak, Community Care of West Virginia

Improving Access to Well-visits

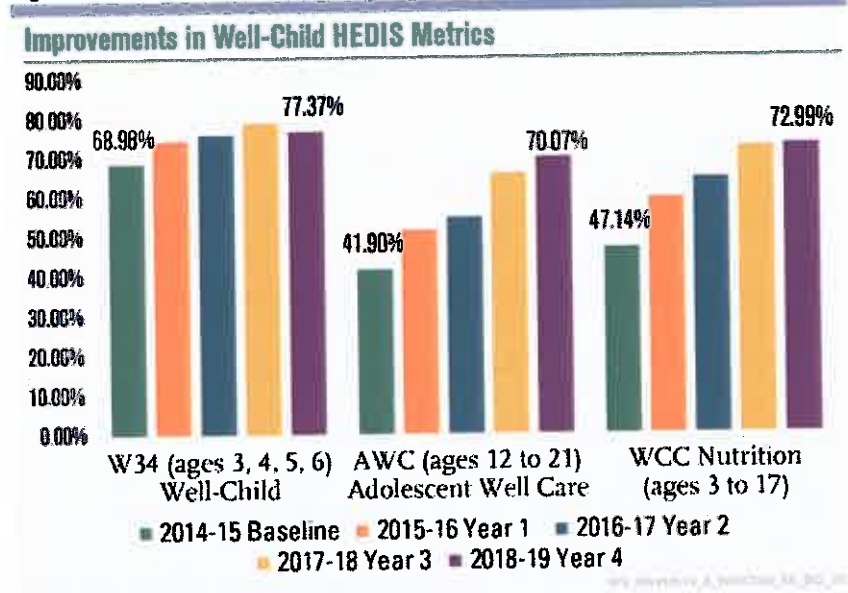
Several years ago, UniCare recognized an important improvement opportunity related to children and adolescents receiving recommended annual check-ups. Our analysis identified the primary barrier to a parent or guardian taking their child in for a well-visit or immunizations was a lack of transportation. In response, we collaborated with community stakeholders and State and local agencies to support the shared mission of improving access to well-child and well-adolescent check-ups by leveraging school-based

health centers (SBHCs). Starting in 2015, the resulting School-based Well-child Incentive Program (SBWIP) also supports the CMS goal for all Medicaid programs of achieving an EPSDT participant ratio greater than 80%.

There are more than 150 SBHCs in West Virginia. The largely rural geography of the state made SBHCs an ideal community partner to increase access to high-quality primary care for children and adolescents. Serving youth at school where they are already spending most of their day reduces transportation needs and minimizes lost instructional time. For each completed check-up, eligible families earned a \$25 incentive. At the end of the measurement period, the host school of the health center with the highest number of participants is awarded a monetary prize. *Our 2018–2019 winners were Beckley Stratton Middle School (\$3,000), Mount Hope Elementary School (\$2,000), and EA Hawse FQHC (\$7,500).*

After multiple years of operating, the contest has demonstrated dramatic improvements in HEDIS measures, including Adolescent Well Care surpassing the 90th percentile. Figure 6.9-8 summarizes improvements; 2019-2020 Year 5 results are pending. Through this quality initiative, *8,027 exams were*

Figure 6.9-8. SBWIP Dramatically Improved HEDIS Rates



completed for members who likely would not have otherwise been completed. HEDIS rates for W34, AWC, and WCC Nutrition each increased more than 11 percentage points, exceeding State goals of

achieving 5% increases over baseline rates. *During year 4, we distributed almost \$90,000 in incentives to schools, members, and school-based clinic providers.*

Healthy Rewards Member Incentive Program

We use HEDIS and other quality data to inform our Healthy Rewards Member Incentive program and improve clinical outcomes. Healthy Rewards is one of our signature VAS. HEDIS prompted us to enhance the available incentives and rewards for this contract to encourage members to take action to improve their health. Our revamped Healthy Rewards program will deliver state-of-the-art communication capabilities and an interactive and personally tailored well-being platform for members. The platform, debuting in July 2020, will include rewards tracking, physical activity and well-being promotion, interactive digital education sessions, and other personalized tools. Members can access the Healthy Rewards platform via single sign-on from our secure member portal or call for phone-based support. The program will use predictive modeling to learn which modes of outreach are most successful in motivating members to make positive behavior changes.



Once enrolled in the Healthy Rewards program, members will receive health education information respective to their gender, age, health risks, and other demographics. Imagery will be bright, inspiring, and personalized. Health education materials will be easy to understand, respectful, culturally competent, and include a clear and simple “call to action” for members.

After completing recommended actions and health services, listed in Figure 6.9-9, members will earn the chance to redeem a large variety of rewards that can be delivered through the mail or electronically. We partner with recognizable and appealing national retailers to offer reward opportunities that members find valuable. To promote healthy lifestyle choices, any rewards selected in the form of a gift card will be

to retailers that do not sell alcohol, tobacco products, or firearms, such as Old Navy, AutoZone, Best Buy, Cracker Barrel, and Panera Bread.

Figure 6.9-9. Healthy Rewards Member Incentives

West Virginia's Quality Strategy and Quality Performance Goals		
	Incentivized Activities for Members	
 Promote Wellness and Prevention	- Complete health risk assessment - Well-child checkup - Wellness checkup - Annual dental visit - First prenatal checkup within 42 days of enrollment - Six prenatal checkups	- Postpartum checkup 7-84 days after delivery - First well-baby checkup - Six well-baby checkups - Complete HPV vaccine series - Complete breast cancer screening - Complete cervical cancer screening
 Improve Coordination and Transition Care	Complete follow-up visit with prescriber within 30 days of initial Rx	Outpatient visit with mental health provider within seven days of discharge
 Improve Chronic Condition Management and Control	Diabetes blood sugar (HbA1c) screening and nephropathy test	Diabetes eye exam

Members who are pregnant will also be eligible to receive a car seat or a portable crib by attending at least six prenatal visits as an additional VAS. *These motivating incentives have helped to boost UniCare's rate for the Timeliness of Prenatal care to 88.81% in HEDIS 2019, surpassing the 75th percentile.* In the past two years, a total of 361 car seats and cribs were distributed to UniCare members in West Virginia.

QU010 1 The Vendor should describe how they will gather and use results for all identified core adult and child quality measures relevant to covered services to identify opportunities to improve member health outcomes, following the technical specifications provided by the Centers for Medicare & Medicaid Services (CMS) (<https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html>), (<https://www.medicare.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html>).

Using Core Adult and Child Quality Measures (QU010)

UniCare supports DHHR's efforts to collect, report, and use standardized measures to drive improvement in the health of Medicaid and CHIP beneficiaries. We also appreciate CMS' growing effort to promote the collection and publication of state-specific Medicaid data, via the adult and child core

measure sets and the Medicaid and CHIP scorecard. We gladly comply with requirements related to the annual collection, reporting, and utilization of the adult and child core measures for Medicaid and CHIP so DHHR may continue to participate in reporting to CMS. Our parent company engages with CMS, measure developers such as Mathematica, and other national stakeholders on making recommendations on the composition of the core sets.

Gathering and Using Core Adult and Child Quality Measures

UniCare uses the same infrastructure and approaches to gather identified core adult and child quality measures as we implement for the collection of HEDIS measures, as described above in our response to QU009. Our enterprise-wide Quality Data Management team has programmed our measure engine to calculate the core measures, both HEDIS and non-HEDIS measures like the Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQIs), according to the technical specifications published annually. Our Quality teams keep apprised of annual updates to adult and child core sets, including measures that are added and removed. Data collection occurs throughout the year, based on administrative data and clinical information abstracted from medical records, and rates are produced once annually. Beginning with this contract, we will produce and submit two sets of measures for Medicaid and CHIP members.

Leveraging Core Adult and Child Quality Results

As we do for all types of quality measures, UniCare is able to track core measure performance over time and trend our rates. We use our internal systems and tools, including our HEDIS Data Warehouse and Health Insight to aggregate clinical, claims, and encounters data and information to assess our performance on core measures. Under the direction of the QM Director, we will incorporate adult and child core measures into our QMC activities, Annual Work Plan, and QM Evaluation to bring additional focus to the measures beyond HEDIS.

We target interventions and initiatives based on our core measure performance. For example, based on our EPSDT activities we believe providers are under-reporting completion of developmental screening, one of the measures in the child core set. In response we will perform additional, targeted, provider education to assure accurate coding for that service. Further, many of our population health program strategies and targeted efforts to improve HEDIS rates are also relevant to the topics and measures in the core sets. For example, clinic days, multi-modal member outreach campaigns, provider payment incentives, and care and disease management programs all support core measure performance.

As CMS publishes increasingly detailed reports of core measure data from other participating states, we can gauge UniCare's relative strengths and weaknesses against national and state-specific rates. A sampling of measures where UniCare is performing above the national Medicaid median or the top quartile is detailed in Table 6.9-12.

Table 6.9-12. UniCare Exceeds State Average Performance and Top Quartile — Examples

Measure Name	States Reporting	Median	Top Quartile	UniCare Rate
Adult Core Set Measures				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	33	57.7%	64.9%	71.6%
Adult BMI Assessment	35	82.0%	89.3%	96.8%
Annual Monitoring for Patients on Persistent Medications	36	87.3%	89.2%	90.6%
Controlling High Blood Pressure	28	57.8%	63.0%	68.9%
Contraceptive Care: Age 21 to 44: Most or Moderately Effective Contraception — 3 days	29	10.6%	12.8%	16.6%
Contraceptive Care: Age 21 to 44: Most or Moderately Effective Contraception — 60 days	29	39.4%	45.7%	45.7%
Comprehensive Diabetes Care: Hemoglobin A1c Testing	38	85.3%	87.2%	88.1%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Using Antipsychotics	32	80.1%	82.4%	82.1%
Prenatal and Postpartum Care: Postpartum Care	37	61.3%	65.7%	68.9%
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) Admission Rate [Lower Rates are Better]	25	94.5	56.7	69.1
PQI 08: Heart Failure Admission Rate [Lower Rates are Better]	25	24.8	19.1	15.8
Children Core Set Measures				
Adolescent Well-care Visits	47	48.9%	57.0%	70.1%
Children and Adolescents' Access to Primary Care Practitioners: 12–24 Months	45	95.7%	96.7%	97.9%

Measure Name	States Reporting	Median	Top Quartile	UniCare Rate
Children and Adolescents' Access to PCP: 25 months to 6 years	45	87.7%	90.1%	90.9%
Children and Adolescents' Access to PCP: 7 to 11 years	45	91.1%	93.8%	93.4%
Children and Adolescents' Access to PCP: 12 to 19 years	45	90.6%	92.7%	91.9%
Contraceptive Care: Age 15 to 20: Most or Moderately Effective Contraception — 3 days	31	3.4%	6.2%	3.9%
Contraceptive Care: Age 15 to 20: Most or Moderately Effective Contraception — 60 days	31	40.8%	46.1%	47.9%
Developmental Screening in the First Three Years of Life	25	42.2%	55.2%	49.9%
Prenatal and Postpartum Care (Timeliness of Prenatal Care)	39	80.6%	86.3%	88.8%

QU011 1 The Vendor should describe how they will develop standards of performance when providing healthcare and related services to members to meet all goals for performance improvement on specific measures, as established by the Department.

Development of Healthcare Standards of Performance (QU011)

We are proud to be a State partner and help meet performance improvement goals that improve the health of West Virginians in the MHT and CHIP programs. UniCare responds to quality improvement priorities communicated by DHHR and the EQRO and supplements them with our own goals, such as boosting measures scored by NCQA.

Developing Standards of Performance to Meet West Virginia Goals

UniCare uses, and will continue to use, performance standards provided by BMS. Where we identify an opportunity to expand upon these standards (that is, where a standard has not yet been developed by BMS), we can and do set our own quantitative targets along with action plans to achieve them. We frequently employ national Medicaid benchmarks from the NCQA Quality Compass and set our goals at the next-highest level of performance to our current rate. For example, a measure exceeding the 75th percentile will have a goal set to exceed the 90th percentile during the following evaluation period. We also consider member, stakeholder, and provider feedback to identify

Clinical Practice Guidelines

For standards in the form of clinical practice guidelines, we rely on nationally recognized sources such as the American Diabetes Association, American Congress of Obstetricians and Gynecologists, and the National Heart Lung and Blood Institute to guide our efforts.

appropriate performance standards. Our HEDIS Manager and other QM team members analyze data by provider, geographic area, race, and ethnicity to identify standards and performance goals.

We will work with providers and other stakeholders through our MAC to incorporate performance measures that are reliable, measurable, and actionable by our providers. We will select measures that are aligned with DHHR priorities, HEDIS, and CMS core set measures and reflect the health care needs of our member populations. We strive to select quality indicators that can be measured using claims to minimize administrative burden on providers and staff.

Standards of Performance to Improve Health Outcomes and Meet Goals

We routinely share quality data and educate providers regarding our expected performance standards. This empowers providers to act on gaps in care, compare their performance to minimum standards, and alert them to areas needing improvement. Clinical Quality Program Consultants specialize in working with either PH or BH providers and collaborate to interpret the practice's data and develop improvement initiatives. We apply rapid-cycle improvement methodology to design and evaluate interventions implemented to improve performance standards. This includes the implementation of clinical and non-clinical PIPs, through the continuous use of the Plan Do Study Act (PDSA) cycle, described further in our response to QU012.

Cross-departmental Collaboration

Meeting monthly, our PIP Workgroups include a collaborative team of multidisciplinary health plan employees who are responsible for analyzing data trends, developing interventions, interpreting barrier analyses, performing quality studies, and monitoring trends related to PIPs.



Identifying Areas for Improvement or Corrective Action

Leaders of multiple functional area teams routinely monitor medical trends, grievances and appeals, and additional data points against standards of improvement. Related to ongoing operational performance, we also continuously track and trend our Member Services Call Center performance and claims processing. When

internal monitoring or notice from DHHR indicates potential for a serious issue that could affect members' care or our relationships with providers, we follow our policy for remedial action and respond rapidly to correct it. We maintain a written plan to guide appropriate corrective action for inappropriate, substandard services or unfurnished covered services. Providers failing to meet established performance standards, whether identified through our ongoing monitoring process or through quality of care concerns, will be faced with committee review and recourse including corrective actions, sanctions, or network termination.

- QU012 1 The Vendor should describe its approach to developing performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Projects 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.

Developing Performance Improvement Projects (QU012)

UniCare has demonstrated our commitment to achieving better outcomes for members through our ongoing collaboration with the State to conduct PIPs. A key part of our QAPI, we maintain written descriptions of our performance improvement program, including identification of responsible individuals. We conduct formal PIPs, maintaining at least three at a time, to achieve and sustain improvement. Under the oversight of the QM Director, we collaborate across functional areas, as well as the State and its EQRO, to identify, design, implement, and evaluate data-driven PIP activities and interventions to maximize results.

Using the PDSA improvement process, we carefully track and monitor each PIP to verify project timeframes are upheld, to revise interventions to meet quality goals, and to help drive new information and interventions to improve quality of care. The core concept of the PDSA cycle is the use of iterative cycles of change to accelerate the rate of improvement. Performance assessments on the selected

indicators are based on systemic ongoing collection and analysis of valid and reliable data and interventions. We analyze interventions regularly and report results of the data analysis to our QMC. We refine interventions based on actual results, repeating the process until we achieve the desired goal.

West Virginia Medicaid PIPs from the last 24 months are outlined in Table 6.9-13. We are proud to have achieved statistically significant improvements in at least one measure included in each PIP.

Table 6.9-13. UniCare PIPs Within the Past 24 Months Resulted in Several Statistically Significant Improvements

Measure/ Target	Summary of Interventions	Baseline	Measurement Year 2108	Significance
Dental Care for Children	- Text message reminder campaign - Outbound calls to families of members with gaps in care - Educating providers to accept 2-3 year old children for initial appointments - Time-limited member incentive for pregnant mothers	- ADV (ages 2-3): 39.87% - PDENT: 49% - Sealants: 25.02%	- ADV (ages 2-3): 41.17% - PDENT: 51.32% - Sealants: 38.25%	- ADV goal met - PDENT statistically significant ($Z = -7.9$) - Sealants goal met and statistically significant ($Z = -18.3$)
Prenatal BH Risk Assessment and Postpartum Care Visit	- Calling members to ask if postpartum visit is scheduled and offer assistance - Calling providers after appointment to verify attendance - Members earn incentives for completed prenatal and postpartum visits - OB Practice Consultant working with providers	Postpartum Care: 62.04%	Postpartum Care: 68.86%	Postpartum goal met, significantly exceeds benchmark rate
Follow-up After Hospitalization for Mental Illness (FUH)	- Encouraging hospitals to begin discharge planning on the first day of admission - Members earn an incentive via Healthy Rewards (offered as a VAS) for a completed visit - Contacting all members discharged to review medications, assess date of or access to post-discharge appointments, transportation, support systems, and identify and assist in resolution of barriers and offer care management services	- FUH-7: 15.48% - FUH-30: 38.69%	- FUH-7: 31.11% - FUH-30: 57.13%	7-day rate statistically significant compared to benchmark ($Z = -6.754$ for 2015-2017) 30-day rate statistically significant ($Z = 4.170$)

Approach to Designing Performance Improvement Projects

Our approach is founded on CQI principles, which focus on processes and tools including the PDSA (Figure 6.9-10), rapid-cycle improvement, and Six Sigma methodologies. Our QMC oversees quality improvement initiatives, including review, approval, and continual oversight of the strategic direction and

progress of these initiatives. In addition, we submit all PIPs (along with all required reporting) to EQRO auditors and the State for approval.

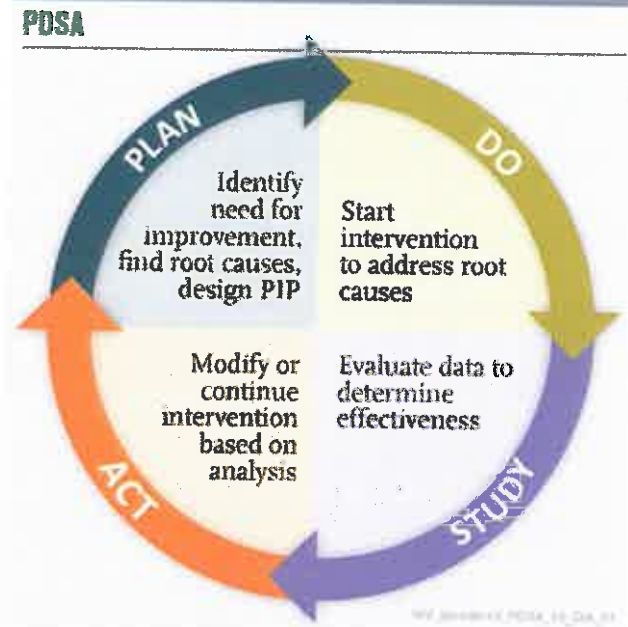
Planning Step

The first step in designing a PIP is to select an aspect of clinical care or non-clinical services to be studied. This starts with an analysis of baseline performance rates against West Virginia and national benchmarks to detect measures needing improvement and notable performance trends over time and among specific sub-populations. We identify PIP topics that are most relevant to

members, represent a priority for the DHHR, and offer a meaningful opportunity for measurable improvement. We prioritize PIPs that reflect DHHR's most pressing health issues, working with the State and its EQRO to finalize PIP topics. For example, beginning with the new Contract in 2020, we will propose a new PIP topic on EPSDT in support of reaching the 80% participation threshold set by CMS and DHHR.

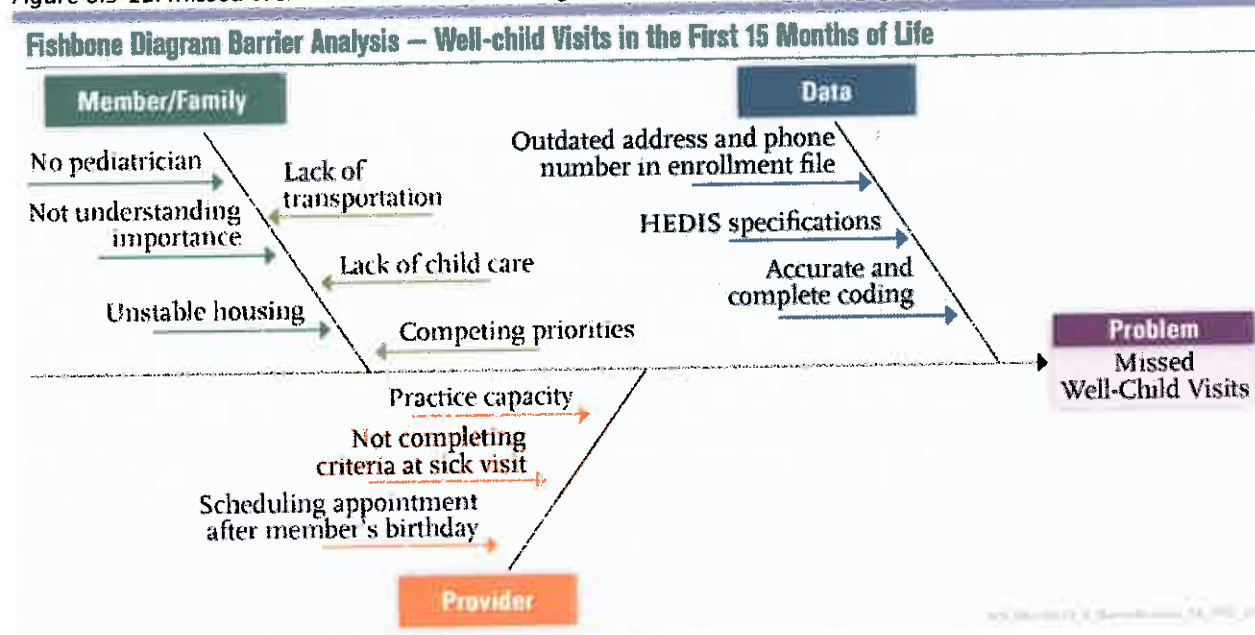
In the planning stage of a PIP, UniCare will designate and document the individuals responsible and establish a PIP team lead with quality improvement training and team members from multiple departments, including designated data analysts. Each cross-functional PIP team will include an executive sponsor who will verify that our senior leadership supports the PIP organizationally and financially. Often, we include providers who serve on our MAC as part of our PIP team to provide additional guidance.

Figure 6.9-10. Plan, Do, Study, Act Methodology



We begin by documenting our current knowledge and rationale for the selected topic, including the evidence justifying the selection of the study topic and the quality indicators we will use to measure performance. Baseline performance data are collected and evaluated against State or national benchmarks to develop the PIP objectives and measurable goals. We outline the data specifications, including the numerator and denominator for each measurable quality indicator in the PIP and the applicable data collection methods (for example, claims or hybrid medical record review). We then define the potential drivers impacting our performance. Our QM team conducts in-depth barrier analyses to identify and assess possible behaviors and contributing factors that may inhibit performance improvement, using tools such as brainstorming, the Five Whys and Five Hows, key driver diagrams, and fishbone diagrams. The problem of missed well-child visits as interpreted in a fishbone diagram is displayed in Figure 6.9-11.

Figure 6.9-11. Missed Well-child Visit Fishbone Diagram



This information will serve as the basis for developing the interventions necessary to achieve the goals. Guided by the team lead, the PIP team maps the process with a high-level process flow diagram from the perspective of the person most impacted by the process (typically the member). We complete a failure

mode effects analysis and lay out actionable barriers, potential interventions, and how we evaluate how well those interventions help in reaching the goals. In close collaboration with EQRO, the PIP team designs and plans interventions after thorough research and brainstorming on evidence-based practices and appropriateness for the targeted PIP population. When selecting an intervention, we consider its potential sustainability and expandability, looking to the following sources:

- Company-wide best practices from Medicaid affiliates
- Data-driven, documented experience from public health agencies such the National Association of County and City Health Officials or national experts such as the Institute for Healthcare Improvement, American Society for Quality, and medical societies
- Internal qualitative and quantitative analyses to evaluate work processes (for example, run charts, scatterplots)

Our PIP team selects interventions to address specific failures, key drivers, or other process improvement strategies. As we design PIPs, we capitalize on our Interactive Analytic Insights tool that includes quality performance trended over time with performance benchmarks and comparable data from affiliate health plans and our competitors. Once design is complete, we document the PIP, describing the proposed interventions, timeline for implementation, measures, and methods for collecting data.

PIP Implementation (Do Step)

Once the PIP team selects the intervention, our Quality Director will review and approve the plan and overall PIP methodology. We then move to the second step of the PDSA cycle and appropriate system interventions to improve performance. The advantages of testing interventions on a small scale before expanding them include minimizing risks of potential failure and adverse or unanticipated side effects, predicting how much improvement to expect, learning how to adapt the change to local environmental

conditions, evaluating costs and side effects, and minimizing implementation resistance. The data applicable to the PIP scope are tracked throughout the project cycle to measure progress. We will regularly review HEDIS data, utilization data, care management and disease management data, member satisfaction surveys, or other sources depending on the topic, to illustrate the effect of the intervention. We repeat data collection periodically to gauge the continuing effect of our interventions.

PIP Assessment (Study Step)

Following implementation of the changes, we move to the third step of the PDSA cycle and begin to study our progress. We may review the key driver diagram, process map, failure mode effects analysis, and interventions based on the results of this evaluation. When appropriate, we will also discuss PIPs in progress at our MAC and Consumer Engagement Council meetings to gather input on barrier analyses and maximize the effectiveness of interventions.

For example, our current PIP with measures of perinatal care was enhanced with additional quality improvement strategies after we observed only modest improvement in the first year. In 2017, UniCare introduced a new VAS so members can receive a car seat or portable crib for engaging in prenatal care, and in 2018, we started text message outreach, began collaborating with OB practitioners and hospitals accounting for about 20% of deliveries in the state, and hired a field-based OB Practice Consultant to educate practices on quality improvement and maternity programs available to members.

Determining PIP Success (Act Step)

Overseen by the Quality Director, the PIP team assesses the overall effectiveness of interventions by comparing the results of re-measurement periods to the initial baseline measurements and evaluating the final results against targeted benchmarks or goals. We then determine: 1) if there is quantitative, measurable, and sustained improvement in processes or outcomes according to the predetermined study

indicators; 2) if any qualitative analysis impacted results; 3) if the improvement in performance is a result of the planned interventions or some unrelated occurrence; and 4) if the improvement has meaningful change or if further work is needed.

Based on testing results, we decide if we should adapt or expand the interventions. We implement successful interventions on a larger scale through an expansion plan and abandon unsuccessful interventions and replace them with new ones. Interventions selected for expansion will be those that are viable as best practices in multiple environments. Our Healthy Rewards Member Incentive program is being expanded and enhanced with new earning opportunities in 2020 as multiple PIPs have employed member incentives as effective strategies to increase engagement in care.

We will measure the results of new or enhanced interventions and, as needed, report the results of the analysis to the QMC, EQRO, and DHHR. We refine interventions and repeat the PDSA process until we achieve the desired results. ***UniCare's current PIPs have all demonstrated statistically significant improvement in at least one measurable indicator of quality.***

QU013 1 The Vendor should describe how they will establish and utilize one or more quality indicators that are objective, clearly and unambiguously defined, and based on current knowledge or health services research, to assess its performance.

Establishing and Using Quality Measures (QU013)

As described throughout this response, UniCare uses a multitude of quality measures to continuously assess our performance as a health plan. In the context of PIPs, we establish at least one measurable quality indicator to be used to evaluate progress at the onset of the project. Indicators may be clinical or non-clinical, depending on the topic of the PIP.

Using Quality Indicators to Assess Performance

UniCare currently operates three PIPs, each with multiple quality indicators that are objective, clearly and unambiguously defined, and based on current industry knowledge or research. Table 6.9-14 lists the relevant measures.

Table 6.9-14. Objective Quality Indicators for UniCare's Performance Improvement Projects

Indicator Name	Indicator Description	Data and Goal
Follow-up After Hospitalization for Mental Illness		
Indicator 1: HEDIS FUH-7	The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within seven days of discharge.	• Data Source: Claims/Encounters • Goal: NCQA Quality Compass National Average
Indicator 2: HEDIS FUH-30	The percentage of discharges for members six years of age and older who were hospitalized for treatment of selected mental illness diagnoses and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner within 30 days of discharge.	• Data Source: Claims/Encounters • Goal: NCQA Quality Compass National Average
Dental Care for Children		
HEDIS Annual Dental Visits for 2–3 Year Olds	Percentage of members two to three years of age who had at least one dental visit during the measurement year.	• Data Source: Claims/Encounters • Goal: NCQA Quality Compass National Average
PDENT — Percentage of Eligible that Received Preventive Dental Services	The unduplicated number of individuals receiving at least one preventive dental service by or under the supervision of a dentist.	• Data Source: Claims/Encounters • Goal: 3% over baseline rate
SEAL — Dental Sealants for 6–9 Year Old Children at Elevated Risk	The unduplicated number of eligible children ages six to nine at elevated risk for dental caries (that is, moderate or high-risk) who received a sealant on a permanent first molar tooth as a dental service.	• Data Source: Claims/Encounters • Goal: 3% over baseline rate
Prenatal Behavioral Health Risk Assessment and Postpartum Care Visit		
HEDIS Postpartum Care Rate	The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.	• Data Source: Claims/Encounters • Goal: NCQA Quality Compass National Average
Behavioral Health Risk Assessment	The percentage of women, regardless of age, who gave birth during a 12-month period seen at least once for prenatal care who received a BH screening risk assessment at one of their prenatal care visits.	• Data Source: Hybrid Medical Record Review • Goal: 10% over baseline rate

Because the indicators are drawn from NCQA's HEDIS measure set or the CMS-published child and adult core sets of measures, we are fully confident they are objective, well-specified, and based on the

most current knowledge of the measure development community. NCQA leads the industry in rigor around health plan performance measurement and carefully tests the scientific properties of all HEDIS measures prior to publication. In cases where indicators are assigned by the EQRO and the underlying specifications are modified, we carefully follow the EQRO's prescribed methodology to assure data accuracy and comparability to other health plans.

As previously described, our approach to PIPs involves documenting a baseline rate of performance, measuring changes on set intervals, and performing analysis of changes observed against our goals. We regularly submit PIP progress updates to the EQRO. We determine a PIP to have been successful if we can attribute the improvement observed to the actions we have taken and demonstrate the ability to sustain positive results for a year or more. When this occurs, we will work with the EQRO and DHHR, as needed, to select a new PIP topic.

QU015 1 The Vendor should describe its policies and procedures to correct and remediate significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

Remediating Significant Systemic Problems (QU015)

UniCare proactively monitors our performance to identify emerging risks and systemic patterns to address them early and minimize any downstream impacts. Our cross-functional approach involves the highest levels of health plan leadership, QM/QI, and other key functional areas. UniCare's President's Panel is charged with identifying and mitigating complex challenges and systemic problems. Under leadership of the CEO, Tadd Haynes, the President's Panel prioritizes issues that have an impact on members and providers to find cross-functional solutions. The President's Panel will use a data-driven approach to inform its monthly meetings and leverage quality management methodology to implement changes. Participants in the President's Panel include:

- Contract Liaison/MHT Administrator
- Quality Director
- Network Development Director
- Compliance Officer
- Operations Director
- MHT Member Advocate
- IT Director
- Any other staff needed to address particular issues

This work is an extension and formalization of current improvement activities underway among UniCare's leadership. For example, we recently managed the influx of a high volume of new members when another health plan exited Medicaid. Our approach targeted the members' transitions of care to make the process as seamless as possible. Going forward, the President's Panel intends to tackle IT enhancements, data integrity, and other issues as they arise. To facilitate quick action, the President's Panel will have funding earmarked with which to implement its recommended changes.

Addressing Significant Systemic Problems

Complementing the efforts of the President's Panel, cross-functional leaders routinely monitor medical trends, grievances and appeals, provider performance, and additional data points for emerging or persistent areas for improvement. We have developed a policy and procedure to govern the collection of complaints, system shortcomings, and near-misses so they can be tracked for root cause analysis.

We proactively configure reports in our Health Insight platform to produce a dashboard of measures on a daily, weekly, monthly, semi-annual, or annual basis, as appropriate, so we can immediately detect and rapidly respond to performance aberrations. We analyze data including the management of chronic and acute diseases and conditions, public health data, statewide and community trends, impacts to core critical functions, SDOH, health disparities, and more. We also prioritize our initiatives based on the needs of UniCare members. Where gaps exist, we review the impact for both short-term and long-term outcomes before implementing any new or modified programs.

Identifying Significant Systemic Problems in Quality of Care

Our QM team investigates all potential quality of care issues, including preventable adverse events. We maintain a Quality of Care Policy and Procedure to guide this important process. We have the capability to identify quality of care concerns when conducting utilization review; reviewing or trending provider complaints, member grievances, and appeals; and monitoring physician practice activities. We may also learn of them from external sources, such as members, providers, DHHR, or the State.

Upon receipt of an identified or potential quality of care issue, all relevant information is entered into our quality of care event tracking system and a reviewer thoroughly investigates, gathers information (such as claims and authorizations history, member communication logs, or medical management files), and obtains necessary consents for release of information. We gather medical records, obtain the provider's response, and develop an action plan to address the identified root cause. If applicable, the peer review process is initiated and followed via the MAC. Quality review of individuals may result in significant interventions depending on severity, including termination from the network, reporting to State licensing agencies, the National Practitioner Data Bank and Healthcare Integrity and Protection Data Bank. If a trend is identified as it relates to quality of care issues, it is reported through UniCare's quality committees. Data on quality of care concerns also informs provider recredentialing and re-contracting decisions.

Internal Surveillance Methods

For transparency and accountability, we monitor, track, and evaluate all areas of health plan performance using the National Executive Dashboard (NED). NED is a Tableau-based reporting tool that assembles key metrics to visualize performance against defined targets, both internally developed and those defined by DHHR. Through NED, the aggregated data is presented in a sortable and actionable

dashboard, which is refreshed regularly. All functional areas are represented, including, but not limited to, Claims Operations, Member Services Call Center, UM, Grievance and Appeals, and Enrollment.

Metric goals range from monthly to annually, and each has a clearly identified business owner responsible for the function's performance and for entering an action plan for missed targets. NED offers a heat map of all operational areas, offering regular status updates and risk identification. NED provides leadership with a comprehensive status of operational performance by tracking and assimilating data that can be used to inform mitigation strategies, if necessary, to help us meet our commitments to members, providers, and State partners. If a functional area has not met their established goal for a three-month period, our Compliance team may create an internal corrective action plan (iCAP). This iCAP will be overseen by the Operations Director and relevant health plan leaders. Compliance and Operations will monitor the iCAP through its ultimate resolution.

Monitoring Member Experience and Grievance Data

Our QMC reviews qualitative and quantitative data for indications of significant systemic problems affecting members, including PCP change requests, CAHPS scores, care coordination satisfaction surveys, complaints, and MEC feedback. If any such issues are discovered, UniCare and our MHT Member Advocate will conduct root cause analysis and make improvements together with the relevant department leads. As detailed in our response to QU002, our ***QM Member Liaisons will provide personal support for members who are disconnected or dissatisfied, proactively preventing complaints.***



We have built robust processes to monitor complaints to identify issues when they arise across the entire spectrum of services we provide — including those provided by our subcontractors. Through our grievance and appeals system, which interfaces with our UM and claims system, we track all grievances and appeals by

provider ID and subcontractors. There is a distinct report using data from subcontractor entries. As a result, our Quality team can sort and track complaints so we can promptly address and provide a resolution. The report breaks down the entries by NCQA-defined categories for each provider. A summary of all grievances and appeals is submitted to the QMC for review and oversight on a quarterly basis. Additionally, grievances indicative of serious provider quality concerns are reported to MAC.

Monitoring Claims for Systemic Issues

We proactively sweep claims for all providers to assure they are being paid accurately and promptly and to rapidly identify systemic issues. Our claims processing system captures the IP address and login for every claim, information that is then used in fraud and abuse detection. The system assigns a unique internal control number to each claim to track its progress from entry to final adjudication. We maintain images of all claims with real-time access to facilitate needed adjudication and research tasks.

Daily exception reports enable us to monitor loading of claim batches into the system. Claims submitted electronically receive an electronic receipt within 24 hours after the start of the next business day; receipts for paper claims are available through our secure provider portal within 10 business days of receipt. We conduct daily reconciliations to confirm that we are accounting for all claims received from all submission sources and either rejected and returned to the provider or loaded into the claims adjudication system and data warehouses within specified periods. The system's reconciliation tool captures the date, trading partner, and source (paper or electronic data interchange) for every claim submitted. We use the data to confirm we process all claims received to a determination of accepted, rejected, paid, pending, or denied.

Correcting and Remediating Systemic Problems

For any significant systemic problems, we will prepare a CAP within 30 calendar days of identification to mitigate and correct the issue. Our CAPs include all contractually required elements, including clear

accountability to an assigned business owner or owners, specific actions, timeframes, and monitoring to completion. We actively conduct follow-up, monitor, and evaluate the success of these changes to confirm effectiveness.

10. CLAIMS AND ENCOUNTERS

- CE001 1 The Vendor should describe its claims processing guidelines and systems requirements that ensure timely payment of all clean electronic and paper claims for covered services from both in-network and out-of-network providers, within thirty calendar days of receipt for Mountain Health Trust (MHT) members.

Paying Timely Claims to Support Providers (CE001)

UniCare knows that providers need timely claims payment. This is particularly true for our smaller and rurally based providers, who may rely on timely payments to pay their staff on time. *In 2019, 99.97% of UniCare clean provider claims for both participating and out-of-network (OON) providers were processed and paid within 30 days.* Clean electronic and paper claims were processed well within the 30-day timeline, with an average turnaround time of eight days from the date of receipt in 2019.

Effective Claims Processing with Our Core Services Systems

Core Services System

The Core Services System serves as the system of record for all provider, member (enrollment and eligibility), claims, and authorization data.

We have configured our Management Information System (MIS) to comply with all of West Virginia's requirements under the current contract. We process claims in the Core Services System, a key part of our MIS, which is seamlessly integrated with other components, including member, and provider websites provided through Availity, the Health Insight platform (our integrated care management system), and reporting data warehouses. The Core Services System serves as the system of record for all provider, member (enrollment and eligibility), claims, and authorization data. As shown in Figure 6.10-1, we load and maintain this data through a combination of user interface and application-specific data loads, such as ANSI X12 837 (837) claims transactions and ANSI X12 834 (834) enrollment files received. We

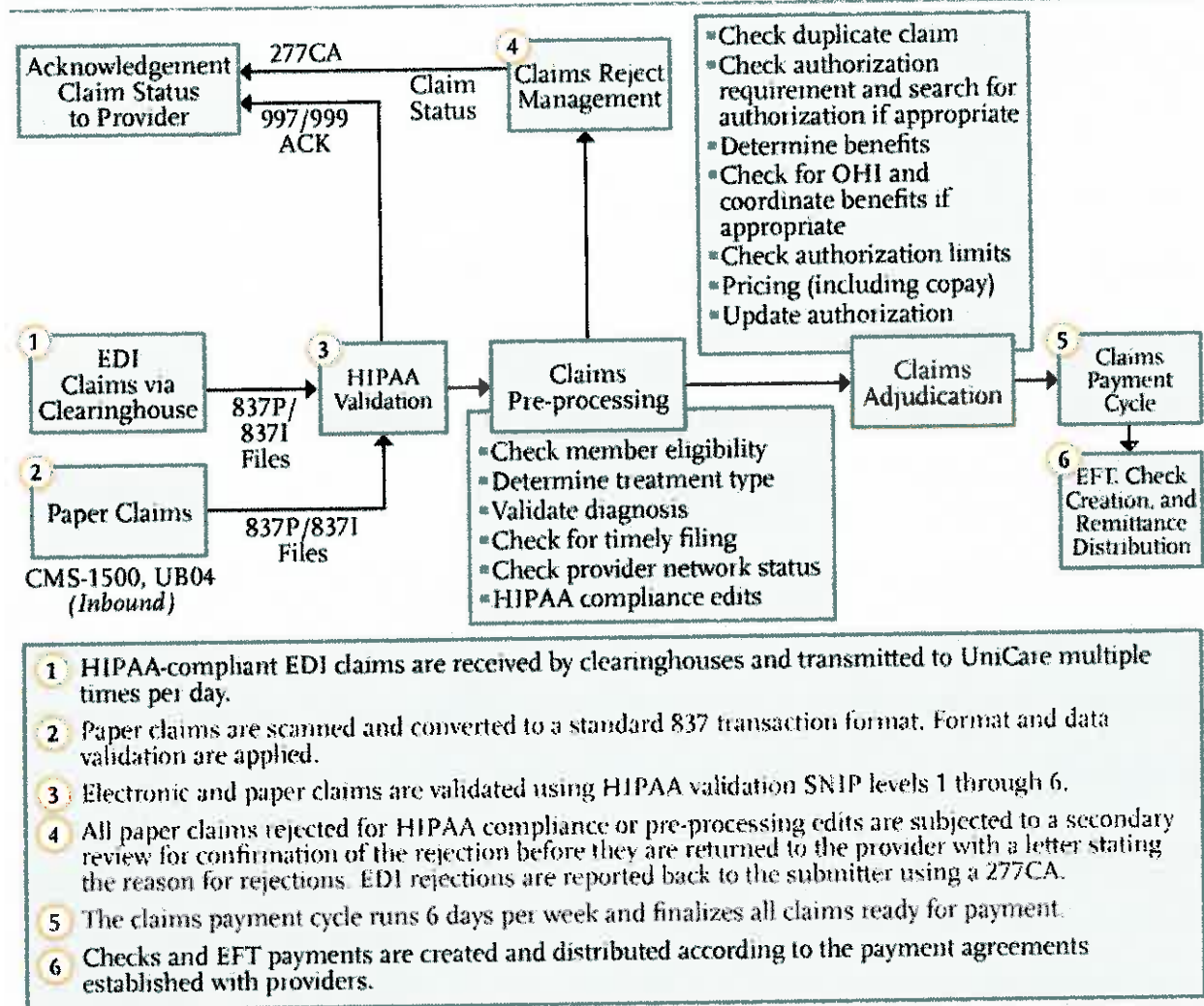
Health Insight

UniCare's integrated care management platform, Health Insight, provides a holistic view of the member's whole-person needs — supporting our staff with the tools and functionality to support the delivery of high-quality care and coordination of covered services. This allows for direct care of physical, behavioral, and social services and supports timely communication between all Care Management team members, as well as providers and the members.

apply extensive edits and validations to verify that data entering the system is complete and accurate. This focus on data at the point of system entry helps maintain reliable information for use in both Bureau for Medical Services (BMS) and our other processes and reports.

Figure 6.10-1. UniCare's Efficient Processes Promptly Identify and Address Issues That Could Delay Claims Payment

Claims Flow



This efficient, precise, and timely claims processing system enables us to achieve:

- Consistently high adjudication accuracy

- Provider satisfaction through prompt claims payment
- Performance and scalability to support current volumes and future growth

We use electronic transactions and payments to the greatest extent possible to facilitate quick and consistent processing, and leverage electronic funds transfer (EFT) to make electronic payments available to all network providers. We also have an established process to pay paper claims.

Enhancing Efficiency and Accuracy with Robust Processes

As depicted in Figure 6.10-1, we capture and adjudicate medical claims by combining the core claims transaction platform with electronic document imaging, a workflow management system, and electronic claims solutions.

Our process leads to higher rates of auto-adjudication and faster, more accurate claims turnaround, and provider payment. For claims we receive on paper, the Document Services team batches, scans, and exports the files for data entry each production day. After we perform quality checks, we create 837 claims data files, enabling all claims (paper and electronic) to enter our process in this same format. The claims processing system captures the IP address and login for every claim, information that is used in fraud and abuse detection.

We run all 837 files through comprehensive HIPAA compliance validation and apply initial business rule edits to all claims prior to adjudication. We reject claims that fail edits before loading into our adjudication system. If we reject a claim, we send the provider a notice with specific denial reasons and codes via the ANSI 999 Functional Acknowledgement and ANSI 277 Unsolicited Notification. We deliver rejection notifications for claims submitted on paper via letter.

The system assigns a unique internal control number to each claim to track its progress from entry to final adjudication. We maintain images of all claims in the document management system with real-time

access to facilitate needed adjudication and research tasks. Daily exception reports enable us to monitor loading of claim batches into the system. Claims submitted electronically receive an electronic receipt within 24 hours after the start of the next business day; receipts for paper claims are available through our secure provider portal within 10 business days of receipt. ***We conduct daily reconciliations to confirm we are accounting for all claims received from all submission sources and either rejected and returned to the provider or loaded into the claims adjudication system and data warehouses within specified periods.*** The system's reconciliation tool captures the date, trading partner, and source (paper versus electronic data interchange [EDI]) for every claim submitted. We use the data to confirm we process all claims received to a determination of accepted, rejected, paid, pending, or denied.

Each claim moves automatically through the system based on its status. When manual intervention is required, the workflows automatically route a claim to the appropriate queue for an analyst's prompt attention. The system adjudicates claims every night. We execute a claims payment cycle that prepares provider remittance advices and generates EFT for network providers that choose electronic payment and physical checks for all other providers six days a week.

Supporting UniCare Teams with Written Policies and Procedures

UniCare has comprehensive written policies and procedures that comply with BMS' claims adjudication performance standards and prompt-pay requirements. Our claims policies and procedures include:

- Policies for all aspects of claims processing, including intake to payment, or denial
- Procedures for the process, including workflows that detail systems and staff involved
- Continuous Quality Improvement processes
- Designation of staff responsible for claims policy and systems support

UniCare's claims processing and payment policies and procedures have supported our ability to meet our obligations successfully under our existing contract. Our claims processes have been demonstrated and reviewed during previous external quality review processes, with no adverse findings. We will continue to make updates and revisions to meet Service Provider Agreement (SPA) obligations or continuously improve quality.

Encouraging Electronic Submission, While Processing Paper Claims

In 2019, we received 99.96% of Medicaid managed care claims electronically. We will continue to accept paper claims from providers that choose to submit them, recognizing challenges faced, in particular, by our smaller, more rural practices; however, we encourage providers to embrace electronic submission and support them by:

- Offering free access to electronic billing and claims submission via our secure provider portal using the Availity tools
- Accepting claims from multiple clearinghouses
- Educating them on the benefits of electronic claims submission using Availity
- Assisting them on how to use Availity and best practices in clean claims submission

Supporting Providers in Submitting Clean Claims

We encourage providers to submit clean claims by offering resources, such as orientation and follow-up training, an online provider manual that includes our Provider Phone Line information, instructions on how to submit clean claims with links to key resources, and an online provider portal to submit and check claims status.

Our staff analyzes claims reports for issues, such as possible provider submission problems, system problems, or other areas of improvement. For example, if we see a high number of claims pending for a

specific reason, we analyze the claims to determine if there is an appropriate intervention such as modifying a system edit. A high volume of claims pending or denied for a specific provider will prompt additional review and often results in proactive outreach to the provider by our team.

Our Provider Services team is dedicated to supporting our providers with complaints resolution, contracting issues, and concerns related to prior authorizations (PAs) and claims. Our Network Relations Consultants are the local touch point for technical support; they are available to meet face-to-face with providers and offer immediate support. They also help educate providers on the resources available through our provider website, which promote communication, convenience, and support during the complaint and resolution process, including:

- Links to online training
- Our provider manual
- Provider bulletins
- Network e-updates that include important information on claims submission processes, pharmacy, behavioral health, and the PA process

Providers can obtain support through our Toll-Free Provider Phone Line for any help needed, questions, or concerns, or by using the email address on our provider website.

Making Sure Claims Payments Are Accurate Prior to Payment

Our goal is to prevent over- and under-payments to the extent possible. We accomplish this through provider education that responds to claims payment trends, claims analysis, and pre-payment edits. Before we accept a claim, we apply a variety of automated pre-processing edits to validate the quality of the data submitted, and verify they are relevant, complete, and contextually appropriate, including:

- Validation of data through HIPAA Level 6 in accordance with the Workgroup for EDI's Strategic National Implementation Process (WEDI SNIP) standards
- Professional (X12 837P) and institutional (X12 837I) claim edits
- Institutional (X12 837I) claim validations
- Checks for data accuracy and completeness, including verifying that the member ID matches a valid UniCare member record and State-specific editing

We reject claims that fail these initial edits. If we receive a claim electronically, we notify the provider within 24 hours after the start of the next business day. For paper claims, we notify the provider via US mail. We load claims that pass front-end validation into the adjudication system and subject them to a series of processes that include:

- Edits based on eligibility, provider status, medical necessity, qualified benefits, valid dates of service, pricing, PA, third party liability, and fraud, and abuse detection
- Verifying the provider is not excluded by Medicare or Medicaid
- Identifying duplicate claims
- Applying enhanced clinical and National Correct Coding Initiative (NCCI) edits to check each claim for codes subject to unbundling or Medically Unlikely Edits (MUE) for codes that may be incompatible
- Evaluating claims for never events, provider-preventable, and hospital-acquired conditions

We process claims that pass all edits during the next payment cycle. The system denies claims that fail edits and immediately generates a remittance advice, available online, or via paper, to notify the provider of the reason for the denial. Remittance advices include the level of payment or denial reason for each claim using standard procedures, codes, and definitions, as well as instructions on how to file a claims appeal.

Focusing on High-dollar Claims

UniCare takes extra steps to help validate the accuracy of high-dollar claims. Claims received with a billed amount (charges) of \$40,000 or more are systematically routed for pre-payment review by a senior claims auditor. The review process includes an end-to-end audit that includes a thorough review of the following elements:

- Membership eligibility
- Pricing against provider contract
- Coding and charge amounts on the claim
- Provider verification and network status
- Prior authorization for length of stay and level of care
- Outlier reimbursement
- Member accumulators
- Potential duplicates in claims history
- Interim billing
- Disproportionate billed services
- Coordination of benefit indicators
- Diagnosis-related group (DRG) readmissions
- UM notes
- Verification of appropriate payee (provider vs. member)

In addition, high-dollar claims expected to pay more than \$300,000 are pended for a second level audit by highly skilled quality assurance auditor.

In 2019, we reviewed 13,493 high-dollar claims. We made \$77.5 million in payments on 81% of these claims and denied payment on the remaining 19%. The top denial reasons were:

- No authorization received
- Primary insurance paid more than Medicaid allowable

Making Sure We Have Paid Claims Accurately After Payment

We maintain operational monitoring and auditing processes to make sure the claims we have paid are accurate and our pre-payment tools and processes are effective. We routinely monitor and respond to weekly trends to identify unusual claims patterns and perform monthly audits on claims payments to measure both financial and payment accuracy.

Monitoring and Responding to Claims Trends

Our West Virginia Operations team monitors a claims operations dashboard that displays claims metrics in a variety of tables and graphs to help us proactively identify both general and provider-specific trends. When we identify trends, such as an increase in a specific denial reason, we perform research to determine the root cause and fix any underlying issues contributing to the trend. For example, if we identify an increase in denials we determine had been caused by processor error, we will bring the examples to the representatives who processed them to provide education. We will continue to monitor these types of claims for accuracy until we are confident the issue has been resolved.

Auditing Our Claims Payment Accuracy

To verify compliance with all federal, State, and internal claims processing and payment requirements, the Claims Support team conducts a monthly end-to-end audit on a random sample of claims. The team also performs specialized audits for high-dollar, individual focus, specific claim types or scenarios, and post-implementation audits.

2019 Claims Accuracy

Our end-to-end audit of our West Virginia claims found that payment accuracy rate was 99.9% and financial accuracy rate was 99.9% in 2019.

We routinely review claims audit results as a standing agenda item during monthly claims team meetings. We also have a dedicated team that trains and audits the auditors and conducts calibration

exercises to assure their knowledge and skills align with current processing rules. Additionally, we have similar processes for auditing subcontractor claims.

CE002	1	The Vendor should describe its claims processing guidelines for contractually obligated services to ensure that claims are paid at no less than 100% of the prevailing rate for Mountain Health Trust (MHT) Medicaid or West Virginia Children's Health Insurance Program (WVCHIP) Fee-for-Service (FFS) rate(s), as applicable.
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Paying Claims at No Less Than 100% of Prevailing Rates (CE002)

UniCare's existing configuration makes sure it pays claims for the following services at no less than 100% of the prevailing rates for Fee-for-Service (FFS) claims for West Virginia Mountain Health Trust (MHT) and West Virginia Health Bridge (WVHB) members.

- Emergency services, including crisis stabilization, and urgent care
- Emergency transportation
- Family planning and related sexually transmitted disease (STD) services
- In-network behavioral health providers
- In-network durable medical equipment providers without an alternative payment schedule
- Critical Access Hospitals (CAHs)

We also pay Right from the Start providers at 100% of prevailing Medicaid rates, and Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs) at 100% of the encounter rate. We will develop similar configuration for the West Virginia Children's Health Insurance Program (WVCHIP).

Our Core Services System is set up to pay in-network providers according to contracted reimbursement terms. Those terms are configured as a set of pricing rules known as contract codes. Contract codes are then assigned to provider records. Some contract codes are simple, such as one that instructs the system to

pay 100% for services on the clinical lab fee schedule. Others are more complex and point to multiple fee schedules depending on the service billed.

The services we are required to reimburse at 100% of Medicaid, such as family planning, are defined in our Core Services System by place of service or procedure codes. Providers that bill these services are assigned contract codes with logic that points to reimbursement at 100% for those places of service and CPT® codes. Similarly, the provider types, such as CAHs, that should be paid at 100% are assigned contract codes with pricing logic to pay 100% of Medicaid.

For non-emergency OON services, UniCare reimburses most non-participating providers at 80% of prevailing Medicaid rates, as permitted by Article III, Section 2.7.3 of the SPA. Other services and provider types we exempt from this rule include:

- Air and ground ambulance
- Right from the Start
- Family planning and related STD services
- Comprehensive Behavioral Health Centers
- Licensed Behavioral Health Centers
- Anesthesia
- CAHs, FQHCs, and RHCs

In addition, UniCare's Operations team periodically runs reports to monitor claims payments for emergency and family planning services to determine they have paid at 100%.

- CE003 1 The Vendor should describe its claims processing guidelines that ensure the denial of claims payment for preventable provider and/or hospital acquired conditions as defined under Section 2702(a) of the Affordable Care Act (ACA) (<https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf>).

Denying Claims for Potentially Preventable or Hospital-acquired Conditions (CE003)

Our claims editing and payment accuracy process, as discussed in detail in CE001, includes claims edits to identify hospital-acquired conditions (HACs) and other provider-preventable conditions (OPPCs) that result in non-reimbursement.

Determining Appropriate Payment for Claims with HACs

To assist in identifying HACs, UniCare requires present-on-admission (POA) indicators be submitted for all diagnosis codes billed on inpatient hospital claims, except the diagnosis codes CMS has designated as exempt from reporting. Our Core Services System checks for POA values, as noted in Table 6.10-1.

Table 6.10-1. Our DRG Grouper Logic Checks for POA Values to Correctly Assign DRGs

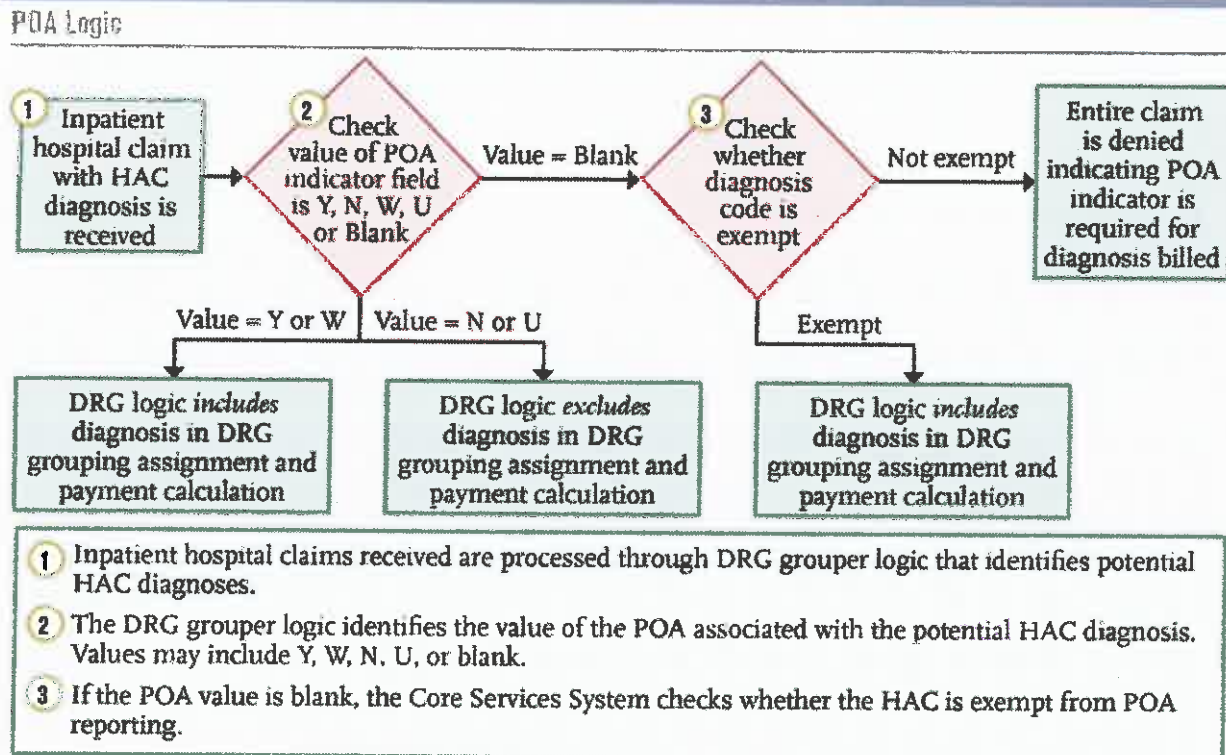
POA Value	Description
Y	POA
W	Clinically undetermined
N	Not POA
U	Documentation insufficient to determine if the condition was present at the time of admission

When an inpatient hospital claim is submitted with a HAC diagnosis code that has a POA indicator equal to N or U, the DRG grouper logic will ignore the services billed for that HAC diagnosis code in assigning the

DRG, which will result in a reduced payment for the new DRG that does not include those services.

A submitted hospital inpatient claim with a POA indicator value left blank will be denied unless the diagnosis code is exempt from reporting. The list of codes exempt from reporting is updated annually in the Core Services System to reflect the information published by CMS, and the system assigns the claim to a DRG based on the POA value, as noted in Figure 6.10-2.

Figure 6.10-2. The DRG Grouper Logic Assigns Claims to DRGs Based on POA Value



The Core Services System and DRG grouper logic look for HAC diagnosis codes and check the value of the POA indicator to assign a DRG, which determines payment:

- Checks for the POA value (Y, W, N, U, or blank) in the POA indicator field for all lines billed
- If a POA indicator value is present, assigns the claim to a DRG including or excluding the HAC diagnosis code, as appropriate, and sends the claim for processing
- If the POA indicator value is blank, checks to see if the diagnosis code is exempt from reporting
- If the POA indicator is blank and the diagnosis is exempt from reporting, assigns the claim to a DRG and sends the claim for processing
- If the POA indicator is blank and the diagnosis code is not exempt from reporting, denies the entire claim, and sends it for return to provider indicating POA indicator is required for diagnosis billed

Denying Claims with OPPCs

Similarly, UniCare processes deny payment of claims submitted with codes for OPPCs, as currently defined by BMS:

- Wrong procedure performed on a patient (Y65.51)
- Procedure performed on the wrong patient (Y65.52)
- Procedure performed on the wrong body part (Y65.53)

In our experience, it is rare that claims with these codes are submitted, since most of them are caught by claims scrubbers at the provider prior to billing. If a claim is submitted with one of these codes, we deny payment. In addition, we periodically run a report to identify any claims that have been submitted with these codes and make sure none have been paid. To date, only a single claim has been submitted with one of these codes, and we have never paid claims for these procedures.

CE004 1 The Vendor should describe how they will implement rate changes adopted by the Department within thirty calendar days of notification of the rate change.

Making Sure Rates Are Updated Within 30 Days (CE004)

UniCare has an established process to meet the State's requirement to apply rate changes within 30 days of notification. We have assigned a designated employee and backup in the Operations department, with responsibility to make sure rate changes are appropriately applied. Specifically, the employee or backup:

- Logs the rate update in a compliance tracker and records all subsequent activities and primary steps in the process in the compliance tracker
- Submits a request for an update to be configured in the Core Services System and logs the submission
- Monitors timely configuration of the update and logs target and completion dates

- Runs a report of all affected claims, requests adjustments in accordance with SPA requirements, and logs claims adjustment activities and completion dates
- Once adjustments are completed, validates, or oversees validation of adjusted claims to make sure payments are accurate

Rate update timeliness is also reported and discussed in our Operational Performance meetings, using the compliance tracker to monitor progress. If we note the 30-day deadline is approaching, we identify activities that need to be expedited and escalate the resolution to the appropriate manager.

CE005 1 The Vendor should describe how its claims processing systems and guidelines uphold payment policies that comport with the National Correct Coding Initiatives (NCCI) edits and/or other claims payment guidance defined by the Centers for Medicare & Medicaid Services (CMS) (<https://www.cms.gov/medicare/coding/nationalcorrectcodinginitiated/index.html>).

Monitoring Accuracy Against NCCI and Payment Guidance (CE005)

UniCare partners with Change HealthCare (formerly known as Emdeon) and Cotiviti to make sure we meet all NCCI and industry-standard coding standards, as noted in Table 6.10-2.

Table 6.10-2. Claims Software with a Focus on Payment Timeliness and Accuracy

Claims Payment Software	Supports Claims	Prior to Payment	Description
ClaimsXten	Outpatient, Professional	Yes	Clinically based claims payment software solution with automated rules to help improve payment accuracy
Cotiviti	Professional	Yes	Clinically based billing accuracy system that matches informed, data-driven, clinically driven decisions with payment policy

We use Change HealthCare's ClaimsXten prior to payment to improve payment accuracy on outpatient and professional claims. ClaimsXten issues quarterly releases that reflect quarterly NCCI updates. Our Reimbursement Policy Management team coordinates the releases, testing, and any issues that arise related to editing. Prior to each release, ClaimsXten sends recommended rule changes to our UniCare employees to compare against State guidelines. If rules conflict with State direction, we make the decision

along with ClaimsXten to not turn on the rule. An example of a conflict is BMS reimbursement of surgical cases based on billed units of operating room time, which is incompatible with NCCI's MUEs.

ClaimsXten reviews each patient's billing history prior to payment against NCCI edits, medical policies, CMS guidelines, and contracting information to make sure services are within the scope of the provider's license. Claims that are processed and flagged by ClaimsXten's NCCI or other edits receive a payment status recommendation, such as:

- Denying a claim or a specific line item
- Bundling or unbundling specific codes
- Limiting payment if the provider has billed more than the maximum allowed

UniCare also uses Cotiviti, after ClaimsXten has designated a claim as payable, which serves as a second pass for professional claims edits. Some examples of items that are configured to deny in Cotiviti include:

- Oxygen system rental when billed more than once a month
- Immunization administration when billed without a vaccine code
- Place of service indicated on the claim not appropriate for the CPT code billed

We will continue to use analytics software to assure our claims payment processes remain in compliance with industry standards.

- CE006 1 The Vendor should describe its claims processing guidelines and systems requirements that waive member co-payment or cost-sharing obligations for all applicable populations and covered services.

Applying Co-payment and Cost-sharing Guidelines Accurately (CE006)

As indicated in response to Sections BA001 through BA003, UniCare assigns members to groups based in part on their co-payment rules. These rules vary by tiers, which are based on income, and some members are exempt from cost-sharing altogether. The co-payment rules include services subject to co-payments, co-payment amounts, and co-payment maximums. Table 6.10-3 details the number of households and members exempt from co-payments by quarter in 2019.

Table 6.10-3. UniCare Configures Our Systems to Accurately Identify Members and Households Exempt from Co-payment

Category	2019			
	Q1	Q2	Q3	Q4
Number of households exempt from co-payments	41,720	41,823	44,330	43,932
Number of members exempt from co-payments	69,934	70,291	74,971	74,868

While the specific rules for co-payment of the existing MHT and WVHB populations differ from those of WVCHIP members, the concepts are the same. UniCare will configure WVCHIP co-payment rules using the same approach we use for current MHT and WVHB members.

During the monthly process to upload the 834 membership files, we load the member into the appropriate group for their co-pay rules and periodic maximum in our Core Services System. If the member is part of an exempt population, such as Native Americans, and Alaskan Natives, they are put into a group configured as “no co-pay required.” For all MHT groups, co-payment rules currently exempt family planning, emergency, and behavioral health services from cost-sharing. We recognize co-pay amounts and the list of exempt services will be different for WVCHIP members and vary by their CHIP plan. New groups will be created for each WVCHIP plan and the co-pay rules configured appropriately for each.

As referenced in our responses to BA001 through BA003, when a household has met its co-payment maximum for the applicable period, our systems logic is configured to essentially turn off co-payments for all enrolled members of the household; however, the systems logic resets the co-payment rules for the group to which the members are assigned at the end of the co-payment period, which is quarterly for current MHT and WVHB members.

- CE007 1 The Vendor should describe its process to evaluate the data quality of its claims/encounters submissions to the Department including, but not limited to, the formatting and all data elements required to complete compliant 837 electronic transactions for medical and dental claims.

Maintaining High-quality Submissions (CE007)

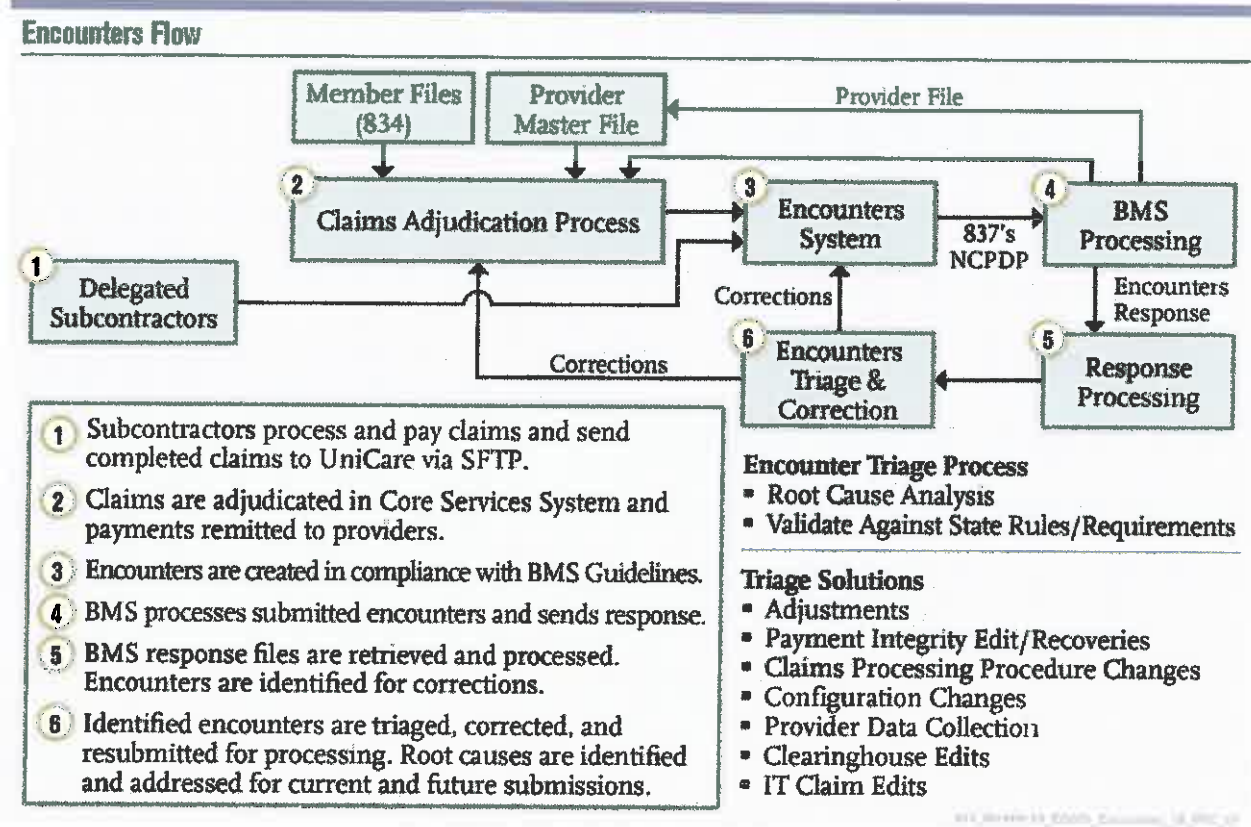
UniCare leverages best-in-class technology and skilled employees who specialize in Medicaid managed care to consistently deliver prompt and accurate claims payment and encounter data submission. As an incumbent MCO, our MIS, and supported claims and encounters processes will continue to comply with all federal and BMS SPA requirements. We have an established relationship with BMS and are ready to discuss issues and pose questions about policy and program changes that affect our systems.

UniCare's Encounter Data Management System

Our robust encounter data management process focuses on transmitting and receiving complete encounter data promptly and accurately to fully support all State requirements. Through our encounter data submission process, we validate and deliver a comprehensive set of encounter data to BMS, including claims data from our Core Services System and subcontractor encounter data from our data warehouse. Through rigorous testing and implementation protocols, we fine-tune claims processing, data extract, and submission monitoring processes to verify full compliance with all the BMS encounter data timeliness, accuracy, and completeness requirements, as documented in the Encounter Data Manual and Encounter Submission Companion Guide.

Starting with the provider's claim submission through final adjudication, we apply multiple claim edits and data quality checks to confirm proper processing of the claim and accurate encounter submissions. During the encounter submission process, we apply extensive editing consistent with the pre-cycle edits applied by BMS. As shown in Figure 6.10-3, our encounter data process combines claims and claims adjustment data processed since the last submission with encounter data from our subcontractors and loads it into our Encounters System. Controls validate all retrieved claims and subcontractor encounter records load properly for subsequent processing.

Figure 6.10-3. Our Comprehensive Process Delivers Complete, Accurate, and Timely Encounter Data



Leveraging Our Configurable, Compliant Claims Management System

As part of our Core Services System, our claims processing subsystem collects, processes, and stores data on all health services delivered, including medical supplies, using standard HCPCS, ICD-9-CM/ICD-

10-CM, and revenue codes. Our system complies with all BMS claims processing requirements and accepts standard paper and electronic claim formats used for the Medicaid FFS programs. Our system also accepts a variety of electronic claims submission options through three nationally recognized EDI clearinghouses: Change HealthCare, Availity, and Smart Data Solutions. Accepting claims through EDI clearinghouses facilitates more accurate, timely, and efficient processing.

Our claims processing system — from claims intake through payment — includes controls that validate and account for all claims submitted. We maintain an image of each electronic claim in our document management system, and real-time access to images facilitates adjudication and research tasks. We quickly capture and adjudicate claims with minimum manual intervention by combining our core claims transaction platform with electronic document imaging, a workflow management system, and electronic claims solutions. This process leads to faster, more accurate claims turnaround and provider payment, and also supports complete, and accurate encounters reporting.

With automated workflows to manage the steps required to auto-adjudicate a claim, the system applies the parameters of prompt-pay standards set by CMS and the American Recovery and Reinvestment Act (ARRA). It assigns each claim a unique internal control number to track its progress from initial entry into our system to final adjudication and online storage. The process includes initial HIPAA compliance and completeness validation prior to adjudication. We reject claims that fail compliance or completeness validation, and notify the provider of the reason. To maintain compliance with claims payment timeliness, leadership reviews detailed dashboards of key program metrics to track our performance, including clean and non-clean claims percentage paid within 30, 45, and 90 days of receipt. Diligent monitoring helps quickly identify any opportunities for improvement.

Evaluating Data Quality Prior to Submission

Our highly configurable subsystems within the Core Services System support comprehensive claim edits to verify timely, accurate, and complete encounter records, including enhanced clinical edits, NCCI edits, and edits that support BMS Program requirements. As part of the Core Services System, our claims process has access to all the required data, including member, provider, OHI, and reference data. System claim editing capabilities include:

- Validating that required data elements are present and match allowable values
- Verifying member eligibility, service coverage, required attachments, and PA
- Requiring the claim to be submitted with an authorization reference number, as appropriate
- Denying claims automatically if required authorization reference numbers are not submitted
- Resolving discrepancies between billed versus authorized units and amounts, cutting back units, or dollars as appropriate
- When it can be reasonably done, applying all edits associated with the claim type and not suspending the editing process when an edit failure is encountered
- Enabling editing or suspending of individual lines on a multi-line claim so that providers can receive payment for those service lines that passed all edits
- Tracking all edits posted to the claim from suspension through adjudication

Monitoring Subcontractor Encounter Data

Our subcontractors, SKYGEN USA, LLC (SKYGEN) and Vision Service Plan Insurance Company (VSP), are required to submit member encounter data. As indicated in Attachment 4, UniCare's Subcontractor Oversight Committee and Subcontractor Oversight Managers work with each subcontractor to provide continuous collaboration and oversight of our contractual relationships, including the submission

of encounter data. We have established a schedule and provided clear process guidance on encounter submission to each through our subcontractor agreement and our policies and procedures.

Experience Matters

Megan Lombard *Operations Director*



Megan is responsible for the oversight and management of UniCare's administrative and technical operations, ultimately assuring compliance with all technical service level standards

If we identify a performance problem, our Operations Director, Megan Lombard, an active member of the Subcontractor Oversight Committee, immediately applies a series of escalating interventions, including increased meeting frequency to discuss challenges and provide training opportunities. If we continue to experience ongoing challenges with a subcontractor, the Operations Director, Subcontractor

Oversight Committee, and relevant operational areas may work with the subcontractor to identify the root cause, initiate corrective actions, and develop a monitoring plan.

Our plan includes a timeline for correcting the deficiency, dashboards to review ongoing metrics, and regularly scheduled meetings with the subcontractor to review progress. The corrective action monitoring process ends when the subcontractor demonstrates ongoing compliance, typically for at least 90 days.



Our established Subcontractor Oversight program provides initial and ongoing education to subcontractors, enables us to detect performance deficiencies, and positions us to resolve issues with subcontractors quickly. Our Operations Director works with local and national oversight committees to provide an additional layer of oversight through monthly, quarterly, and annual meetings, and audits.

- | | | |
|-------|---|--|
| CE008 | 1 | The Vendor should describe its encounter certification process that requires its Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other designee to certify the accuracy and completeness of its claims/encounter data information submitted to the Department. |
|-------|---|--|

Complying with Encounter Certification Processes (CE008)

We will continue to certify all encounter data. Our CEO, Tadd Haynes, will continue to sign our completed Attestation Forms with each encounter submission. The certification will continue to include complete file names, file sizes, and date range for the submitted files, as well as attest to the accuracy, completeness, and truthfulness of the encounter data we submit to BMS, based on our best knowledge, information, and belief at the time of submission. Specifically:

- The Encounters team notifies the Compliance team when the monthly encounter data has been submitted to BMS
- Compliance completes the “Data Certification for Monthly Encounter Data Report Submission” form and forwards it to the CEO
- Our CEO reviews the data and signs the certification and returns it to the Compliance team
- The Compliance team provides the signed and completed form to the appropriate individuals at BMS, retaining copies of the signed form and documentation of date and time of submission

- | | | |
|-------|---|---|
| CE009 | 1 | The Vendor should describe its process that ensure complete and accurate encounter data is submitted to the Department on a monthly basis and no later than thirty calendar days after the end of the period in which the service was paid. |
|-------|---|---|

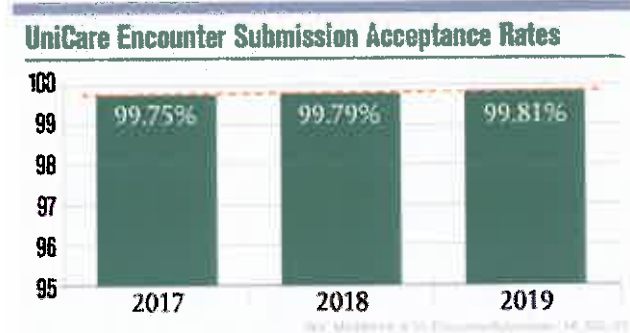
Submitting Encounter Data on Time (CE009)

UniCare will continue to submit all claims to BMS through its Encounter Management System to make sure all claims experience has been successfully submitted. We maintain strict controls throughout our encounter process to deliver accurate and complete encounter data to BMS. Our encounter process

captures, stores, and manages all dispositions of claims, including paid, denied, corrected, adjusted, voided, and zero dollar paid claims processed by us or our subcontractors.

Our consistently high acceptance rate and steady progress are highlighted in Figure 6.10-4, which shows the percentage of encounters accepted within 30 days for 2017 through 2019. In each year, we exceeded the SPA requirement for a rate of 95% for completeness and acceptance.

Figure 6.10-4. UniCare Consistently Submits Timely Encounter Data



The large volume of encounters we process each year has enabled us to refine our monitoring and submission processes that support continuous improvement in submission acceptance rates. Along with our affiliates in 24 markets across the country, we submit nearly **20 million** encounter transactions per month and more than **237 million** encounter records per year. In West Virginia alone, we submit approximately **240,000** encounter transactions per month and nearly **three million** encounter records annually.

Monitoring Timely Submission of Encounter Data

Our weekly encounter submission schedule includes time for careful review and remediation of any errors, and our Encounter Management team closely monitors the process to support compliance. A comprehensive schedule of system processes, review tasks, and submission dates enables us to deliver timely encounter data to BMS. The schedule documents each step and deadline, and Encounter Management analyst's monitor each encounter data file submission as it moves through the process. Most claims are submitted within two to three days of adjudication.

To remain compliant with the BMS timeliness requirements, our Encounter Management team uses weekly encounter aging reports to monitor the age and volume of encounters previously pended during

the encounter submission process. We have several checkpoints during our process to prevent encounter data submission problems, including:

- Logging details of each submission and capturing source claim information such as claim number, type (original, adjustment, void), file name, path, and creation date
- Checking for and removing duplicate records
- Reconciling the queued encounter data to claims processed for eligible services during the matching time period (including paid, denied, and voided claims), and verifying compliance with the BMS Encounter Data Manual and Encounter Submission Companion Guide reporting requirements
- Checking for HIPAA-compliant standards

Using online dashboards and status reports, we monitor, and assess our encounter performance.

Monthly meetings that include our CEO, Chief Financial Officer, Operations Director, and the Encounter Management team provide a regular opportunity to review encounter performance and discuss any issues or concerns. This shared responsibility and oversight of encounter data enable us to combine local expertise with best practices gleaned from our affiliate health plans.

We continuously monitor our encounter data processes, and if we identify gaps or errors, we use a systematic approach to investigate and resolve them. This includes implementing business process improvements, systems enhancements, staffing changes, or any, and all of these efforts as needed.

We have the capacity to track all erred encounter records and provide a report detailing transmission reconciliation of each failed file within 30 days of the error, and we re-submit encounter records within 30 days of the date the record is returned to us. We use procedure codes, diagnosis codes, MS-DRG, and other codes for reporting encounter data in accordance with guidelines and versions of all code sets defined by BMS. We also use the National Provider Identifier and provider numbers for encounters directed by BMS.

- CE010 1 The Vendor should describe its process and how they will implement a data accuracy and completeness monitoring program for its encounters that includes delegation oversight of subcontractors, as applicable.

Monitoring Accuracy and Completeness of Encounter Data (CE010)

UniCare maintains robust processes to verify encounter data submitted to BMS is complete; accurate, including subcontractor data; and submitted on time.

Confirming and Monitoring Encounter Data Is Complete

We confirm completeness of encounter data with a robust process that rapidly remediates any rejections from the original submission file. Remediation includes correction of a data file, recoupment of a claim, or requiring a provider to submit a corrected claim. We continuously work with our provider community to make sure claims are submitted accurately. Because most of our providers are paid on a FFS basis, their incentive is to submit timely, accurate claims, which results in complete encounter data. Our claims processing system — from claims intake through finalization — maintains controls that validate and account for all claims submitted, whether electronically, or on paper.

For all providers, we confirm correct billing compliance through record audits and data trending analysis, including comparing claims volume from similar providers, to identify potential issues. Record audits may identify a provider failing to submit claims for specific services, as well as a provider billing for services not rendered. We address any billing and compliance issues with the provider through education and overpayment recovery (when applicable). The goal is to achieve proper billing for rendered services, which results in correct claims payment and accurate encounter submission. Should we find errors in billing that potentially represent fraud, waste, and abuse, we have a process to share that information with our Program Integrity Unit and our State partners for investigation.

Enhancing Encounter Data Accuracy

Claims formats are industry-standard and HIPAA-compliant. Regardless of entry source (paper or electronic), or provider type (in-network or OON), all claims pass through the same edits and adjudication processes. Our claims processing system includes controls that validate and account for all claims submitted from intake through payment.

We subject claims to extensive front-end edits during claims processing, denying claims submitted without the data required by BMS to support successful encounter submissions. Then, prior to encounter data submission, our system applies HIPAA compliance checks and business rules as a final validation. Records that fail edits pend for review, investigation, and remediation. Our Encounter Management team coordinates corrections with the operational unit and includes them in a subsequent encounter submission.

We require our subcontractors to submit encounter files in a HIPAA-compliant X12 format with all the required data elements specified in the Encounter Data Companion Guides. Our encounter process includes several steps to verify the accuracy of subcontractor encounters files we receive.

First, we run HIPAA level 1–4 compliance checks on the 837 files. If any record in the file fails, we reject the submission, and return the file to the subcontractor with the reason for the failure.

Subcontractors typically submit a corrected file within 24 to 48 hours.

Then the file goes through a set of data validation edits, including checks for claims previously submitted, and duplicates within the same file. The process marks individual encounter records that fail validation edits as rejected and returns them weekly to the subcontractor so they can initiate a correction and re-submit action. We track rejected records to verify that subcontractors re-submit within 30 days.

We carefully review the response files we receive from BMS and evaluate any rejected encounter records. We work with the subcontractor to resolve any rejected encounter records. As necessary, we

perform a root cause analysis to understand the reason for the error and identify opportunities to mitigate future rejections.

Reporting on Encounter Performance

We have established a dynamic and precise reporting toolkit to monitor encounter performance. The reports track high-level performance with respect to complete, accurate, and timely data, as well as more granular drill-downs supporting day-to-day inventory management. The reports include:

- Financial and claim count completeness
- Data balancing
- Encounter and file submission accuracy
- FQHC and RHC performance reports
- Aging and service level tracking
- Predictive reporting

Providing Guidance on Encounters to Providers

We work proactively with our providers to prevent errors before they occur. Our efforts start with educating and supporting them on submitting timely, accurate claims data. We know from our experience in West Virginia that making it easy for providers to get understandable information about submitting claims, viewing claims status, and accessing payment information quickly and conveniently significantly improves the likelihood of them submitting clean, timely claims the first time. Our new providers receive comprehensive training on submitting claims and encounter data as part of the initial onboarding process. Our education covers a range of discussion topics, including current statistics, and trend data about claims and encounters. Through these trainings, we identify any issues early in a collaborative environment, and if there are errors from a specific provider related to encounter data, we take a personal approach and work with them directly to resolve the issues or errors.

UniCare works continuously to improve our encounter submissions to BMS, and we expect our providers to do the same. Providers receive training on encounter submission during onboarding training

and have access to many resources on our provider website that support them and their teams in submitting clean claims. We take a personal approach with providers when they need additional assistance in billing correctly, which ultimately results in accurate and complete encounter submissions. For example, our team spent several months on frequent one-on-one calls with one of our FQHCs to educate them on properly billing a claim for payment consideration and ultimately the wrap payment processed by BMS. We have also conducted a hot topic webinar series on claim edits.

When we see patterns in claims submission that suggest providers could benefit from additional training, our Provider Services team works to change provider behavior through identification, prevention, education, and monitoring. The team includes certified professional coders and investigators and researches medical trends, CMS guidelines, CPT codes, and more to identify unexpected provider billing practices that may include commonly misinterpreted codes and coding guidelines. The goal of the process is to enhance claims accuracy by helping providers with appropriate coding, resulting in accurate, and complete encounters.

Data mining tools, including Anomaly Detection models, also help identify outlier behavior. Our Provider Services team reviews the list of providers flagged for education, along with the reason, prior to outreach. With this information, we can reinforce messaging with our providers during our normal interactions and make necessary updates to our training and education materials so that all providers can benefit.

Our Provider Services team reaches out to providers with consistent billing issues or who appear to be outliers for specific topics. We analyze data, isolate areas of billing, or coding interest, perform a medical records review, and provide feedback to the providers on opportunities to enhance coding and billing accuracy. We assist them with specific training or familiarize them with the resources available on the provider website to help educate their teams. We monitor through ongoing data analysis whether training

and enhanced awareness of the issues results in a sustained change in provider billing behavior. Failure to demonstrate a change in billing behavior may result in a referral for medical record audit or to the Special Investigations Unit for possible investigation.

CE011 1 The Vendor should provide its annual encounter data accuracy and completeness plan with its bid.

Annual Encounter Data Accuracy and Completeness Plan (CE011)

UniCare's Annual Encounter Data Accuracy and Completeness Plan can be found as Supplemental Document 6.10-1, Annual Encounter Data Accuracy and Completeness Plan. It contains information on teams responsible for monitoring and correcting data accuracy and completeness, the processes they follow, the tools they use, the standards for completeness and accuracy they apply, and responsibilities applied to subcontractors.

- CE012 1 The Vendor should describe its process to submit reports to the Department that summarize the encounter activity including, but not limited to, the following:
- CE013 2 A detailed summary of the file submission that includes total claims and dollars by service category
- CE014 2 A detailed change log that includes specifications for any change in the claims processing system that has an impact on the representation of the data in monthly encounter files

Providing Summary Reports That Meet DHHR Needs (CE012, CE013, CE014)

We have worked closely with the West Virginia Department of Health and Human Resources (DHHR) to produce and submit reports on monthly encounter activity that not only meet current SPA requirements, but also present information in a clear and concise manner. We will continue our dialogue with DHHR about how to present information that is timely, accurate, and useful.

We provide summary reports on total claims and dollars with each monthly submission of encounter activity that is created when the MIS team generates the encounter submission. The summary includes subcontractor data on dental and vision encounters. The summaries include:

- Number of records submitted
- Total submitted charges
- Total paid amount
- Total covered charges

For medical encounters, we further provide summaries by place of service, primary diagnosis code, procedure codes, revenue codes, bill types, and a lag report.

We understand the requirement in our current SPA to submit a detailed change log if we have a change to our claims system that affects data representation on the encounters. Under the current SPA, we have not had a change that met this definition and therefore have not submitted a detailed change log. We understand the requirement and are prepared to submit the detailed change log if we experience a change to the claims system that affects encounters.

Currently, we provide the periodic reports related to encounters as noted in Table 6.10-4.

Table 6.10-4. UniCare Supports DHHR with Useful and Compliant Information

Report Topic	Timing
Suboxone Provider List	Weekly
MAXIMUS Enrollment Report	Monthly
Molina 820	Monthly
Molina 834	Monthly
Molina DOD Adjustment	Monthly
Fee Schedules (RBRVS, Imaging Codes, CLF, HHA, UCR, Hospice, DMS)	Annually, biannually, ad hoc
DRG Calculator (In-state and Out-of-state)	Annual
MCO Contract	Annual
Preferred Drug List	Quarterly
Alerts File	Monthly
Blood Lead	Monthly
Eligibility (Full) (834)	Monthly, 4 th week (State Calendar)
Eligibility (Incremental) (834)	Monthly, last business day (State Calendar)
ENC Molina (Medical/Behavioral, Dental, Vision, NCPDP)	Weekly
Immunization	Monthly
Maternity — 837	Dependent on State Calendar
Maternity Kick Errors from the State — 824	Dependent on State Calendar
Maternity Kick Payment Remittance — 835	Dependent on State Calendar
Maximus Provider	Weekly
Maximus Provider Network Errors	Weekly
*Proprietary Dental Encounters	Monthly by 15 th
*Proprietary Rx Encounter File (ESI Run Out)	Monthly by 15 th
*Proprietary Medical Encounter File and Summaries	Monthly by 15 th
*Proprietary Rx Encounter File	Monthly by 15 th
Premium Payment Remittance from the State (EDI 820 file)	Monthly, Dependent on State Calendar
Third Party Liability	Monthly
Pharmacy Claims File	Monthly
*These files are being sunset as of July 2020	

- CE015 1 The Vendor should describe its process to reconcile encounter data submitted to the Department with the financial data that it reports on a quarterly basis, including a narrative explaining any difference of five percent (5%) or higher.

Reconciling Encounter and Financial Data (CE015)

UniCare understands the importance of making sure the encounter data we submit and the financial data used for capitation purposes is as accurate as possible. As of the first quarter of 2019, we are no longer required to submit the MHT8 Form on a quarterly basis, but we continue to reconcile accepted encounter paid dollars compared to financial paid dollars. Table 6.10-5 outlines our calculated variances in total for

2018 and for each quarter of 2019. We showed overall variances 2.96% and 2.14% in 2018 and 2019 respectively. In each quarter of 2018 and 2019, the variance between accepted encounter paid dollars and financial paid dollars was less than 5.00%.

Table 6.10-5. UniCare Meets Requirements for Reconciliation of Encounter and Financial Data Consistently

	2018	2019				
		Q1	Q2	Q3	Q4	Total
Total claims dollars						
Variance percent	2.96%	1.80%	2.78%	1.99%	1.96%	2.14%

Results for the fourth quarter of 2019 represent only October and November; final December data was not available at the time this response was prepared.

UniCare uses a self-service internal reporting tool called Checkbook that is refreshed daily as our reconciliation tool for encounter and financial paid dollars. We can pinpoint at any time differences in accepted encounters and paid financial encounters, so that we can continuously remediate issues.

UniCare Health Plan of West Virginia 2019 Data Accuracy & Completeness Plan

UniCare understands the importance of the collection and reporting of encounter data to the State which details all of the services provided to members. Accurate and complete encounters data is critical to support the monitoring and management of the program and functions such as measuring performance, tracking historical utilization patterns, determining service and health care delivery trends, determining the impact of policy changes, modeling benefit changes and new programs, forecasting budgets, and setting rates.

Within our organization, the Medicaid Encounter Unit monitors performance on a weekly and monthly basis. We have monitoring procedures to track each submission. Every record and every submission file is accounted for throughout this process. First and foremost, the Encounter Unit is responsible for ensuring that all contractual commitments related to encounter data submissions are met.

Specifically for purposes of encounter data management and reporting, UniCare has developed an Encounter Data Warehouse (EncDW) solution that provides for the effective and efficient storage and retrieval of claims and related data required for the submission of encounter data and files under state contract. The solution also provides for robust data analytics and reporting.

Adjudicated claims are loaded daily into the Encounter Data Warehouse, where they are maintained and then submitted to the State according to pre-defined contractual reporting requirements and timeframes. While claims have undergone extensive edits in during claims processing, the EncDW system performs additional data quality checks prior to loading the encounters to the database. Any errors detected are corrected before the encounter is released for submission to the State. This system not only maintains a comprehensive database of all encounters but also provides a great deal of flexibility in supporting ongoing and ad hoc reporting requirements as well.

UniCare recognizes that failure to satisfy the contractual requirements can subject the Plan to sanctions and or liquidated damages. These include:

- | | |
|---------------|---|
| Timeliness: | UniCare will maintain processes and procedures to ensure encounter data is submitted timely by the 20 th of each month, and weekly each Friday. |
| Accuracy: | UniCare will maintain policies and procedures to ensure that encounter claims submissions are accurate and that all encounter claims data is submitted accurately and represent the services provided and that the claims are accurately adjudicated. |
| Completeness: | UniCare is responsible for submitting encounter data for all services rendered that fall within the defined benefit package. UniCare shall attest to the truthfulness, accuracy, and completeness of all encounter data each time data is submitted to BMS. The encounter data set will include at least those data elements as specified by BMS. |

UniCare Health Plan of West Virginia 2019 Data Accuracy & Completeness Plan

PROCEDURE:

UniCare's Encounter Unit is responsible for monitoring and submission of encounter data to the Department. UniCare maintains an Encounter Data Warehouse (EncDW) that enables the tracking of each claim that we receive from the claims processing system as well as encounters that we receive from our subcontractors.

Once the claims and encounters have passed our claims and encounter edits, they are submitted to the Department. The Encounter unit tracks each submission to ensure that it is successfully transmitted and received. The Encounter Unit monitors the submissions of all encounters to ensure that they are submitted per the required timeframes. The Encounter Unit receives reports that show any encounters that do not meet the submission and timeliness requirements

Adjudicated and finalized claims are loaded daily into the UniCare's Medicaid Encounter Data Warehouse (EncDW) where they are maintained and prepared for state submission, monthly. West Virginia encounter claims are sourced from UniCare's WGS claims system. Upon loading, systematic data validation is performed against all data elements to ensure claims data is accurate and complete. A daily load exception report is created identifying any data/load error requiring correction or review.

Claims data successfully loaded to the Encounter Data Warehouse undergo a secondary validity check to ensure finalized claims data includes all required information for encounter submittal.

Subcontractor Encounter Claims

UniCare also subcontracts various services such as vision and dental third party service vendors. These vendors also submit encounters documenting all of the services provided to UniCare members on a monthly basis. These encounters are also maintained in the Encounter Data Warehouse.

Each of our subcontractors have claims processing systems with edits for verifying claims data to ensure that all required information is provided in the proper format, that all codes are valid, members and providers are eligible for the program and the specific benefit, program limitations and restrictions are not exceeded, and that the claims are not duplicates. Once claims are completely adjudicated in their systems, the resulting encounters are transmitted electronically to UniCare per agreed upon schedule.

Our subcontractors must comply with all state encounter reporting guidelines and requirements. With each monthly encounter file submission, our subcontracts provide a monthly submission Attestation of Compliance attesting to the fact that their encounter files meet state contractual submission requirements. In addition to the attestation our subcontractors also provide encounter Control Reports which includes but not limited to the following information:

- Total number of records within the file
- Total Paid Amounts – by Procedure Code
- Total Billed Amount – by Procedure Code
- Monthly Claims Lag Report

UniCare Health Plan of West Virginia 2019 Data Accuracy & Completeness Plan

Upon receipt, subcontractor encounter files are systematically validated to ensure they meet state encounter layout specifications and structure. Additionally, subcontractor encounter files are manually reviewed by our Encounter Unit upon receipt to determine if any issues exist. If any subcontractor file errors are identified, the subcontractor is notified immediately and asked to correct and resubmit the file to UniCare.

If an issue is identified with a subcontractors encounter records or file the Encounter Unit first works directly with the subcontractor to resolve the specific issue. If the issue is a one-time issue and is satisfactorily resolved, no further action will be taken. If the issue is not satisfactorily resolved or indicates a trend of repeated similar issues, then the Encounter Unit notifies our Compliance Unit. The Compliance Unit will initiate action based on the issue. If the issue is a contract compliance issue, the subcontractor will be notified and required to provide a corrective action plan. If the issue is not specifically a contract compliance issue, UniCare will meet with the subcontractor and develop a mutually acceptable resolution. The Compliance Unit tracks all subcontractor issues until they are satisfactorily resolved.

11. PROGRAM INTEGRITY

PI001	1	The Vendor should describe its administrative and management arrangements or procedures that are designed to detect, prevent, investigate, and report potential fraud, waste, and abuse (FWA).
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UniCare's Program Integrity Structure and Procedures (PI001)

UniCare's program integrity structure comprises dedicated staff, an integrated system of activities, processes, and controls, and the deep resources of the national shared services of our ultimate parent company, Anthem, Inc. (Anthem). Our West Virginia-based Program Integrity team leads and oversees efforts to detect, prevent, investigate, and report fraud, waste, and abuse (FWA) in the State with the goal of making sure proper payments are made to legitimate providers for necessary and appropriate services rendered to eligible members. The team is led by our interim Program Integrity Lead, Rick Levoch. Rick will serve in this role on an interim basis while we actively recruit a full-time candidate. Supporting the Program Integrity Lead are James Corns, SIU Investigator, and Teresa Meadows, Special Investigations Unit (SIU) Investigator Assistant. Our local Compliance Officer, Richard Chapman, and MHT Regulatory Manager, Amber Nary, support program integrity functions through their reviews and audits of operations to guard against FWA (as specified in the Compliance Plan) and their collaboration with the SIU. Until a permanent Program Integrity Lead is hired, Rick will perform all of the duties outlined in Section 8.1.2.1 of the Service Provider Agreement (SPA). He is our primary point of contact for all

Experience Matters

Rick Levoch
Program Integrity Lead



Rick has over 20 years of West Virginia Medicaid Program Integrity experience.

Experience Matters

Richard Chapman
Compliance Officer



Richard has 20 years of experience overseeing West Virginia health care Compliance and Program Integrity.

Experience Matters

Amber Nary
MHT Regulatory Manager



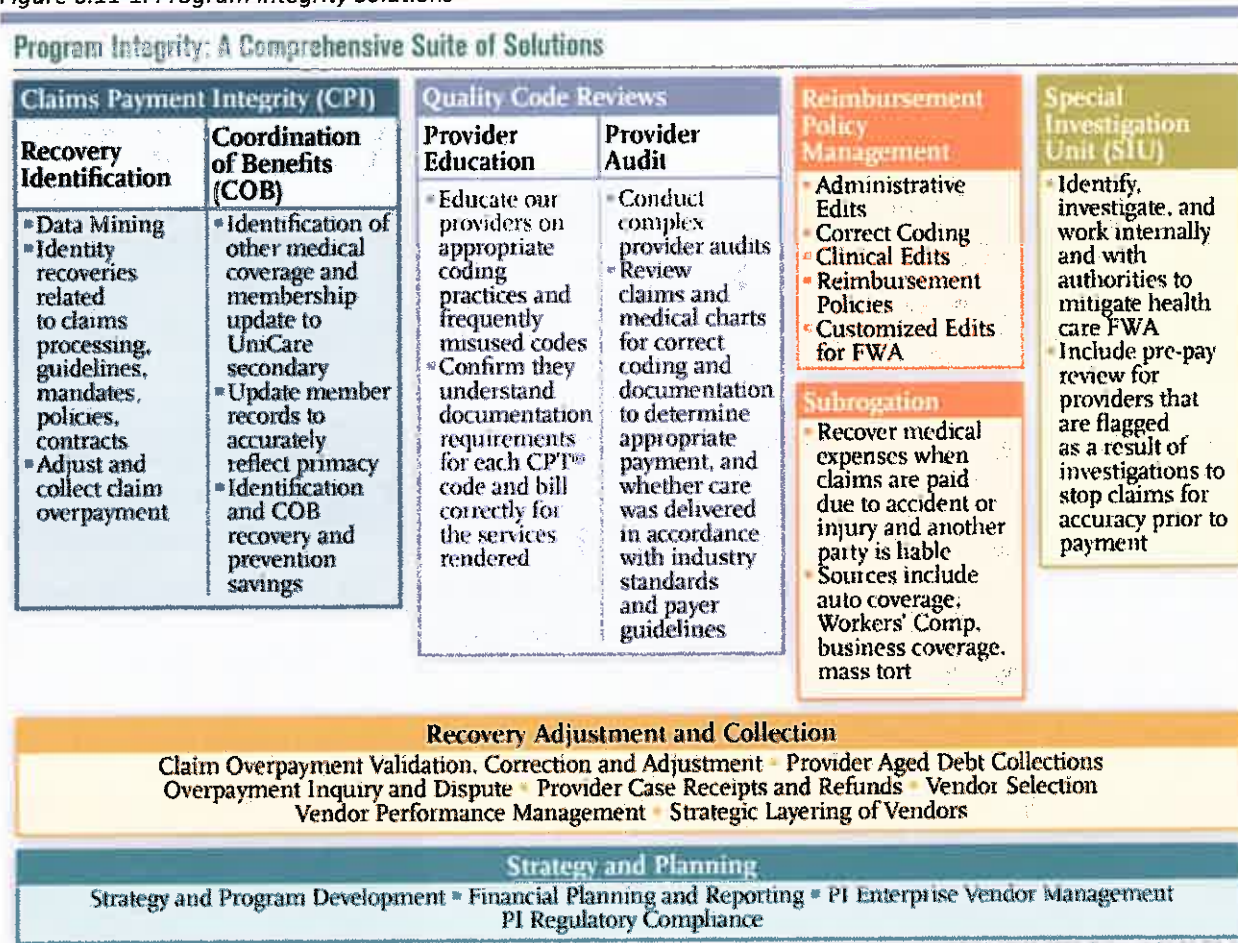
Amber oversees all regulatory compliance functions in accordance with the contract.

Bureau for Medical Services (BMS) Program Integrity and Medicaid Fraud Control Unit (MFCU)

requests for data, records, or other information, and for program integrity deconfliction. Amber is our secondary point of contact.

As shown in Figure 6.11-1, our program integrity operations offer comprehensive, sophisticated, and efficient methods for identification, investigation, and resolution of FWA issues involving our providers, subcontractors, and members.

Figure 6.11-1. Program Integrity Solutions



UniCare leverages the deep resources of Anthem's program integrity organization. We work in concert with the following Anthem departments and teams to implement our program integrity plan. Our local

program integrity team oversees the activities of the Anthem teams; we have accountability for their activities. Two Anthem program integrity staff, James Corn and Teresa Meadows, are located locally in West Virginia.

- The ***Claims Payment Integrity*** (CPI) department performs recovery identification and coordination of benefits. CPI's Cost Containment Unit focuses on cost avoidance through coordination of benefits prior to claim payment and post-payment recovery after payment of a claim.
- The ***Quality Coding Review*** team conducts retrospective reviews of claims by internal resources and vendors to make sure providers bill in accordance with their contract and with AMA-based coding requirements, medical policy and guidelines, or generally accepted medical practices.
- The ***Special Investigations Unit*** (SIU) performs investigations of known or suspected FWA committed by members, network providers, subcontractors, and employees. SIU referrals originate from both internal and external sources. In addition, the SIU performs functions such as collaborating with law enforcement and regulatory agencies and providing program integrity training and education for employees.
- The ***Reimbursement Policy Management*** (RPM) department consists of business units dedicated to accurate provider billing. One of RPM's functions is the coordination of testing and any issues that arise from implementation of updates to National Correct Coding Initiative rules. RPM's Provider Education team utilizes data mining systems to identify providers with aberrant billing and coding patterns and educates those providers on appropriate billing and coding guidelines.
- The ***Subrogation*** department's key function is to recover expenses when a claim is due to accident or injury or another party is liable for the services provided.

- The ***Recovery, Adjustments, and Collection*** team is responsible for claim overpayment validation and adjustment, provider aged debt collection, overpayment inquiries and disputes, and provider cash receipts, and refunds.
- The ***Strategy and Planning*** department provides financial, performance, and project updates. The department also produces program integrity financial and performance reports and functions as a liaison to resolve issues, remove barriers, and foster collaboration to support program integrity.

Detecting FWA

UniCare and our ultimate parent company, Anthem, employ a number of methods to detect FWA.

These include:

- Data mining, including anomaly detection
- Pre-payment review
- Post-payment review
- Monitoring over- and underutilization of services
- Referrals from internal and external sources (including, but not limited to, employees, members, and providers)
- Member verification of services
- Visits to provider locations

Data Mining, Including Anomaly Detection

Mining claims data is the primary way investigators detect and deter FWA. We apply data analytic algorithms across the claims life cycle, both pre-payment, and post-payment. We detect anomalous provider behaviors using coding software, FWA analytics, and our internal, proprietary health care analytics. The size

of our membership and the number of claims we process give us the ability to develop complex algorithms and scorecard development on a level that cannot be reached by our smaller competitors.

Anomaly Detection is a suite of proprietary advanced analytics models that predict and flag suspicious trends in provider billing patterns. Models access large amounts of data to identify high-risk areas that were previously undetected. Model algorithms look for abnormal trends, sudden spikes, and surges of payments, patients, or visits. Anomaly Detection models include algorithm learning techniques that enable the analyst to select a confirmed suspect and identify other providers with similar questionable behavior for further investigation. Insights generate leads for formal investigations and provider education, as well as opportunities for development of new concepts for detection.

Our proprietary models use industry-leading technology and business intelligence software, including Tableau®, Cloudera Impala, Python, Apache Hive, and Apache Spark. These tools support our ability to quickly access data and present it through an interface that supports data visualization and allow users to sort, filter, and drill down into the data to spot trends and identify areas that require further investigation.

A key design feature of Anomaly Detection is the ability to quickly modify existing models or parameters and implement new models to be responsive to new and changing FWA threats. In 2019, we deployed two new Anomaly Detection models that focus on facility usage. The Facility Trending Model analyzes abnormal spikes and surges in facility billing; the Facility Network Model identifies patterns of patients treated by two or more facilities that may suggest fraudulent or abusive referral or billing patterns.

Our advanced analytics development resources include advanced analytics consultants, data scientists, health information managers, machine learning, and artificial intelligence specialists, data and technical engineers, and claims specialists.

Pre-payment Review Process

When our Claims department identifies a high error rate in a provider's billing and there is a suspicion of FWA, it notifies the SIU to place the provider on pre-payment review to evaluate the provider's claims. A provider under pre-payment review must submit medical records to support the services they have billed under the identified procedure codes.

We keep a provider on pre-payment review until the provider has achieved an accuracy rate of 75% or higher for three consecutive months.

Post-payment Review Process

While we focus heavily on pre-payment activities, we also use proactive, analysis-driven, post-payment review to identify erroneously billed claims and behaviors undetectable by up-front edits. Our detection systems and resources include West Virginia-based and national medical management staff who review and analyze facility site data, membership information, and provider medical records, among other things. During post-payment claim review (as part of systematic data mining) and referral follow-up, we apply sophisticated detection tools that our affiliate health plans have found effective in detecting FWA and recovering inappropriate payments.

Internal and External Referrals of FWA

Our FWA detection program makes it as easy as possible for individuals both within our organization and outside of it — employees, members, providers, subcontractors, and law enforcement officials — to report suspicious behavior to us. We make available multiple channels for reporting FWA, including email (medicaidfraudinvestigations@unicare.com), our FWA hotline, our External Compliance Hotline, mail, Enrollee (Member) Call Center, Provider Phone Line, and direct contact with a member of our Compliance team.

We use an array of methods to educate our members about provider FWA and encourage them to report FWA when they think they see it. Our member welcome packet includes a Quick Start Guide with information on how to identify and report suspected FWA and where to report it. Our member handbook and member website instruct members they have a responsibility to report FWA by a member or provider and how to report it. When a member calls our Member Call Center to report possible FWA, a Member Services Representative documents their report in our Investigations Case Management System, where it is reviewed by the SIU.

Member Verification of Services

In accordance with BMS requirements and 42 C.F.R. § 455.20, UniCare has a regular process to verify with members they in fact received services billed by their providers. On a quarterly basis, we mail service verification letters to members identified from a random sample of 225 claims submitted in the previous period. The sample excludes claims for sensitive procedures such as women's health care, family planning, sexually transmitted disease testing, or behavioral health. The letters, which are culturally appropriate, and written in both English and Spanish, contain information on the services billed by the providers and direct members to call the Member Call Center if they do not think the service information provided is accurate. We train our Member Services Representatives on how to respond to member calls about service verification letters.

Like other West Virginia MCOs, we find that few of our members respond to the service verification letters. We are therefore working proactively with the other MCOs to develop solutions to obtain a higher response rate to member verification communications.

Visits to Provider Locations

We make announced and unannounced visits to provider locations, during which we review medical records and conduct interviews with provider staff.

Preventing FWA

At UniCare, we focus substantial efforts on FWA prevention through behavior change across our entire operations, including with providers, subcontractors, members, and employees.

Preventing Provider FWA

We prevent provider FWA using four approaches — excluding federally sanctioned providers from our network, education, and training, outreach and tracking, and sanctions imposed under our provider agreement.

Excluding Federally Sanctioned Providers from Our Network

During our credentialing and recredentialing processes and on an ongoing basis, we check federal sanctions databases and reject or terminate providers that have been excluded from participation in a federal health care program.

Educating Providers on FWA

Through our UniCare Training Academy (Academy), we offer providers initial, and ongoing educational programs on FWA several times per year. Providers receive initial training from our Provider Services staff within 30 days of joining our network. FWA training covers the following topics: definitions and examples of FWA; how to report FWA via email, website, hotlines, and mail; how we investigate FWA and possible actions; how providers can help prevent FWA (for example, verifying member identity, providing proper documentation, and billing accurately); and where to find more information, including our provider handbook, and provider website.

In addition to the Academy, our provider website contains information on how to prevent FWA and the various methods to report potential or suspicious FWA, including an online form. Our provider handbook includes detailed FWA information for providers on their role in educating members, examples of provider, and member FWA, reporting FWA, and details of the investigative process. Provider newsletters, bulletins, conference calls, emails, and fax blasts provide additional modalities for educating providers about FWA. Our provider agreements require providers to conduct general compliance and FWA training at orientation and annually for all employees.

Provider Outreach and Tracking

When we become aware through data mining tools, including anomaly detection models, that a provider's billing practices raise questions, our national Provider Education team notifies the provider by letter of our findings. The letter informs the provider that during our review of paid claims, we found the provider's utilization percentage of certain codes was higher than expected when compared to the average billing behavior of other providers within the same specialty and peer group. The provider is advised to make sure their documentation supports the level of care billed and to contact the Provider Education office if they have any questions. *In 2019, we sent 1,050 billing education letters to network providers.*

Ongoing data analysis helps determine whether education results in a sustained change in provider billing behavior. Failure to demonstrate a change in billing practices results in a referral for a medical record audit or to the SIU.

Provider Agreements

Our provider agreements help deter fraud by requiring providers to agree they will be terminated immediately if they commit fraud or make any material misstatements or omissions on any documents related to the agreement that the provider submits to UniCare or a third party. UniCare's provider

agreements require providers to cooperate with UniCare's anti-fraud program. If providers identify any actual or suspected fraud, abuse, or misconduct in connection with the services rendered under the agreement, they must promptly report the activity directly to UniCare's Compliance Officer or to the Compliance Hotline.

Preventing Subcontractor FWA

UniCare's subcontractor selection and oversight process includes controls to confirm delivery of services to our members while minimizing FWA. Education begins during the contracting process and continues with annual audits and training and awareness sessions. We work closely with our subcontractors to make sure they understand their obligation to comply with federal and State laws related to Medicaid program integrity and execute processes to prevent FWA within their organizations.

Contracting with Subcontractors and Annual Audits

During the contracting phase, we carefully go over the contract with our subcontractors, including sections specifying their obligations related to FWA and the internal controls, policies, and procedures to prevent, and detect FWA. In addition, we audit our subcontractors annually. The audit includes, among other things, a review of the subcontractor's FWA policies and procedures and evidence they have provided FWA training to their employees and subcontractors and vendors. The audit team provides technical assistance, as necessary, to help subcontractors understand, and come into compliance with our FWA policies and procedures.

Training and Awareness

Annually, our Program Integrity Lead conducts an FWA review with each subcontractor during one of the monthly oversight meetings. The discussion, performed approximately six months after the annual audit, covers the subcontractor's role in preventing FWA. It also highlights examples of identification,

investigation, and resolution of cases, with particular emphasis on collaboration between our organization and the subcontractor for ongoing exchange of information on potentially fraudulent activity.

Preventing Member FWA

We employ the following practices to discourage and prevent member FWA:

- Include the following statement on the member ID card: “Use of this card by any person other than the member is fraud”
- Require members associated with an investigation that resulted in identified or strongly suspected FWA to provide a photo ID to obtain services
- Require Member Services Representatives, Nurse Line staff who answer member calls, and Medical Management employees to verify member eligibility every time a member calls

Employees Monitor FWA

UniCare promotes a culture of vigilance concerning FWA among our employees through training and supervision. During the first 30 days of employment, employees receive extensive FWA training. Annually thereafter, we require employees to attend educational sessions on FWA. Program Integrity is responsible for developing the annual general compliance and FWA training for employees. Examples of topics covered include: an overview of Anthem’s Ethics and Compliance program; channels for reporting compliance, ethics, privacy, or FWA concerns, and for asking questions; an overview of relevant policies and procedures; consequences of non-compliance; important related laws and requirements; and the Standards of Ethical Business Conduct. At the conclusion of the annual training, employees complete an acknowledgement to confirm they have completed the course and agree to comply with all requirements.

Investigating FWA

FWA investigations are conducted by the SIU. The SIU's investigations processes are described in our response to PI002.

Reporting FWA

UniCare submits two reports to BMS within 15 calendar days of the end of each month: the FWA Report and the Suspension and Adverse Enrollment Action Report. These reports include all of the information required by Section 8.1.4 of the SPA. Our Program Integrity Lead prepares the FWA Report. The FWA Report includes all program integrity activities initiated by UniCare or one of our subcontractors and related outcomes, referrals UniCare made to BMS/MFCU (including provider education letters), and all overpayments that have been identified and recovered.

With input from the Program Integrity, Operations, Provider Services, and Credentialing teams, our Compliance Officer, Richard Chapman, prepares the Suspension, and Adverse Enrollment Action Report.

This report includes all in-network provider suspensions, terminations for cause, credentialing denials, non-renewals for cause, payment suspensions, and reinstatements that occurred during the prior month. It also contains the amount we withheld from providers during the month and on a cumulative basis year-to-date. UniCare's MHT Regulatory Manager, Amber Nary, oversees the submission of both reports to BMS.

PI002	1	The Vendor should describe its Special Investigations Unit (SIU) policies and procedures for identifying and investigating potentially or suspected fraudulent behavior, and its criteria for referring such behavior to the Department.
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Our Special Investigations Unit (SIU) (PI002)

Our SIU is a critical part of our effort to fight FWA. The SIU identifies and investigates potential FWA engaged in by network providers, subcontractors, members, and employees. It collaborates with law enforcement and regulatory agencies to mitigate FWA; increases awareness of prevention, detection, and

prosecution of FWA through training; participates in a number of national initiatives, such as the Federal Healthcare Fraud Prevention Partnership and the National Health Care Anti-Fraud Association (NHCAA); and supports compliance with laws and regulations governing the prevention and reporting of FWA. In addition, the SIU works closely with the Credentialing department when investigating a provider and notifies the Credentialing department when issues affecting a provider's continued participation are discovered.

The SIU tracks their investigations in the Investigations Case Management System, a custom-built in-house application that houses information about the case and documentation of all actions and steps taken in the development of the case, including, but not limited to: correspondence with the provider, medical records, referral information, results of interviews, and financial information. Anthem SIU team members, James Corn, and Teresa Meadows are located in West Virginia and are supervised by Amanda Patacsil, our West Virginia SIU Manager. UniCare's leadership team maintains a close and collaborative relationship with the SIU through ad hoc and regularly scheduled meetings and oversight.

Identifying and Investigating Potentially or Suspected Fraudulent Behavior

Our national SIU receives referrals of potential FWA for UniCare. These referrals come through multiple channels, including the mail, telephone, in person, email, internet, intranet, and the Compliance Hotline. Sources of FWA referrals include, but are not limited to, members, providers, employees, law enforcement agencies, and professional organizations.

The SIU also utilizes more proactive intelligence gathering methods that include, but are not limited to:

- Information sharing with other carriers for early identification of schemes
- Participation in fraud workgroups and taskforces
- Use of the Special Investigations Resource and Intelligence System "Schemes" database (which includes data related only to schemes, not specific individuals or entities)

- Review of news articles related to FWA nationwide
- Dedication to education and training related to FWA
- Coordination and partnership with internal departments to identify areas of risk

The SIU staff triages all referrals related to UniCare to the SIU manager for West Virginia, Amanda Patacsil. Amanda, with the assistance of an SIU investigator (James Corns) and SIU investigator assistant (Teresa Meadows), evaluates the referral. If she determines the referral is within the scope for review by the SIU, she converts the referral to a lead and enters the lead into our Investigations Case Management System. The SIU then begins an investigation to determine the validity of the allegation. *In 2019, of the 17 referrals the SIU accepted for review as leads, seven were converted into a full investigation based on the findings of the initial review.*

Investigation

If the SIU determines there is a credible allegation of FWA, it begins a full investigation. As an investigation moves to the information gathering and reporting stages, the investigator collects information from a variety of sources such as interviews, records reviews, and other sources of investigative information. At the point where the investigator determines they have sufficient information, they move from information gathering to evaluation.

At the evaluation stage, SIU management and the assigned investigator assess the investigative results of the information gathering phase and reach a conclusion as whether or not the evidence confirms inappropriate activity. Frequently, at this stage of an investigation, discussion with other areas of the company, such as Legal, Medical, Provider Services, Care Management, and Operations, is necessary.

If SIU management, in collaboration with the investigator, conclude that the results to date do not support a formal conclusion of fraud, they may decide to continue the information gathering process while

monitoring the subject's activity. If an investigation supports a reasonable suspicion of fraud, the SIU reports this to BMS in accordance with the requirements of the SPA.

Resolution of the Investigation

Following the conclusion of an investigation, the SIU may take one of the following actions depending on the nature and degree of the provider's behavior:

- Sending a warning letter to the provider, giving notice that continuation of the activity in question will result in further action
- Pre-payment review
- Recommending suspension or termination of the provider from participating in UniCare
- Seeking recovery of payments made to the provider
- Imposing other sanctions and/or actions as directed by the SPA

Criteria for Referring Potential or Suspected Fraud to DHHR

The SIU refers cases to BMS when our investigation supports a reasonable suspicion that fraud may have occurred or may be occurring. Referrals depend upon the facts, the legal authority that supports our interpretation, and the pattern identified, if any. Examples of potential or suspected fraud that we have referred to BMS include a pattern of inappropriate billing about which the provider has previously been educated, claims with no medical records to support the claim, and provider billing practices that conflict with published guidelines/statutes.

PI003	1	The Vendor should describe its process to work with the Department, the Medicaid Fraud Control Unit (MFCU), the Centers for Medicare & Medicaid Services (CMS), and the Department of Health and Human Services (DHHS), to administer effective fraud, waste, and abuse (FWA) detection and prevention practices.
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Working with DHHR, MFCU, CMS, and DHHS to Administer Effective FWA Detection and Prevention Practices (PI003)

UniCare is committed to collaborating and coordinating with the West Virginia Department of Health and Human Resources (DHHR), MFCU, the Centers for Medicare & Medicaid Services (CMS), and the Department of Health and Human Services (DHHS) to make FWA detection and prevention practices as effective as possible. In addition to submitting regular reports to BMS, we assist BMS and MFCU in identifying and preventing FWA by referring cases of likely FWA to them and by cooperating with them in their FWA investigations as requested. We provide investigative support in response to requests from DHHR, MFCU, CMS, and DHHS that includes, but is not limited to, providing claims data analysis, professional medical reviews, medical policy guidelines, provider contracting agreements, hard copy claims, explanations of benefits, and copies of cashed checks.

When BMS notifies UniCare that the State has suspended payments to a provider, UniCare suspends payments to the provider within one business day. To make the process of recovering overpayments more effective, we worked cooperatively with DHHR as a member of the Finders Keepers Task Force to develop a deconfliction process that avoids duplication of efforts in the recovery of overpayments.

We meet monthly with BMS to discuss questions we have received from BMS, new cases we have referred to BMS, recent provider terminations and suspensions resulting from program integrity concerns, and other activities related to program integrity. At our annual meetings with BMS, MFCU, and the other

MCOs, we share, and receive information on FWA trends, schemes, and successful cases. We use this information to enhance our data mining systems.

PI004	1	The Vendor should describe how they will maximize resources for fraud, waste and abuse (FWA) issues.
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Maximizing Resources for FWA Issues (PI004)

UniCare maximizes resources for FWA issues in the following ways:

- Our SIU and Program Integrity staff meet with other West Virginia MCOs at SIU Health Care Fraud Workgroup meetings to discuss program integrity organizational structures, trends, best practices, common bad actors, challenges, and solutions. These discussions have resulted in investigations of certain providers and heightened awareness of potential FWA in connection with certain procedure and diagnosis codes. They also provide a forum in which MCOs alert each other about providers they have identified as engaging in FWA.
- Our Program Integrity Lead and SIU staff attend monthly meetings with investigators from our affiliated health plans to learn about and present case-specific outcomes and highlight known or emerging FWA schemes.
- We receive leads from our commercial plan in West Virginia and meet quarterly with the commercial plan's Program Integrity team to discuss FWA trends.
- We consult with our affiliates across the country about FWA trends they are seeing in other states so we can start looking for them in West Virginia.
- The Advanced Analytics teams boost the resources of our SIU and local Program Integrity team with sophisticated data analytics, reporting, and analysis.

PI005	1	The Vendor should describe its process for responding to all program integrity and Medicaid Fraud Control Unit (MFCU) requests within the timeframes established by the Department.
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Responding to Program Integrity and MFCU Requests Within DHHR

Timeframes (PI005)

Our program integrity infrastructure is built on accountability and technology that assures our compliance with the State’s timeliness requirements. The SIU has primary responsibility for making sure we respond timely to all requests for information (RFIs) received from BMS and MFCU. The State sends RFIs from BMS and MFCU to Teresa Meadows, SIU Investigator Assistant, with a copy to our West Virginia SIU Manager, Amanda Patacsil. Teresa logs the RFIs into our case management tracking system and creates a task application, which includes a timing mechanism, for each RFI.

We classify all RFIs as “high priority” to meet the turnaround time, which is 14 calendar days unless we request and are granted an extension by the State. Teresa and Amanda monitor the workflows of staff in departments outside the SIU that are assigned to gather information for the responses to assure that they are meeting their respective timelines. Teresa performs time checks throughout the process. In Teresa’s absence, Amanda assumes responsibility for responding to the RFI and meeting DHHR timeframes. *In the last 12 months, we were 100% compliant with BMS and MFCU timeframes.*

PI006	1	The Vendor should provide its compliance plan with clear goals, timelines, assignments, and measurements as outlined by the Department.
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Compliance Plan (PI006)

UniCare submits our Medicaid Compliance Plan to BMS by October 1st of each year. Our Compliance Plan comprises three documents: (1) the Ethics, Compliance, and Privacy Plan, (2) the Medicaid Compliance Plan Addendum (which supplements the Compliance Plan with Medicaid-specific details and requirements), and (3) the SIU Anti-fraud Plan, which has an addendum specific to UniCare and West

Virginia requirements. The addendum in the SIU Anti-fraud Plan describes how we administer our Compliance Plan and FWA detection, prevention, investigation, and reporting activities in accordance with the State's requirements. It also includes our Compliance Plan goals, milestones, and timelines, assignments for compliance tasks, and measurements. We update all three Compliance Plan documents annually.

Compliance Plan Goals

The UniCare Compliance program strives to improve operational quality by fulfilling four primary goals:

- Demonstrate UniCare's commitment to compliance as well as ethical and legal business conduct
- Develop and implement internal controls and processes to promote compliance with applicable State and federal laws and regulations, as well as contractual, and policy requirements
- Prevent, identify, and correct non-compliant behavior as well as FWA
- Establish an environment of open communication that encourages employees and subcontractors to identify and report potential non-compliant practices and that disciplines non-compliant behavior in an effective manner

Assignments and Timelines for Compliance Plan Tasks

Compliance Plan tasks, assignments, and timelines are enumerated in Table 6.11-1.

Table 6.11-1. Compliance Plan Tasks, Assignments, and Timelines

Tasks	Assignments	Timeline
Manage and assure the operation and effectiveness of Compliance Program initiatives	Richard Chapman, Compliance Officer	Ongoing
Provide regular updates to the Audit Committee of the Anthem Board of Directors and UniCare Compliance Committee (UCC) on Compliance program activities, including but not limited to, compliance effectiveness reviews, compliance risks, sanctions and penalties, and recoveries	Richard Chapman	Monthly
Responsible for the daily operation of the Medicaid Compliance Program	Richard Chapman	Daily
With Medicaid Governance, develop, and execute Medicaid Compliance Work Plans	Richard Chapman	Annually
Maintain a standardized compliance risk assessment and management framework	Richard Chapman	Ongoing

Tasks	Assignments	Timeline
Conduct compliance effectiveness reviews	Richard Chapman	As needed
Deliver compliance training and guidance to employees and business partners	Richard Chapman	Annually and as needed
Manage the regulatory activities and support processes of UniCare to facilitate, monitor, and promote understanding of and compliance with the regulatory and contractual obligations to State agency partners and responsibility to members	Amber Nary, MHT Regulatory Manager	Ongoing
Provide health plan and shared services partners with regulatory and contractual resources and research products	Amber Nary	Ongoing
Coordinate regulatory reporting and collateral submissions	Amber Nary	Ongoing
Serves as a primary liaison with State agencies	Amber Nary	Ongoing
Initiate investigations and develop FWA cases for future action	Amanda Patacsil, SIU Manager	Ongoing
Follow-up on leads from BMS in a timely and appropriate manner	Amanda Patacsil	Ongoing
Execute and respond to RFIs from BMS or other State actors within	Amanda Patacsil Teresa Meadows, SIU Investigative Assistant	14 calendar days or within the timeframe designated in the request
Continuously identify system vulnerabilities that may increase the risk of FWA and report them to Medicaid Compliance management, Internal Audit, corporate Ethics, Compliance and Privacy departments, and other impacted areas of company, with recommendations to address the issues	Richard Chapman Rick Levock, Program Integrity Lead Amanda Patacsil	Ongoing
Educate and sensitize employees and subcontractors about compliance requirements and FWA, through the annual Ethics, Privacy, Information Security, and Compliance training	Richard Chapman Human Resources department	Annually
Provide FWA training to all new employees	Human Resources department	Within 30 days of employment
Conduct compliance risk and FWA investigations in a thorough, timely, and confidential manner	Richard Chapman Amanda Patacsil James Corns, SIU Investigator Teresa Meadows	Ongoing
Monitor the Office of the Inspector General (OIG) federal sanctions reports and terminate excluded providers	Credentialing department	Monthly
Review State license suspensions and revocations and terminate the providers from UniCare's provider network	UniCare's Medical Director Credentials Committee Credentialing department	Monthly

Measures, Goals, and Milestones for Our Compliance Program

The Compliance team monitors and reports on key performance metrics. These metrics tie to performance requirements in the SPA as well as internally identified performance objectives. They are designed to evaluate and improve effectiveness of processes and related controls or systems, and to support compliance with requirements. Our measures, goals, and milestones for our compliance program are detailed in Table 6.11-2.

Table 6.11-2. UniCare's Compliance Plan Measures, Goals, and Milestones

Measure	Goal	Milestone
Provider Education — Monitor Provider Billing and Provide Education	250 provider education letters quarterly	Quarterly
DRG Audits — Medical Record Review — Validation of Diagnosis Codes Billed	333 cases	Annually
SIU Cases	10	Annually
Employee FWA Training — New Hires	100%	Within 30 days of hire
Employee FWA Annual Training — All Employees	100%	Annually

PI007

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The Vendor should describe its training and education of the compliance officer and the organization's employees, including senior management, on State and federal standards and contract requirements.

Training and Education of Employees on State and Federal Standards and Contract Requirements (PI007)

All UniCare employees receive online ethics and compliance training, including modules on FWA, within 30 days of hire and annually thereafter. Orientation training includes the *New Hire Introduction to Fraud, Waste, & Abuse* web-based course, which defines FWA and its impact and explains the roles of employees (including the requirement to report suspected or known FWA immediately), the SIU, how to submit a referral, and where to find more information. The training introduces employees to the “Red Flag Checklist,” which provides examples and red flags for identifying provider and member FWA and how to

handle suspicious events, including reports to our Member Call Center and Provider Phone Line. Periodic quizzes within the module measure and reinforce employee understanding.

In 2020, the Compliance team will launch a new educational program that will highlight topics from our Standards of Ethical Business Conduct and reinforce UniCare's commitment to ethics, compliance, and privacy. During our first session in March 2020, we will provide employees with an overview of our commitment to integrity, our shared responsibilities, and ways to report any violations of the Standards of Ethical Business Conduct. Each quarter after, we will cover additional topics from our Standards of Ethical Business Conduct, including our work environment, protecting information, ethical business practices, and compliance with State, and federal laws and program requirements. A SharePoint site will be used to track employee attestations of review and understanding of the primer. The site also includes links to key documents such as the contract between UniCare and BMS and the Code of Federal Regulations.

Additional Compliance Education for Senior Management, Including CFO

UniCare provides additional training on State and federal standards and contract requirements for senior management, including our CFO, through quarterly meetings of the UCC, a committee on which all members of UniCare's leadership team serve. Co-Chaired by UniCare's Compliance Officer, Richard Chapman, and CEO Tadd Haynes, the UCC focuses on oversight and monitoring of Medicaid compliance efforts and programs at the leadership level. Examples of topics discussed at recent meetings that increased senior managers' awareness and understanding of State and federal standards and contract requirements included: updates on compliance risks and issues; alerting the State of newly identified risks; and regulatory updates. Senior manager learning is enhanced by the opportunity for them to ask questions, discuss specific compliance risk and issues within their departments, and seek guidance on compliance-related topics.

Training and Education of Our Compliance Officer

Richard receives additional training specific to his responsibilities as a compliance official. Focus areas include the development and implementation of compliance work plans, maintenance of a compliance risk and issue assessment and management framework, routine review of program effectiveness, and the development, and delivery of Medicaid-specific compliance training and guidance to employees and subcontractors as required. The training is provided by Anthem’s Chief Compliance Officer, Anthem’s Chief Medicaid Compliance Officer, and Tadd, UniCare’s CEO.

Ongoing Education for SIU Staff

To remain up to date on the current trends and tools in health care fraud prevention, our SIU staff members regularly participate in CMS-sponsored FWA outreach and education events. In addition, we require SIU investigators to attend 10 hours of continuing education each year. For this training, investigators can use industry resources such as the NHCAA, American Association of Professional Coders, Blue Cross Blue Shield Association, Association of Certified Fraud Examinations, as well as internal resources such as our Medical Directors and claims coding professionals. In addition, UniCare SIU staff attend all BMS-sponsored training on FWA issues.

PI008	1	The Vendor should describe its disciplinary guidelines and procedures for enforcement of compliance standards.
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Disciplinary Guidelines for Employees and Subcontractors (PI008)

Our Ethics, Compliance, and Privacy Plan specifies expectations for employees and subcontractors and disciplinary actions for non-compliance. We inform employees of our compliance standards, statutory and contractual requirements, and disciplinary guidelines through online news articles and announcements, online training, the Ethics, and Compliance Resource Center, screensavers, posters, and newsletters.

Employee training includes relevant scenarios and guidance. We convey our standards and expectations to subcontractors during the contracting, pre-delegation, and annual delegation processes. We require subcontractors to have their own compliance program and fraud plan, as well as training programs for their employees and providers.

Anthem's Ethics and Compliance Office administers and advises employees on the Ethics, Compliance, and Privacy Plan, serves as an independent resource to receive and investigate allegations of employee misconduct, provides employees with training on ethics and compliance issues, and maintains high-level oversight of compliance programs across the enterprise, including UniCare's.

Enforcement of Disciplinary Guidelines

Any employee approving or participating in actions that violate the Ethics, Compliance, and Privacy Plan, the Compliance Plan, UniCare policies, or applicable laws, and regulations is subject to corrective action, up to, and including termination of employment. When an employee is found to have engaged in misconduct, our UniCare Compliance Officer, Richard Chapman, works with the UniCare leadership team and Human Resources department to develop a plan of action to bring the employee into compliance. Factors considered in developing the plan of action include previous investigations of the same or similar misconduct by the employee, information from interviews, and input from Human Resources. Richard monitors the implementation of the plan of action from initiation to completion. He consults with the employee's supervisor as needed to validate compliance with the plan of action and reports monthly to the leadership team.

Subcontractors in violation of their contract, Medicaid program provisions, or UniCare's compliance program are subject to corrective action up to and including contract termination. Corrective action depends upon the nature and circumstance of the violation.

PI009	1	The Vendor should describe its procedures for routine internal monitoring, auditing, and remediation of compliance risks and identified issues.
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Routine Internal Monitoring, Auditing, and Remediation of Compliance Risks (PI009)

Monitoring Compliance Risks

UniCare, with the support of our national organization, has an effective system for monitoring and oversight of compliance with applicable federal and State requirements and internal policies and procedures. Our national Ethics, Compliance, and Privacy team, in collaboration with our national Internal Audit and Enterprise Risk Management teams and other stakeholders, coordinates ongoing compliance risk, and issue management to proactively identify risks and issues and perform monitoring reviews of critical processes. Risks are defined as future events with the potential for non-compliance if not effectively mitigated; issues are deficiencies or concerns that have already occurred and require remediation.

On an annual basis, Anthem develops a Medicaid Compliance Strategic Work Plan that outlines and tracks the Medicaid Compliance program's strategic initiatives. The Work Plan serves as a foundation for compliance oversight and risk/issue management in the Medicaid Compliance program. The Work Plan is developed by taking account of all key components of an effective compliance program and by identifying risk areas, internally, and externally, as well as reviewing the OIG's annual work plan and other relevant external resources (for example, State, and CMS guidance documents).

Tools to Monitor Compliance Risks and Issues

We identify compliance risks and issues through various oversight and monitoring activities, including, but not limited to, audits, compliance checks, revalidations, and regulatory notices. We use the following tools to monitor compliance:

- **National Executive Dashboard (NED).** NED is used to track and monitor contractual requirements that are “metric-based” measures.
- **Compliance 360 (C360).** We use C360 to distribute new and revised contractual requirements and track impacts and tasks needed to comply with those changes.
- **Risk Assessment and Management.** A focused risk assessment to identify priority non-metric contractual requirements for which evidence of compliance is not readily available.

Monitoring Roles and Responsibilities

UniCare’s Compliance Officer conducts hands-on monitoring of compliance risks in West Virginia. He participates in all meetings of the UniCare leadership team, makes and receives quarterly reports through the UCC, and assesses outstanding compliance risks on an ongoing basis to determine if they are likely to become issues.

The UniCare leadership team is required to identify compliance risks, report them to Richard, and work with him to remediate the risks. Anthem’s Ethics, Compliance, and Privacy team leads compliance monitoring activities. They maintain a Helpline (1-877-725-2702) that is available 24/7 for reports by employees. In addition, employees may submit concerns in writing through an online form, to a post office box, and to an email box. Reports may be submitted confidentially and anonymously.

When UniCare is in the process of implementing a new requirement or protocol such as the new deconfliction/Finders Keepers requirements, our national Business Change Manager assists UniCare in assessing the impacts and implementing processes to achieve compliance. This Business Change Manager attends regularly scheduled meetings with the Program Integrity Lead, SIU staff, UniCare’s Operations department staff, Richard, and our MHT Regulatory Manager. Our Program Integrity Lead reports on any new issues or provides updates on implementation activities. Following the meetings, the national

Business Change Manager follows up with staff assigned action items at the meetings and monitors their progress in completing those items.

Our local Compliance and Program Integrity teams are supported by our national Ethics, Compliance, and Privacy team. When an abnormal pattern or compliance concern is identified, this team will work with the applicable business leader(s) to identify the root cause, develop appropriate corrective actions, and monitor the corrective actions to make sure they remediate the issue. In addition, the Ethics, Compliance, and Privacy team periodically administers an Integrity Survey to assess the overall culture in Anthem, including specific questions on ethics and integrity.

Auditing Compliance Risks

Anthem's Internal Audit department supports the overall strategy for performing and monitoring compliance risk audits of Anthem, its affiliates such as UniCare, and subcontractors. Each audit is overseen by a Staff Vice President of Internal Audit and a Director. The audit process consists of three phases: planning, fieldwork, and reporting. The audit team conducts pre-planning and planning, followed by a formal announcement memo. An audit opening conference is held to discuss the audit process and the scope and frequency of status updates.

Audits range in hours from approximately 100 to 1,200 hours depending on the scope, and are completed within a three- to four-month timeframe. Most of the larger audits tend to focus on end-to-end reviews or major initiatives.

At the conclusion of the audit, the Internal Audit team generates an audit report that details the scope of the review and audit findings. Audit reports are disseminated to a broad audience, including, but not limited to, business management, executive leadership, Compliance, and IT. Audit findings are given three different ratings: *Low*, *Moderate*, and *Critical*. Findings require an action plan to remediate the risks

and gaps noted in the finding as well as a remediation due date. The Internal Audit department tracks each finding within its workflow system and performs follow-up to make sure management is making progress towards remediation. Validation testing is performed by Internal Audit prior to closing the findings.

Remediation of Compliance Risks

When Richard identifies a compliance risk or issue, he works closely with our national Compliance department and UniCare leadership to develop a plan of action to remediate the risk or issue. Richard is charged with the responsibility for monitoring the implementation of the plan of action. He documents and tracks remediation using the Risk and Issue Tools on our SharePoint site. He meets monthly with UniCare leadership to receive updates on the status of the plan of action, the steps taken to date, and the effectiveness of those steps in remediating the risk or issue. Additionally, Richard seeks feedback, and approval from UniCare leadership concerning the closure of a UniCare compliance issue or risk.

PI010	1	The Vendor should describe its oversight and monitoring process for any delegated functions and services, as provided by a subcontractor, in accordance with guidelines defined under the contract.
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UniCare's Subcontractor Oversight and Monitoring Process (PI010)

UniCare views subcontractors as valued partners in delivering the highest quality services to members, providers, and DHHR. As an incumbent health plan serving Medicaid-eligible West Virginians since 2003, we have established a proven approach to working with subcontractors to coordinate seamless delivery of services. Our approach centers on identifying areas where DHHR, our members, and providers can be best served through subcontractors with specialized capabilities and whose core business represents a capability required by the State's Contract.

UniCare retains sole responsibility for fulfilling West Virginia Contract requirements. We are fully accountable for our subcontractors' performance through processes implemented to monitor, supervise, and enforce Contract compliance. Additionally, we promote frequent, open, and effective communication that

emphasizes delivery of quality services to members. These well-defined processes have proven successful throughout our tenure in West Virginia and across our affiliate health plans in 23 other markets.

Activities and Tools to Monitor Each Subcontractor

Health Plan-level Oversight

UniCare benefits from a multi-level approach to subcontractor management that is overseen at the health plan level, but supported by national departments focused on subcontractor management. At the local health plan level, UniCare's Subcontractor Oversight Committee regularly meets with subcontractor representatives and our national Subcontractor Managers, who are their day-to-day liaisons to review reports that enable us to monitor performance and confer with subcontractor representatives. The Subcontractor Oversight Committee comprises representatives from UniCare, Compliance, Quality, and Operations. *Additionally, UniCare will hire a West Virginia-based Subcontractor Oversight Manager who will lead the Subcontractor Oversight Committee and expand its scope.* The Subcontractor Manager will also assist as needed with Program Integrity and SIU processes.

Subcontractor Managers assigned to each subcontractor are responsible for focused day-to-day management, oversight, and ongoing communication with that subcontractor. Managers are assigned to subcontractors based on area of expertise, thereby maximizing their level of collaboration and effectiveness in monitoring performance. Subcontractor Managers keep the Subcontractor Oversight Committee apprised of concerns with, or significant changes by, the subcontractor. This approach places a subject matter expert (SME) as the first line of oversight while giving UniCare overall responsibility for overseeing subcontractor performance.

National Oversight Committees

National oversight committees provide an additional level of support to our program. Regular communication between these committees and our West Virginia Subcontractor Oversight team maintains focus on delivering high-quality services to our members. National oversight committees and their functions include:

- The ***National Quality Improvement Committee***, which meets quarterly and reports any quality or compliance issues to local committees, including those related to subcontractors.
- The ***Delegate/Vendor Oversight and Management Committee (DVOMC)***, which oversees subcontractors serving multiple health plans. It is responsible for compliance with State, federal, NCQA, CMS, and individual program requirements, and standards, as well as other regulatory or accreditation standards. It reports to the National Quality Improvement Committee quarterly.
- The ***Delegation Operations Committee (DOC)***, which includes representatives from Account Management, Quality, Legal, Compliance, and other areas as needed. Reporting to the DVOMC monthly, the DOC assesses oversight, and compliance, monitors corrective action plans (CAPs) (including recommending escalation), evaluates subcontractor performance through reports analysis, and makes recommendations to DVOMC on findings as well as the use of audit tools.
- ***Joint Operations Committee (JOC)*** meetings, which are held quarterly to assure appropriate oversight and communication occurs between the national teams, health plans, and Plan Compliance Officers. Meeting agendas can include national and health plan updates, delegate updates, delegated function report overview, market-specific issues, collaborative project reports, and many other items. The Subcontractor Managers report meeting minutes, including significant deficiencies identified and reported to the DVOMC, are made available for the annual State audit or internal audits.

Subcontractor Selection and Oversight Program Activities

Our Subcontractor Oversight program begins with a thorough, rigorous evaluation process to confirm subcontractors meet operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical standards. We use our internal regulatory guidelines, policies, and procedures to vet and evaluate new subcontractors, including our Subcontractor Management Due Diligence Policy, Medicaid Disclosure of Ownership Policy, and Medicaid Offshore Governance Policy.

During our pre-delegation audit, we examine items such as the organization's HIPAA privacy and security compliance, grievance, and appeals history, operating procedures, staffing ratios, and financial viability. We audit our subcontractors for their comprehension of these items and their ability to train providers on such items. We offer guidance and instruction for our subcontractors on topics such as UniCare policies and procedures, HIPAA compliance, FWA avoidance and prevention, and cultural competency.

When possible, we also check credible references in the industry on subcontractor service delivery.

Our program enables us to monitor subcontractor performance and financial stability. In collaboration with our Quality Management (QM) department, we also monitor subcontractor over- and underutilization and adherence to complaint and grievance policies and procedures. We tailor our program, including scope, and frequency of oversight, to functions, and services each subcontractor provides. We outline our ongoing oversight activities in Table 6.11-3.

Table 6.11-3. Our Oversight Program Monitors Subcontractors Throughout the Contract

Timing	Oversight Activities
Daily	Subcontractor Managers and SMEs work with subcontractors as necessary to answer questions, collaborate on problem solving, discuss opportunities for improvement, and escalate urgent performance concerns.
Monthly	- Complete Performance Indicator dashboard on each subcontractor. - Review performance against standards, including trends, and report submissions. - Review performance with subcontractor, Subcontractor Managers, and West Virginia Oversight team. - DVOMC meeting to discuss approval of delegation, performance monitoring, CAPs, and terminations.
Quarterly	- JOC meetings with UniCare leadership to review performance metrics, HEDIS® and health plan-specific initiatives, and CAPs. - Meet with subcontractors to discuss performance across markets and present issues, gaps, and concerns to the DVOMC or health plan. - DVOMC reports to the National Quality Improvement Committee to discuss any quality issues with subcontractor performance. - Report additions, terminations, CAPs, and risk to UCC.
Annually	- Perform audit or annual review to confirm that subcontractor meets operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical requirements. - Present audit findings to the DVOMC and the West Virginia Oversight team.

On a scheduled basis, the Subcontractor Manager, and assigned subcontractor meet with the West Virginia Oversight team to review performance against standards. The meetings provide a forum to discuss issues and brainstorm potential solutions. Our experience shows that transparency and open, constructive dialogue is critical to maintaining a collaborative partnership and seamless service delivery to members.

UniCare performs annual formal reviews of our subcontractor performance. To assure an unbiased review of performance, our subcontractors are also reviewed by our national Oversight Support Services. We utilize standardized audit tools to evaluate subcontractors prior to delegation and annually thereafter. The audit tools are functional area- and product-specific, and based on contractual, federal, and State regulatory, and accreditation standards. If a CAP is required, a CAP Notification letter outlining deficiencies is sent to the subcontractor via email. The subcontractor is required to submit a CAP with all action items completed within 30 calendar days of the electronic receipt of their CAP Notification letter. For non-compliant CAPs or if a CAP is not received within a specified time frame, the issue is escalated for resolution.

Improving Subcontractor Performance and Results

UniCare always strives to improve the level of service we deliver, and we expect our subcontractors to do the same. During subcontractor oversight and monitoring, we not only review areas with substandard performance, but also seek out opportunities to “raise the bar” and deliver better service. For example, we use our Performance Indicator Report to monitor performance, track actions taken to improve performance, set new targets, and drive positive results from our subcontractors.

Clearly defined expectations and consistent performance monitoring are key pieces of our Subcontractor Oversight program, and written agreements detail performance standards and the actions we take to address inadequate or substandard performance. If at any time performance does not meet our expectations, we will take action, and work closely with the subcontractor toward a resolution and return to complete and ongoing compliance. If we identify a performance or operational problem with a subcontractor, we immediately address our concerns by applying a series of escalating interventions, including increased meeting frequency, and data submission, development of an informal action plan, development of a CAP, financial penalties, and other sanctions.

UniCare views interventions not as a punitive action, but rather a documented process to improve performance and more closely collaborate with our subcontractors. The type of intervention depends on a combination of factors, including the severity of the issue and historical performance. We track and monitor all interventions. If interventions are unsuccessful in generating a sustained performance improvement, we consider termination, and promptly notify DHHR.

Subcontractor Reports and Data to Help UniCare Manage Benefits

UniCare monitors all subcontractors with which we have contractual and other performance requirements. We require subcontractors to submit two primary report types: (1) reports we need to fulfill

regulatory reporting requirements; and (2) operational information so that we can monitor subcontractor performance against standards. Subcontractor Managers maintain a schedule of due dates for both types of reports and collaborate with subcontractors if they are late or submit incomplete or inaccurate data. During implementation, we will review DHHR reporting requirements and identify the subcontractor data we need (including format and due date) to present a collaborative and complete picture of our West Virginia Mountain Health Trust Contract activities. For all reports, we identify an internal due date prior to the DHHR deadline to provide time for a thorough quality review.

SKYGEN USA, LLC (SKYGEN) provides UniCare with more than 20 reports to help us manage benefits. The subset of reports shown in Table 6.11-4 includes those used to ***assure appropriate subcontractor oversight and member access, satisfaction, and continuity of care.***

Table 6.11-4. SKYGEN Provides UniCare with More than 20 Different Reports, Including the Five Listed

SKYGEN Report	Frequency	How we use report data to assure appropriate subcontractor oversight and member access, satisfaction, and continuity of care	Does this report help us manage the medical, social, or any other benefit?
Appeal and Denial Letters	Quarterly	Used to monitor State and contract metrics and provide oversight of performance	Yes
Authorization Denial Report	Monthly	Used to monitor State and contract metrics and provide oversight of performance	Yes
Medicaid GeoAccess*	Quarterly	Used to monitor member access to providers	Yes
Performance Indicator Report	Monthly	Used to monitor State and contract metrics and provide oversight of performance	Yes
Provider Satisfaction Survey	Annually	Used to monitor member access and satisfaction	Yes

Similarly, Vision Service Plan Insurance Company (VSP) provides UniCare various reports to help us manage benefits. We have identified two sample reports in Table 6.11-5.

Table 6.11-5. VSP Routinely Provides UniCare Reports to Help Manage Benefits

VSP Report	Frequency	How we use report data to assure appropriate subcontractor oversight and member access, satisfaction, and continuity of care	Does this report help us manage the medical, social, or any other benefit?
Medicaid GeoAccess	Quarterly	Used to monitor member access to providers	Yes
Performance Indicator Report	Monthly	Used to monitor State and contract metrics and provide oversight of performance	Yes

VSP Report	Frequency	How we use report data to assure appropriate subcontractor oversight and member access, satisfaction, and continuity of care	Does this report help us manage the medical, social, or any other benefit?
Provider Satisfaction Survey	Quarterly	Used to monitor member access and satisfaction	Yes

Exchanging Information and Data

UniCare requires our subcontractors to send and receive data files and other information on a specified schedule. We use secure transmission methods to exchange all information and data with our subcontractors. Data files are typically exchanged using secure file transfer protocol or other secure communication protocol. Reports and other information are typically exchanged through encrypted email or other secure methods.

We document not only the schedule (frequency, day, and time), but also the format, and secure transmission method. If we do not receive a file on its due date, we send an email alert to notify the Subcontractor Manager to ascertain the status and reason for the delay.

Identifying Frequency of Calls with Each Subcontractor

We understand the importance of frequent, ongoing contact, and collaboration with our subcontractors, particularly those that provide benefits to our members — both upon go-live and ongoing thereafter. Two of our subcontractors — SKYGEN and VSP — are benefits providers, while the remaining five are administrative services providers. Because our benefits manager subcontractors are client-facing and our ultimate goal is to make sure members have no disruption in service, our frequency of calls with these subcontractors includes weekly implementation meetings and daily post go-live calls that eventually change to monthly post go-live calls. When the contact frequency reverts to the regular schedule, our communications include:

- **A Monthly Operations Call.** A touch base and review of monthly report summaries to make sure that service level agreements (SLAs) and contract requirements are being met
- **A Quarterly JOC Meeting.** To review performance metrics and CAPs
- **Ad Hoc Meetings as Needed.** To review detailed performance, monitor operational activities, and address broad scale issues

Our contact with administrative services provider subcontractors tends to be less frequent as these subcontractors are not client-facing and their services are based on tested, successful processes. We are always available to both our benefits and administrative services providers and reach out to them as needed.

Addressing Subcontractors Unable to Fulfill Contract Obligations

If we identify a performance or operational problem with a subcontractor, we immediately address our concerns by applying a series of escalating interventions, including increased meeting frequency, and data submission, development of an informal action plan, development of a CAP, financial penalties, and other sanctions. If we determine that a CAP is needed, the Subcontractor Manager, West Virginia UniCare Oversight team, and appropriate operational areas work with the subcontractor to identify the root cause, initiate corrective actions, and develop the CAP. The CAP includes a timeline for correcting the deficiency, dashboards to review ongoing metrics, and regularly scheduled meetings to review progress. The corrective action monitoring process ends when the subcontractor demonstrates ongoing compliance, typically for at least 90 days.

Our approach to identifying and addressing subcontractor deficiencies centers on establishing and maintaining a collaborative partnership with each subcontractor and regular, consistent monitoring. The Subcontractor Manager works daily to identify and discuss resolution of performance issues early before

they become a problem. We supplement our proactive account management structure with robust monitoring, including monthly performance reporting, quarterly reviews, and annual audits.

If, following an annual audit, we continue delegation of a subcontractor with a CAP, the subcontractor submits a CAP for all noted deficiencies, which includes the time frames for completion (CAP due dates may be more immediate, if necessary, depending on the severity of the deficiency), follow-up evaluations, and deficiency resolutions of the issue(s). The subcontractor must submit the remediated CAP within the time frame specified. Follow-up assessments are performed as needed, depending upon the nature, and scope of the deficiencies. Such assessments are in addition to the annual assessment. The subcontractor must agree to implement the CAP and resolve the issue(s) within the determined time frame(s). The CAP response is evaluated for acceptable resolution. The ongoing monitoring of the CAP and its status is reported to the DVOMC monthly until all findings are resolved. A subcontractor that receives a score of Non-compliance may be subject to escalation.

Improving Subcontractor Performance and Results

We use our Performance Indicator Report to monitor performance, track actions taken to improve performance, and drive positive results from our subcontractors. Clearly defined expectations and consistent performance monitoring is a key piece of our Subcontractor Oversight program, and written agreements detail performance standards and the actions we take to address inadequate or substandard performance. If at any time performance does not meet our expectations, we take action, and work closely with the subcontractor toward a resolution and return to complete and ongoing compliance. Our subcontractor agreements outline specific SLAs, metrics, and key performance indicators that align with DHHR requirements for each function we delegate. If DHHR modifies a standard, we amend the

subcontractor agreement to reflect the change. Where applicable, a program-specific addendum is part of all subcontractor agreements outlining critical components of the State Contract.

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| PI011 | 1 | The Vendor should describe its process for monitoring provider fraud for underutilization of services and member/provider fraud for overutilization of services. |
|-------|---|--|

Monitoring Provider Fraud for Underutilization of Services and

Member/Provider Fraud for Overutilization (PI011)

Monitoring Provider Overutilization for Fraud

Monitoring provider fraud in connection with overutilization of services involves analysis by multiple national departments and teams (including Program Integrity, Claims Processing and Payment, Utilization Management [UM], Quality Management [QM], Provider Services, and local Finance) of reports on outlier provider behavior generated from claims data. Our *over- and under-utilization reports* identify potential over and underutilization patterns using incurred claims data. These reports shows both standard deviation results for the current quarter and year-to-date, as well as year-over-year changes in select services such as physician visits, outpatient diagnostic services (including radiology and lab), and outpatient therapeutic procedures (including physical therapy, occupational therapy, speech therapy, home health, and outpatient surgery). We use these reports to review a provider's utilization compared to their peers, assess year-over year regional trends, and identify patterns of service utilization that exceed what would be expected. Our RPM department utilizes *reports from our suite of proprietary advanced analytics models* to flag suspicious trends in provider billing and coding patterns, including overutilization. Our UM nurses look for patterns of overutilization by providers when they review prior authorization requests.

When a provider has been flagged through our data analytics reports as engaging in suspicious billing practices, our SIU monitors that provider through our *pre-payment review process*, which requires the provider to submit medical records to support its bills for certain codes.

Monitoring Provider Underutilization for Fraud

Fraudulent provider underutilization typically occurs in the context where a provider bills a code that covers more than one service, but does not provide all the required services. Examples we have seen in West Virginia include: (1) an Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) provider bills a code that includes both tests and preventive services such as hearing and vision screening, but does not provide the preventive services; (2) a psychiatrist bills a code that includes both medication management and counseling, but does not provide any counseling.

Monitoring fraudulent underutilization by providers usually requires a review of provider medical records to identify that a billed service was not provided. UniCare's QM team performs medical record reviews of select providers, including EPSDT, and behavioral health providers, every three years. The QM team reviews a sample of the provider's medical records for both quality of care and accuracy of billing practices. Medical record reviews are one of the most effective ways in which we monitor for provider fraud involving underutilization. When the QM team finds potential provider fraud, they refer the provider to our SIU.

The responses to our Member Services Verification letters (which we previously discussed in Section PI001) provide an additional source of information for monitoring fraudulent provider underutilization.

Monitoring Member Overutilization for Fraud

In West Virginia, an example of member fraud involving overutilization might include an arrangement where the provider and member collude so that the provider fraudulently bills for services (for example,

home health) or durable medical equipment that the member does not receive, and the provider shares a percentage of the profits with the member. Our monitoring of this type of member fraud occurs at the SIU, which analyzes the FWA referrals they receive (which could include a report from someone who is aware of the member's scheme) in conjunction with our overutilization and other data analytic reports. If the data indicate potential fraud, the SIU conducts an investigation of the member.

- PI012 1 The Vendor should describe its policies and procedures for denying, suspending, nonrenewal, or terminating affiliation with a contracting healthcare professional, including an appeals process, and for reporting serious quality deficiencies to appropriate authorities.

Excluding Health Care Professionals from Our Network and Reporting Serious Quality Deficiencies (PI012)

Our written credentialing policies and procedures specify processes for denying initial credentialing applications and suspending or terminating affiliations with health care professionals whose professional conduct affects or could adversely affect the health and welfare of a member or calls into question the practitioner's capacity or intent to deliver quality care. Unless the disqualification is due to federal exclusion or loss of license, we give the health care professional the opportunity to contest the credentialing determination. When we determine that a health care professional's actions constitute a serious quality deficiency (based on our Internal Potential Quality Issue [IPQI] ranking scale, which is described later in this section), we report the conduct to the appropriate authorities.

Anthem's Policies and Procedures for Excluding Health Care Professionals

During both initial credentialing and recredentialing, our Credentialing team collects, and reviews information to determine whether the health care professional meets Anthem's credentialing standards. They query federal sanctions databases such as the OIG's List of Excluded Individuals/Entities and the System for Award Management to check whether the health care professional has been excluded from

participation in federal health care programs. They search the National Practitioner Data Bank (NPDB) for actions that raise serious concerns about the practitioner's fitness to provide health care services, including, but not limited to, State licensure actions, negative actions by peer review organizations, and health care-related civil judgments. They check State licensing boards, including the West Virginia Board of Medicine's Recent Board Actions report, for disciplinary actions.

Between recredentialing cycles ("off-cycle review"), Credentialing employees conduct ongoing, and frequent monitoring of network health care professional qualifications. In addition to searching the federal exclusion and NPDB databases and the licensing board website on a monthly basis, they review monthly and ad hoc reports from the SIU, Grievances and Appeals (G&A), QM, and other internal departments for information about health care professionals' actions that reflect negatively on their professional conduct and competence and may be grounds for suspension or termination of affiliation. Examples of such information include substandard professional conduct, loss of required medical staff membership, history of professional disciplinary actions, malpractice history, moral turpitude, and involvement in an IPQI.

Automatic Denial of Application and Immediate Termination

If the Credentialing department finds a health care professional's name on the federal exclusion database or learns the health care professional's license has been suspended or revoked, they are required to deny the health care professional's application or, if the health care professional is already in our network, invoke the process for immediate termination of their contract. In addition, if it is determined necessary to protect our members from imminent danger to their health or welfare, the Chair, or Vice-Chair of the Credentials Committee or the Medical Director, after an expedited investigation, and consultation with legal counsel, may terminate a network health care professional effective immediately. The Credentials Committee reviews immediate termination actions at its next meeting.

For-cause Suspensions and Terminations That Are Not Immediate

If the Credentialing department receives information that raises questions about a network health care professional’s professional conduct or competence but does not require immediate termination, they refer the practitioner to the Credentials Committee for a decision. The Credentials Committee investigates and reviews the health care professional’s records. For one or more of the following reasons, the Credentials Committee may issue a “for-cause” suspension or termination:

- Failure of a provider to meet predetermined credentialing criteria related to professional conduct and competence
- Quality of care
- Patient safety and/or professional conduct or competence which could adversely affect the health or welfare of a patient and/or that in the determination of the Credentials Committee, poses some potential risk to the health of our members

Following the Credentials Committee’s recommendation to suspend or terminate for cause, the Credentialing department will notify the health care professional and advise them of the right to appeal the determination. If the health care professional exercises the right to appeal, the following process will occur.

Appeals and Informal Reviews/Reconsiderations

Our network providers have the right to contest our decision to deny an application or suspend, terminate, or not renew a provider agreement as specified in Table 6.11-6.

Table 6.11-6. Opportunities for Informal Reviews/Reconsiderations and Appeals

Disposition	Type of Review
Initial applicants denied network participation	• Informal review/reconsideration • In those limited instances when the refusal of network participation results in Anthem making a unique report to the NPDB, the initial applicant may also pursue a formal appeal
Participating practitioners whose network participation has been terminated by the Credentials Committee for professional	• Informal review/reconsideration • Formal appeal

Disposition	Type of Review
competence and conduct reasons, including an immediate termination imposed due to the Credentials Committee's determination that the practitioner's continued participation poses an imminent risk of harm to our members, or when termination requires a unique report to the NPDB	
Participating practitioners whose network participation has been terminated due to the practitioner's suspension or loss of licensure or criminal conviction	• No review
Participating practitioners whose network participation has been terminated due to sanction, debarment, or exclusion from Medicare or Medicaid	• No review

Informal Review/Reconsideration

Our informal review/reconsideration process, which is conducted by our Credentials Committee, gives health care professionals the opportunity to submit additional information that may lead to a reversal of the suspension or termination decision. At either a regularly scheduled or special review meeting, the Credentials Committee reviews the additional information along with the information obtained during the initial credentialing, recredentialing, or ongoing monitoring process, and the basis for its initial decision. The provider may submit written information, but is not present during the Credentials Committee meeting. The Credentials Committee determines whether to uphold or overturn its initial decision, and the Credentialing department notifies the provider of the decision.

Formal Appeal

A provider who has been suspended or terminated from the network or whose denial for initial participation has been rejected may request a formal appeal hearing in writing within 30 calendar days following the date of receipt of Anthem's notice. If the provider timely requests a hearing, the Medical Director, or designee will select the members of the hearing panel, which will consist of three to seven credentialed practitioners in good standing. At the hearing, which may be in person or by telephone, the provider may call, examine, and cross-examine witnesses, present evidence, and be represented by an

attorney of their choice. The hearing panel will issue a written decision, including a statement of the basis for the decision. The Medical Director reports the decision to the Credentialing department, which is responsible for notifying the provider.

Reinstatement if Anthem's Decision Is Overturned on Review or Appeal

If Anthem's decision to terminate a provider is overturned on review or appeal, then we will reinstate the provider and the provider will not lose any of the protections to which they had been entitled before the termination.

Reporting Final Adverse Actions to BMS

Pursuant to Section 8.1.4 of the SPA, UniCare submits a monthly Suspension and Adverse Enrollment Action Report to BMS that lists every suspension, termination, provider credentialing denial, and nonrenewal for-cause action that we took during the prior calendar month. The report also lists reinstatements of providers that occurred as a result of the reversal of our decision on appeal or reconsideration or following the end of the provider's suspension period. Our Medical Director and legal counsel review the report prior to submission to make sure that it is complete and accurate.

Identifying, Investigating, and Resolving Potential Quality Issues

Anthem identifies, investigates, and resolves health care professional quality issues through its IPQI process. An IPQI is defined as a concern that appears to decrease the likelihood of desired health outcomes and is inconsistent with current professional knowledge. IPQIs include, but are not limited to:

- Any member issue, concern, or allegation involving clinical practice or judgment
- Any delays in planned service at the provider level
- Any patterns of care that are unusual or outside the scope of community practice patterns (especially those that are deemed to be potentially harmful to the member(s))

- Any contractual issues involving clinical practice and judgment

The G&A and QM departments are responsible for identifying, investigating, and resolving IPQIs. Upon receipt of an IPQI in the IPQI Shared Mailbox, a G&A Manager documents the receipt in the electronic medical management system and assigns the case to either a G&A or QM clinical employee to research the case and present their findings to the Medical Director. The Medical Director reviews the case and makes a determination, involving specialty providers, and the Medical Advisory Committee as appropriate. The Medical Director stratifies IPQI incidents into six severity levels (0–5). The six levels are described in Table 6.11-7.

Table 6.11-7. IPQI Severity Level Definitions

Severity Level	Definition
Level 0	Not a quality of care issue
Level 1	- No quality issues substantiated - Care rendered is within the national and community standard of care and behavior for that condition or situation - Case raises mild concern about quality of care - If a pattern of similar episodes is identified, the case would be moved to a higher level
Level 2	- Quality issue — does not impact care outcome - Amount and types of care were inadequate - Care was not provided in a timely manner - Care was not provided in a medically appropriate setting - Failure to comply with accepted ethical and professional standards of behavior (for example, engaging in a pattern of rudeness or lack of respect for others) - Represents part of a pattern of substandard care that is likely to result in future dangers to member or the health plan (for example, repeated instances of poor surgical judgment, which develop into a pattern of poor care)
Level 3	- Clear and significant quality issue — does impact care outcome - Clinical practice clearly falls below national and local standards and expectations (for example, failure to pursue a diagnosis for a mass found on mammogram) - The amount and types of care were inadequate - Care was not provided in a timely manner - Care was not provided in a medically appropriate setting - The issue is clear enough that the Medical Director does not need to consult the Medical Advisory Committee (MAC) before taking action - At the discretion of the Medical Director, issues may be submitted to the MAC or for peer review and additional recommendations - A quality issue has been identified and the peer review will issue a CAP
Level 4	- Complex and significant quality issue - A quality issue has been identified and the peer review will issue a CAP - MAC/peer review will render a decision before action is taken - Issues might be repeated, complex, unclear, ambiguous, or especially serious

Severity Level	Definition
Level 5	d. Situations or cases present complex or ambiguous issues or data (for example, multiple inter-related diagnosis, multiple providers, or a prolonged episode of care) e. The situation or case involves an apparent serious, but not emergent and/or repeated, pattern of substandard care that is likely to result in future danger to members or to the health plan • Emergency quality issue — issue raised is egregious a. Alleged action represents a clear and serious breach of accepted professional standards of care such that continued care of patients by that provider could endanger their safety or health (for example, a surgical event, or situation that indicates loss of judgment or skill) b. Alleged action by provider represents clear and serious breach of accepted ethical behavior (for example, includes an allegation of sexual molestation) c. The situation is of such severity that it warrants immediate, but temporary, suspension of the provider to protect members from dangerous conduct or incompetence, or protect the health plan's reputation or operations

Reporting Serious Quality Deficiencies to the Appropriate Authorities

Our Medical Director (or if the health care professional has been referred to the Credentials Committee, the Credentialing department) reports IPQIs at Severity Levels 4.e and higher to the appropriate authorities. These authorities include BMS, the applicable licensing authority in the State, and outside accreditation agencies as applicable.

PI013	1	The Vendor should describe its policies regarding identification and recoupment of provider overpayments, and processes to coordinate with the Department.
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Identification and Recoupment of Provider Overpayments, and Processes to Coordinate with DHHR (PI013)

Identifying and Recouping Provider Payments

UniCare oversees provider recoveries through tracking databases, regular reporting, and application of a structured recovery process. Our recovery tracking system tracks provider overpayments through the life cycle of the recovery, including validation, provider notification, claim adjustment, and collection. Our pre- and post-payment processes enable us to identify provider overpayments through:

- CPI processes and analysis, including Third Party Liability, coordination of benefits, and data mining that analyzes claims against applicable payment, reimbursement, and benefit policies, and retroactive eligibility changes
- Quality code reviews through claims audits for specific concepts
- Claims quality audits performed on a random sample of West Virginia claims
- SIU investigations

Identified provider overpayments may include a single claim or multiple claims. If a provider is under investigation by the SIU, we place a hold on other overpayment recovery efforts. Regardless of the type of overpayment, we take the following steps:

- Log the overpayment
- Notify the provider in writing of the requested overpayment, including specific instructions, and times
- Wait a minimum of 45 days for the provider to respond to the written request
- Take appropriate action based on the provider's response or lack of response
- Adjust the claim record(s)

If the provider responds with a payment or requests that future payments be offset, details are recorded, and claims records updated accordingly to reflect payment amount changes in encounter filings. If the provider sends us a check, the Recovery, Adjustment, and Collection team applies the refund within 30 days of receipt. If the provider does not respond within the time period, we adjust the claim record(s) in our system to offset future payments to the provider by the overpayment amount. We report all overpayments identified and/or recovered to BMS on our monthly FWA Report.

Regular reports and monthly meetings with BMS enable UniCare to monitor the status of provider overpayment recovery efforts, including prior month and year-to-date dollars recovered and pipeline

information on cases at each phase of the overpayment recovery life cycle. We review providers and associated claims identified for recovery before provider notification. This review step confirms the accuracy of the overpayment and keeps leadership and Provider Services informed.

Our Processes to Coordinate with BMS on Overpayment Recoveries

UniCare is (also) positioned to comply with DHHR's deconfliction/Finders Keepers policy provisions that are incorporated into Section 8.3 of the SPA. That policy was developed by the Finders Keepers Task Force, a group comprising BMS, and the MCOs. The Task Force members worked collaboratively to design deconfliction processes to prevent duplication of BMS and MCO program integrity activities. UniCare reports its program integrity activities in the monthly Fraud, Waste and Abuse report. We understand that BMS may use the reported information to coordinate recovery activities. In addition, when the State informs us that a provider has been added to MFCU's list of providers under investigation, our Program Integrity Lead sends a request to all applicable departments to place a hold on recovery efforts for that provider. In response to this notice, the Anthem Claims Recovery system immediately stops all payment recoupment for the identified claims.

12. INFORMATION MANAGEMENT SYSTEMS

As an experienced partner to the West Virginia Department of Health and Human Resources (DHHR) for the past 17 years, we have the systems, processes, and staffing necessary to fully comply with all West Virginia Mountain Health Trust (MHT) program requirements, State administrative rules, and statutes, capitalizing on specialized systems and supports of our ultimate parent company, Anthem, Inc. (Anthem).



Our Management Information System (MIS) is managed internally through combined health plan accountability and support from Anthem. Anthem's Technology Services team is experienced in managed health care technology and committed to delivering real solutions to DHHR and our affiliates' state partners. Built on a managed Medicaid model with a design and configuration that is based on Anthem's experience supporting managed care programs, our MIS is highly configurable and scalable, and has been customized for West Virginia Medicaid program requirements.

- IM001 1 The Vendor should describe its written policies and procedures for safeguarding and maintaining the confidentiality of data, including differences for adult and children populations.

Safeguarding Data Confidentiality (IM001)

Our first priority is always to protect the privacy of all West Virginia Medicaid members, including Protected Health Information (PHI) and Personally Identifiable Information (PII). UniCare affirms we maintain HIPAA-compliant operating procedures for all aspects of our contracted services in accordance with Service Provider Agreement (SPA) requirements and HIPAA. Leveraging the resources of Anthem, we have established processes, systems, and policies, and procedures to protect the privacy of all health, medical, enrollment, financial, and any other personal identifiable information. Our established HIPAA-compliant systems, policies, and processes fully meet federal, State, and DHHR requirements, including appropriate safeguards for paper and electronic PHI.

Our privacy policies and procedures define appropriate access, use, and disclosure of PHI, and PII and include those listed in Table 6.12-1.

Table 6.12-1. UniCare Privacy Policies and Procedures

Policy/Procedure Title	Brief Description
Administrative Requirements	
Clean Desk Policy	Establishes diligent security measures to safeguard both paper and electronic forms of PHI and other confidential information.
Personal Information (Including Social Security Number) Privacy Protection Policy	Establishes provisions to protect the confidentiality of personal information, including social security numbers obtained from members and employees.
Workforce Training	Requires the provision of role-based training on privacy policies and procedures to all workforce members.
Collection and Use of Protected Health Information	
Protected Health Information Access Classification Policy	Expands the classification of the term “employee” to apply to employees as well as temporary employees and contractors who have access to PHI as part of their work performed for our organization.
Collection of Protected Health Information Policy and Procedure	Provides guidance on collecting the minimum amount of PHI as required and approved for their specific job function.
Data Use Agreement Form	Agreement form regarding use of a limited data set to be used between our organization and data recipient.
Confidentiality Agreements (Clinical Review Form, Tours Form)	Limited use/non-disclosure agreement that is used for noted recipients when exposed to confidential/proprietary information.
Disclosure of Protected Health Information	
Address Change Policy	Establishes rules on who is allowed to change a member’s address.
Deceased Member Disclosures Policy	In compliance with the HIPAA Privacy Rule, establishes that deceased members have the same privacy rights and protections as living members.
Disclosure of Protected Health Information Outside of Organization Policy	Establishes the circumstances for which disclosure of PHI is permitted outside our organization.
Disclosure When the Individual Is or Is Not Available Policy	Establishes rules for authorized employees to follow when disclosing PHI to a member’s authorized personal representative.
Disclosures to Agents, Brokers, and Producers Policy	Establishes appropriate steps to be taken by employees prior to the disclosure of PHI to verify the identity and authority of individuals and entities requesting PHI.
Disclosures to State Medicaid Agencies Policy	Defines appropriate disclosure of PHI to state Medicaid agencies.
Disclosures to Veterans Health Administration Policy	Defines appropriate disclosure of PHI to Veterans Health Administration agencies.
Disclosure with Authorization Policy	Establishes rules for disclosing PHI pursuant to the terms of an authorization.
Group Health Plan and Employer Disclosure Policy	Provides guidance on providing information to fully-insured and self-insured group health plans.
House Account Data Protection Policy	Establishes limits on access, use, and disclosure of house account data based on what is necessary to perform job function, excluding access, or use for personal reasons.
Independent Physicians Association/Physician Hospital Organization Disclosure Policy	Establishes rules for disclosure of PHI related to treatment, payment, and health care operations between our organization and specified providers.

Policy/Procedure Title	Brief Description
Limited Data Set Disclosures (No Authorization Required) Policy	Provides guidance on the disclosure of PHI created as part of a limited data set.
Media Disclosure Policy	Establishes which business functions are authorized to disclose PHI to the news media, and what information can be disclosed under specified circumstances.
Mitigation Policy	Establishes organizational requirement to take necessary steps to mitigate any known harmful effect of an unauthorized use or disclosure of PHI.
Presentations, Demonstrations, and Tours Policy	Requires written approval be obtained from an individual prior to sharing their PHI with external parties during a presentation, demonstration, or tour.
Privacy and Security Disclosure Reporting Policy	Requires employees to report any unintended/non-permitted disclosure of member PHI via the Privacy and Security Disclosure report eForm.
Quality Control Disclosure for PHI Policy	Establishes guidelines to be followed when disclosing PHI.
Social Security Number Limitation Policy	In compliance with HIPAA Privacy requirements and other federal regulations, establishes rules to guard the confidentiality of member PHI, which includes social security numbers.
Specialized/Non-Routine Disclosures (No Authorization Required) Policy	Establishes guidelines for disclosing the minimum amount of PHI necessary for specialized activities without individual authorization.
Averting Serious Threat to Safety Disclosure Procedure	Provides guidance for disclosing PHI without authorization to avert a serious threat to safety.
Coroners, Medical Examiners & Funeral Directors Disclosure Procedure	Provides guidance for disclosing PHI without authorization to coroners, medical examiners, and funeral directors.
Disaster Relief Efforts Disclosure Procedure	Provides guidance for disclosing PHI to a public or privacy entity authorized by law or its charter to aid in disaster relief efforts.
Health Oversight Release Disclosure Procedure	Provides guidance for disclosing PHI to a Health Oversight Agency for oversight activities without the authorization of the individual.
Judicial and Administrative Disclosure Procedure	Provides guidance for disclosing PHI without authorization to respond to court or administrative orders and other discovery requests.
Law Enforcement Release Disclosure Procedure	Provides guidance for disclosing PHI without authorization for law enforcement purposes to a law enforcement official.
Public Health Activities Disclosure Procedure	Provides guidance for disclosing PHI without authorization for public health activities.
Required By Law Disclosure Procedure	Provides guidance for disclosing PHI without authorization to the extent that the disclosure is required by law.
Research Disclosure Procedure	Provides guidance for disclosing PHI without authorization for research.
Specialized Government Functions Disclosure Procedure	Provides guidance for disclosing PHI without authorization for certain government programs providing public benefits, to correctional institutions, and for other law enforcement custodial situations, for military activities, national security, and intelligence activities or protected services for the President and others.
Victims of Abuse, Neglect, or Domestic Violence Disclosure Procedure	Provides guidance for disclosing PHI without authorization about an individual whom it reasonably believes to be a victim of abuse, neglect, or domestic violence.
Workers' Compensation: Disclosure Procedure	Provides guidance for disclosing PHI without authorization to meet Workers' Compensation disclosure requirements.
Summary Health Information Disclosures (No Authorization Required) Policy	Provides guidance for disclosing summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information.
Treatment, Payment, Health Care Operations Disclosures Policy	Establishes for the disclosure of PHI used for treatment, payment, and health care operations (TPO) (no authorization required).

Policy/Procedure Title	Brief Description
Content of the Notice of Privacy Practices Policy	Outlines the content of our organization's Health Plan Notice of Privacy Practices.
Right of Access to Inspect/Copy Protected Health Information Policy	Establishes a member's right of access to inspect and obtain a copy of their PHI in a designated record set.
Right to File Privacy Complaints Policy	Establishes a member's right to file privacy complaints to our organization and to the Secretary of the Department of Health and Human Services concerning our organization's privacy policies/procedures.
Right to Receive the Notice of Privacy Practices Policy	Establishes a member's right to receive a Notice of Privacy Practices from our organization, which describes uses, and disclosures of PHI.
Right to Request an Accounting of Disclosures of Protected Health Information Policy	Establishes a member's right to request an accounting of specialized/non-routine disclosures of PHI by our organization and its Business Associates made on or after April 14, 2003, if disclosure is not for TPO disclosures.
Right to Request an Amendment of Protected Health Information Policy	Establishes member's right to request an amendment to their PHI in a designated record set.
Right to Request Confidential Protected Health Information Policy	Establishes a member's (or their personal representative's) right to request that our organization send communication of PHI by alternative means or to an alternate location if the disclosure of all or part of that communication could endanger the member.
Right to Request Restrictions Policy	Establishes a member's right to request that our organization restrict certain information.
Who Is Authorized To Request an Individual Right Policy	Defines who is allowed to request an individual's PHI information.
Corporate Individual Rights System (CIRS)	Establishes a CIRS to record and support HIPAA Privacy Individual rights and disclosures.
Sensitive Services	
Psychotherapy Notes	Provides guidance on the request, use, and disclosure of psychotherapy notes.
Sensitive Services and Substance Use Disorder Policy and Procedure	Provides guidance around the use and disclosure of sensitive services.

Managing Appropriate Disclosure of PHI and PII

To facilitate appropriate disclosure of PHI and PII in accordance with both HIPAA and HITECH privacy regulations, we provide all employees who interact with members and providers with HIPAA and privacy training, as well as a quick reference guide and an online decision-making tool. Our HIPAA Verification and Disclosure Guide provides pop-up guidance on what information may or may not be disclosed based on member information, the party making the request (for example, parent or guardian), and the requested information (including non-PHI or PII information). This tool also logs requests and the information provided during the interaction. For example, when responding to a call about a West

Virginia Medicaid member, we would first request, and verify the member's first and last name, date of birth, and Medicaid Assistance Identification number.

Disclosure Differences for Adult and Child Populations

This tool is especially helpful in clarifying different rules that apply for children and adult populations (in particular, rules for personal representatives, including parents, and legal guardians). Unless parental rights have been terminated, parents are presumed to be the personal representative of their minor children. For adults, a personal representative may be specifically identified by the member, or personal representative status can be inferred through assigned health care power of attorney. Personal representatives have the same rights as covered individuals with respect to disclosure of PHI unless one of the following exceptions applies:

- The personal representative's authority has been limited
- The information requested is considered sensitive
- State law grants a minor special rights, or confidential communication has been invoked
- Parental rights have been terminated

IM002 1 The Vendor should provide its plan for how it will maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department.

Maintaining HIPAA Compliance (IM002)

UniCare has a responsibility to our members, providers, and DHHR to meet HIPAA, federal, and State enterprise information security policies, standards, security initiatives, regulations, and requirements relating to the protection of electronic PHI, including Title XIX of the Social Security Act and 45 CFR 162 and 164, specifically administrative procedures and safeguards (45 CFR 164.308), physical safeguards (45 CFR 164.310), and technical safeguards (45 CFR 164.312). Our organization maintains the systems, processes, tools, and strict security policies, and procedures to secure and protect all West

Virginia Medicaid data, assuring the privacy of our members and providers. We will continue to do so throughout the life of the SPA at no additional cost to DHHR.

We recognize the complexity of data-sharing for Medicaid managed care and will continue to adhere to guidance the State provides regarding the sharing of information. Technology Services has proven expertise in laws and regulations governing data exchange and protected health care information, privacy, and confidentiality, including HIPAA regulations, 42 CFR Part 2, and the HITECH Act.

Our Approach to Privacy and Security

In compliance with the HIPAA Security Rule, our approach to privacy and data security includes:

- Administrative procedures and safeguards in accordance with 45 CFR 164.308
- Physical safeguards in accordance with 45 CFR 164.310
- Technical safeguards in accordance with 45 CFR 164.312

Administrative Procedures and Safeguards

We understand the sensitive nature of the information we collect and store to conduct our business and the importance of securing it to protect the privacy of our members and providers. We leverage our ultimate parent organization's extensive experience maintaining security measures to protect electronic health information in compliance with federal Medicaid managed care rules, including measures regarding the following:

- Security management
- Assigned security responsibility
- Workforce security and information access management
- Security awareness and training
- Security incident procedures
- Business Associate Agreements (BAAs)

Security Management

Security management forms the foundation upon which our organization's security activities are built. Technology Services has established policies and procedures to safeguard our information and systems. Our parent organization's security program is documented in a comprehensive Workforce Information Security Program (WISP) document. The overall objective of the WISP is to establish effective enterprise-wide policies, standards, procedures, guidelines, and strategies that address the security of our organization's computer resources, infrastructure, data, and information assets, regardless of the party responsible for use or management, the physical location, or the medium in which such information assets reside (for example, electronic, digital, paper, etc.). The WISP is based in part on organizational risk assessment processes and reflects the application of relevant information technology (IT) controls, including those listed in Table 6.12-2. WISP is reviewed at least annually, or as new vulnerabilities and threats become known, and new business, technology, and regulatory requirements are identified.

Table 6.12-2. Workforce Information Security Program Components

WISP Components
Regulatory Requirements
Controls that allow us to adhere to applicable federal (such as HIPAA and HITECH) and State regulations, international law, legal requirements, and best practices.
Industry Framework Standards
Compliance with industry standards and certifications, including Common Security Framework for HITRUST.
Information Security Policies and Standards
- Basic protection requirements for all stored information and data, and the requirements that must be followed by anyone who uses a computer system, software program, or other enterprise information assets. - Internal publication of policies, programs, standards, procedures, and guidelines that address the technical implementation, control, management, auditing, and administration of computer security and information asset protection. - Requirements for the physical protection of our organization's technology infrastructure. - An information security awareness program to assist in the education of all employees and help reduce levels of risk associated with electronic data processing and computer system usage. - An information security administration function responsible for coordinating and administering requests for user access to computer systems and data resources, removing access to these resources when no longer required, and performing routine audits to validate that security protection mechanisms are functioning properly. - A security risk management function to assess, manage, and communicate risks to enterprise assets and the actions to be taken to mitigate these risks. - Mechanisms to monitor, analyze, and report on the effectiveness of WISP. - Maintenance of liaison relationships with internal and external organizations and departments.

Risk Analysis and Risk Management

Technology Services performs various risk assessment activities using both internal and third-party services, penetration tests, and vulnerability scanning to maintain a strong and stable security posture that aligns with industry standards and regulations. Our MIS has achieved and maintained Common Security Framework (CSF) Certified status from the HITRUST, most recently in August 2018. The CSF is an overarching security framework that incorporates and leverages existing security requirements placed upon health care organizations, including those from federal (such as HIPAA and HITECH), State, third-party (such as Control Objectives for Information and Related Technology [COBIT]), and other government agencies (such as CMS and National Institute of Standards and Technology [NIST]). To successfully maintain our certification, an independent third-party services firm evaluated our MIS and its ability to meet 314 unique Baseline Security Control Statements across 19 domains, including network protection, password management, and data protection, and privacy.

Sanction Policy

Workforce controls assure appropriate security processes are in place for the selection, employment, and termination of workforce members. This includes the screening of potential workforce members and sanctions for failure to comply with established information security policies.

Information System Activity Review

Allocation and use of privileged accounts is restricted, controlled, tracked, and monitored, especially over privileged access rights that allow users to override system controls. A privileged account is provided to an end-user who is authorized to perform critical system privileged relevant functions that ordinary users are not authorized to perform. These privileged functions include the capability to override system, security, and audit controls, and the ability to perform server administration, security administration, database administration, system control, or technology management type functions.

Authorizations for special privileged access rights are reviewed during quarterly system access validations. Privileged operations are logged and monitored. Our security policy requires protection of audit records for any privileged accounts and functions. Privileged accounts must be vaulted to enable checkout when needed to perform privileged functions. Passwords for privileged accounts must be changed at least once every 60 days, and standard service accounts at least once every 180 days.

Assigned Security Responsibility

The Anthem Chief Information Security Officer (CISO) is responsible for managing the WISP program and developing, implementing, and enforcing the program's policy statements across the enterprise. The CISO will provide periodic reports regarding the status of the program and the overall state of corporate security to the CEO, Information Technology Director, Senior Leadership team, Executive Leadership team, and Anthem Board of Directors as may be necessary or appropriate. The CISO and all Information Security staff are committed to continuous review, improvement, and maturation of the WISP.

We comply with the HIPAA Privacy Rule, including designation of Privacy, and Security Officers through our national Privacy and Information Security Offices. In addition, we have a Medicaid-specific Privacy Officer and a Member Privacy Unit that focus on fulfilling members' privacy rights requests, investigating and resolving privacy incidents, and maintaining Medicaid privacy procedures. Our Member Privacy Unit consists of a Chief Privacy Officer and several analysts who:

- Maintain HIPAA privacy policies and procedures
- Develop HIPAA privacy training
- Review and fulfill member privacy rights requests
- Investigate and resolve privacy incidents
- Provide breach notifications

UniCare maintains a strong local program led by our West Virginia Compliance team to promote awareness of employees' obligations to keep member information confidential. Compliance is an essential part of our culture. As such, we educate our employees, and monitor their adherence to policies and federal and State regulations.

Workforce Security and Information Access Management

We apply the least privilege access rule in accordance with assigned administrative roles and their levels of responsibilities. Privileged accounts may only be used for actions requiring privileged access rights and must be authorized, and assignment is role-based where applicable using the privileged account registration and de-registration process. Any usage of non-role-based privileged accounts requires approval. Our security policies require that the built-in administrative accounts shipped with operating systems, databases, network, and storage devices shall either be disabled or the credential vaulted and regularly rotated, and that default passwords be changed. Unique user IDs are assigned to privileged account owners for identification and auditability and will be different from their normal user ID.

Security Awareness and Training

A reliable and adaptable infrastructure supports continuous compliance with security requirements, including the development, and adoption of policies and procedures. All staff receive initial training on security and HIPAA compliance, and annually thereafter. We disseminate updates and amendments to the policy resulting from changes in State or federal requirements or as requested throughout the life of the SPA during regularly scheduled staff meetings or as email alerts.

In addition, all staff must complete compliance training upon hire and then annually. This mandatory training includes HIPAA privacy and security requirements as well as information about identifying fraud, waste, and abuse (FWA). Figure 6.12-1 provides an example of the frequent PHI disclosure reminders we use throughout the year.

Security Incident Procedures

Our organization maintains an Information Security Incident Response Plan designed to manage, communicate, conduct, and coordinate all incident response and investigations regarding IT or those related to the use or misuse of enterprise computer systems, applications, data, or resources for UniCare, Anthem, and our affiliates. This program encompasses three core phases: investigations of incidents, incident response planning, and incident notification, and reporting.

For all security incidents, our focus is on timely reporting of the incident, containing the incident, and cooperating in the ensuing investigation and resolution of the incident. A security incident may be discovered through audit or reporting. Any UniCare employee who makes or learns of the actual disclosure of PHI to an unintended recipient must immediately report the incident to the Privacy department through the Compliance Officer. The Compliance Officer will submit a privacy report to the Detection, Analysis, and Response team for review. For security incidents identified via systemic means (for example, through the use of intrusion detection systems), Technology Services will follow the incident response procedure, including notifying the IT security officer.

Figure 6.12-1. Screen Savers Are an Excellent Way to Reinforce Key Security Concepts



Business Associate Agreements

As an additional undertaking, we review agreements with all Business Associates to verify, as part of the terms of the agreement, that the Business Associates will encrypt electronic data accordingly and maintain the confidentiality, integrity, and availability of the data within the HIPAA Security Rules. This means electronic coding and transmission of health care data subject to 42 CFR Part 2 is also subject to IT security standards that include encryption of the data and communications to third parties of the encryption requirement.

Physical Safeguards

To control physical access to data and systems, UniCare, and Anthem have established safeguards for the security of our facilities, employees, and assets. Anthem's national Security team administers access control features and functions at every facility, including:

- **Proximity-based electronic security badges that control access to buildings or zones based on specific personnel access needs.** All employees and visitors must complete a security access request form and obtain approval signatures for unsupervised access. Access levels and authorized access times are determined for each employee by the individual's manager in accordance with their work needs. After-hours access requires use of specially coded security badges.
- **Limited data center access for employees responsible for network engineering, system administration, and network security.** All servers and data storage devices located within secure areas can only be accessed with electronic lock/Personal Information Number (PIN) access.
- **Facility access is recorded.** Details are collected every time an electronic badge is used to access a building zone. Access is also monitored and recorded with closed-circuit television (CCTV) equipment.

Technical Safeguards

Technical safeguards are becoming increasingly more important due to technology advancements in the health care industry. As technology improves, new security challenges emerge. We take the challenge of protecting PHI from internal and external risks very seriously and have established comprehensive policies and procedures to safeguard our information and systems. Audit and accountability programs establish a risk-based process to identify potential security risks and determine corrective actions as necessary.

System Access

Access to workstations or systems requires a unique user identifier and password (complex and changed at regular intervals). Remote system access requires two-factor authentication that verifies the identity of the individual using “something they know” (user identifier and password) with “something they have” (such as a key card or token). Access to privileged administrator accounts requires complex, three-factor authentication.

Role-based security limits update capabilities and access to application functionality and PHI. Users with inquiry-only privileges are unable to modify or update information. These different security functions enable us to provide users with multiple levels of privileges. Our care management system member dashboard logs all views of member clinical data.

Network security is managed and monitored using a number of technologies and security management systems that provide 24/7 real-time security event monitoring and reporting capabilities. A vulnerability management program executes processes that identify vulnerabilities, reports them for remediation, and tracks, and reports remediation efforts. In addition, an independent third-party performs an annual external penetration test. Twice each year, managers receive requests to review and affirm employees’ need for continued access to specific systems and databases and the level of access required.

Data Encryption

We use encrypted file transfer protocols to secure PHI exchanged both internally and externally. In compliance with 42 CFR Part 2, we have established protocols to protect the confidentiality of all member data, encrypting data at rest, and data in motion.

Data at Rest. All data in our enrollment and claims processing system are secured at rest via encrypted disk storage. Of all other surrounding applications and databases, 70% are currently encrypted and the remaining 30% are scheduled to be moved to encrypted storage media by the second quarter of 2020.

Data in Motion. All data in our enrollment and claims processing system are secured in motion through a secure cryptosystem, which is part of Oracle's Advanced Security Option and uses the AES256 algorithm. Of the surrounding SQL databases, 80% are currently encrypted in motion using TLS1.2 protocol and owned security certificates as per our organization's security standards. In motion data processes for the remaining 20% are scheduled to be encrypted by the end of the second quarter of 2020.

Security Monitoring, Cyber Testing, and Forensic Investigation

Our Technology Services team has invested significant time and resources into our information security workforce, technology, and facilities to create an industry-leading cybersecurity program featuring the following:

- The Detection Analysis and Response Team (DART)
- A Cyber Security Operations Center
- A Cyber Security Testing Center
- In-house Digital Forensics Operations

Watching for Threats 24/7/365

DART is committed to actively safeguarding member and provider information day and night, holidays, and weekends. Dedicated security monitoring uses sophisticated tools to detect and respond to

cybersecurity events, managing cyber threat collection, and dissemination. DART operates out of a cutting-edge Cyber Security Operations Center specifically designed to effectively and efficiently communicate about, collaborate on, and respond to cybersecurity efforts.

Focused on Continuous Improvement

The Cyber Security Testing Center offers innovative capabilities for evaluating security of our website and mobile solutions by internal and external customers. It provides dedicated assets in a secured environment for audits, compliance assessments, regulatory reviews, and third-party testing.

Gathering and Providing Evidence to the Authorities

The Computer Forensics Investigation team and secure in-house Digital Forensics Operations and lab meet federal standards. Forensic investigators use cutting-edge tools to analyze our IT systems. The team examines digital media to identify, preserve, and recover data, analyze evidence, and present findings to the appropriate individuals. In addition to providing critical findings for internal investigations, the team has provided crucial evidence to local, State, and federal law enforcement authorities.

- | | | |
|-------|---|--|
| IM003 | 1 | The Vendor should describe its policies to ensure that its staff, contracted providers, and all subcontractors that provide cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation maintain the confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI). |
|-------|---|--|

Protecting the Confidentiality of Personally Identifiable Information and Protected Health Information (IM003)

We will continue to make sure member medical records and health enrollment information containing PII are used and disclosed in accordance with HIPAA Privacy Rule requirements. We comply with all other applicable State and federal privacy and confidentiality requirements, including 42 CFR Part 2.

We maintain processes and protocols to support each member's individual rights for:

- **Access.** The right to access, inspect, and obtain a copy of their PHI
- **Amendment.** The right to amend or correct their PHI
- **Complaints.** The right to voice a complaint about our privacy policies and procedures
- **Confidential Communications.** The right to receive their PHI by alternate means or to an alternate address or location
- **Notice of Privacy Practices.** The right to be notified about the information we will collect, how it will be used, and how it will be shared
- **Restrictions.** The right to request restrictions on the use and disclosure of PHI
- **Accounting of Disclosures.** The right to request an accounting of certain specialized disclosures that are not made for the purposes of treatment, payment, or health care operations

Our privacy program supports ongoing compliance, including the development, and adoption of policies and procedures, provider contract language, provider educational materials, execution of BAAs, and annual training of all employees. Our privacy policies govern our practices with regard to PII and PHI. Policies include specific guidelines for when and how member information may be used, disclosed, or accessed. They detail mechanisms to safeguard, retain, and destroy PHI, requirements for employee training, and employee sanctions. We only use and disclose member PHI as permitted or required by law for activities relating to provider treatment, payment, or health care operations. For example, our Enrollee (Member) Call Center, Provider Phone Line, and our 24/7 Nurse Line use a workflow management system that enforces the rules pertaining to PHI, collects required information, and routes requests for appropriate approval and tracking. We also take additional precautions to protect member privacy and reduce the chance of accidental disclosure of health information by verifying all fax numbers and addresses are correct and making sure PHI is not visible on the cover page.

Contracted Providers

Our Network Relations team performs facility site reviews as part of the provider credentialing and recredentialing process for all PCPs, OB/GYNs, and high-volume specialists, including psychiatrists.

These reviews verify medical record keeping practices, including both locked paper records and secure computer systems, comply with HIPAA privacy practices. The reviewer will also check how sound carries from within exam rooms and other places where private discussions are held, requiring providers implement sound buffering or white noise where needed.

Privacy and Security Training for Employees

Employees are trained on HIPAA privacy rights and reminders are posted in key areas in the workplace, including computer screen savers as shown in Figure 6.12-2. Our Compliance team monitors privacy and security with support from the Member Privacy Unit.

We do quarterly HIPAA audits to verify employees lock up passwords, documents, and computers appropriately; shred applicable

documents with PHI; and protect member PHI around the office and on copy and fax machines. We have an established reporting process for potential privacy incidents. We train our helpline employees to verify the identity of all callers using a combination of first and last name, date of birth, and identification number prior to disclosing any information.

This process uses a specialized workflow management system. Call logs record all caller activity and are a permanent part of member records.

Figure 6.12-2. Frequent Use of Privacy Reminders Facilitates Compliance



Provider Contracts and Business Associate Agreements

UniCare's provider contracts include specific language regarding member privacy and the handling of confidential information. Providers must treat all information obtained through the performance of their contracted services as confidential information to the extent required under State and federal laws, rules, and regulations. Providers can only use information obtained as necessary to the proper discharge of their obligations. Provider roles and responsibilities outlined in the provider manual also inform providers of medical record standards to assure effective and confidential member care.

In addition to our contracted provider network, UniCare and Anthem also contract with a number of subcontractors to perform HIPAA covered functions on our behalf, including the following functions:

- Administrative services
- Clinical chart reviews
- Claims adjudication and processing
- Management of dental benefits
- Utilization management
- Paper claims keying and claims data capture
- Management of medical injectables
- Management of vision benefits

To maintain the confidentiality of PII and PHI, we require the execution of a BAA prior to the disclosure or exchange of any PII or PHI with any subcontractor, or other external entity involved in health care services, administrative, operational or review functions, including claims processing, utilization management (UM), coordination of benefits, or subrogation. We also provide subcontractors with the minimum necessary information needed to support their function.

All Business Associates, including subcontractors, are permitted to use or disclose PII or PHI it receives from our organization only to perform specified functions and activities on UniCare's behalf, as set forth in the BAA and for the management and administration of the Business Associate's operations or to carry out Business Associate legal responsibilities.

Subcontractor Oversight

We maintain a Subcontractor Oversight program that begins our association with each subcontractor with a thorough, rigorous evaluation process to confirm they meet operational, financial, legal, compliance, regulatory, accreditation, NCQA, and ethical standards. During our pre-delegation audit, we examine items such as the organization's HIPAA privacy and security compliance, grievance and appeals history, and operating procedures. We audit our subcontractors for their comprehension of these items and their ability to train providers on such items. We offer guidance and instruction for our subcontractors on topics such as UniCare policies and procedures; HIPAA compliance; and FWA avoidance and prevention.

Our agreements with vendors who access, process, communicate, or manage confidential information or information assets for our organization include information security control requirements that align with our internal security policies and procedures. We maintain a comprehensive assessment process to monitor compliance of key Business Associates in accordance with the WISP, privacy policies, and other governing documents on an ongoing basis. We have also developed policies for managing the security of external network connections between UniCare/Anthem and its vendors.

We do not permit the hosting or storing of PII or PHI offshore, and we require vendors who access PII or PHI from offshore locations to comply with technical controls to prevent the PII and PHI from being moved to offshore locations and physical controls for offshore facilities. Remote access by vendors and business partners to our computer networks requires multifactor authentication.

- IM004 1 The Vendor should describe how its health information system collects, integrates, analyzes, and reports data necessary to implement and maintain its Quality Assessment and Performance Improvement (QAPI) Program.

Integrating Data Necessary to Support UniCare's Quality Assessment and Performance Improvement Program (IM004)

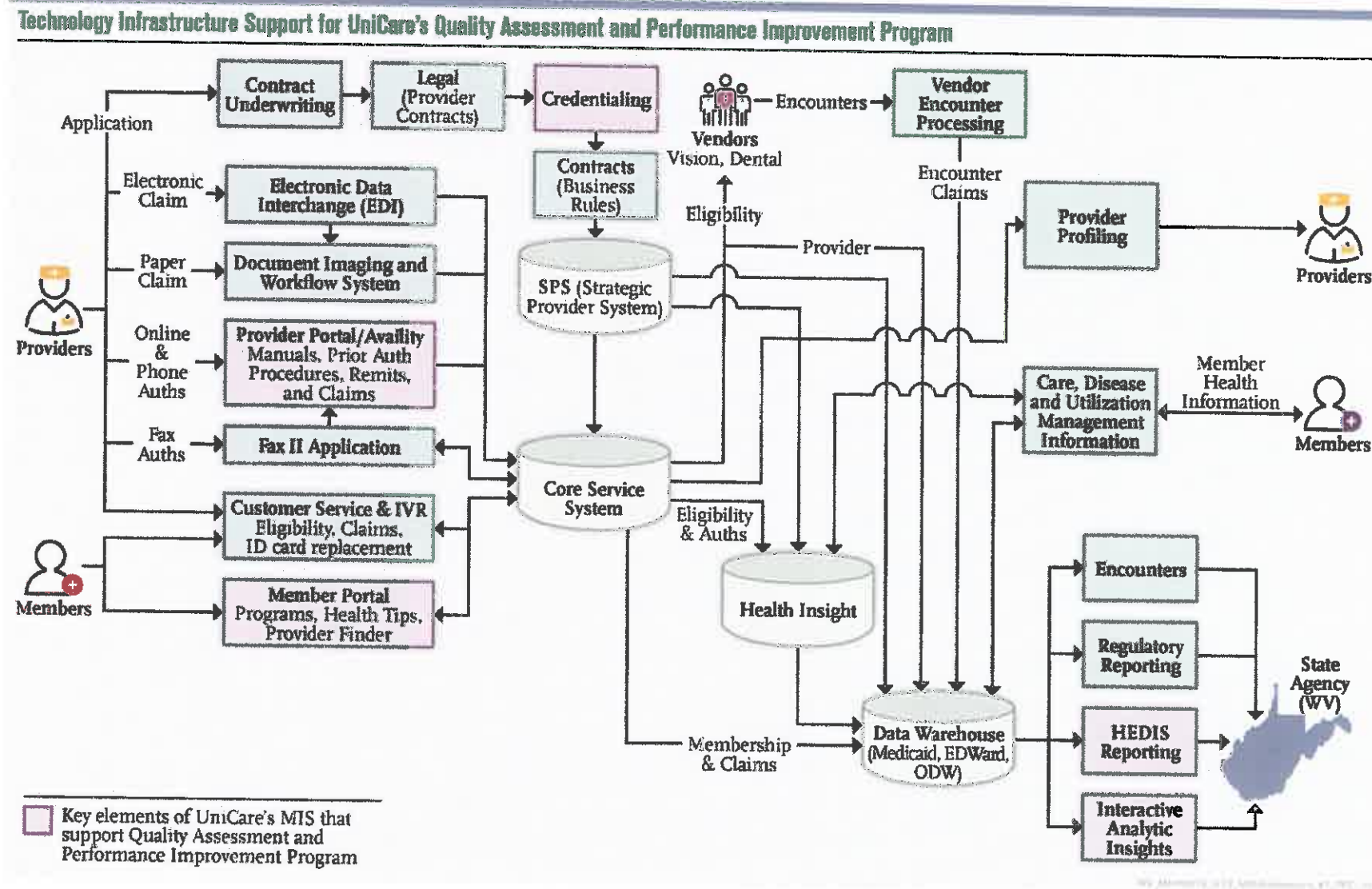


UniCare's data-driven Quality Assessment and Performance Improvement (QAPI) program capitalizes on a technology infrastructure that supports capture and evaluation of performance measurement data across all functional areas. This technology foundation enables us to enhance performance by monitoring quality, cost, and utilization trends across our membership. The tools in our MIS facilitate quick identification of negative performance trends so we can address them early. *We systematically and objectively collect, integrate, and measure access to care, demand for services, and quality of care to improve member outcomes.*

UniCare's Innovative Health Information System

Data collection, analysis, and reporting form the backbone of UniCare's comprehensive approach to quality management and improvement. Our MIS has been customized to meet all MHT QAPI requirements. We use our sophisticated quality infrastructure to systematically and objectively measure access to care, demand for services, and quality of care. Figure 6.12-3 illustrates the components of our MIS that are directly involved in collecting, integrating, analyzing, and reporting the data necessary to implement and maintain our QAPI program. These components are highlighted in purple and are further described in the narrative that follows.

Figure 6.12-3. Health Information System Support for QAPI Requirements



Data Collection, Integration, Analytics, and Informatics Capabilities

Inputs to UniCare's Core Services System and Health Insight Platform

We consume data in multiple forms and from multiple sources, processing, and storing each one through specific protocols. One of the important functions for quality management is the ability to communicate to providers through the *provider website*, and with members through the *member website*. On the provider portal, we take in provider data through the application and contracting process to support *credentialing* and recredentialing. This data, along with other inputs, flow to our Core Services System, Health Insight, and ultimately, our data warehouse. On the member website, we offer health education, benefit information, enrollment in Healthy Rewards member incentives, and our Find a Doctor tool.

Inputs and Outputs of Health Insight

Health Insight is our information platform that shares and aggregates actionable data across systems and organizations, promoting effective, efficient, and collaborative care management. Health Insight includes available data from UniCare's care management, utilization management, and claims processing systems, and connects the entire community of stakeholders. We currently send enrollment data to the West Virginia Health Information Network and our platform is fully capable of integrating with available Health Information Exchanges. Health Insight aggregates and shares actionable data across systems and organizations. Most data are updated in real-time (as it is received) or within 24 hours for information that requires manual uploading. The Health Insight platform includes available data from UniCare's care management, utilization management, and claims processing systems.

For providers, Health Insight presents a single health record that provides a complete picture of the member's medical history. This is especially vital during care transitions and when coordinating care across different disciplines. Health Insight includes a HIPAA-compliant website that facilitates provider



access to a single view of member data in an easy-to-navigate dashboard that includes member demographic information, HEDIS® and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) care alerts, authorizations, prescriptions, and claims for previous services. It enables sharing of member care management information, including screenings, assessments, and the person-centered treatment plan (care plan). A longitudinal health and service record that travels with members over time can improve communication, avoid redundant assessment processes, and reduce service duplication, and fragmentation. These member-facing and provider-facing tools support improved quality outcomes.

Inputs and Outputs of the Data Warehouse

We use our *integrated data warehouse* to support our operational processes, analytics, and reporting, and receive data directly from the system of record to promote data quality, control, and consistency. Our data warehouse comprises a comprehensive source of information about our members and includes encounter data for medical, behavioral health, pharmacy, and vision services as well as lab results and immunizations. The data warehouse supports access to member health data through our member dashboard. We apply advanced data analytics, including predictive modeling, to identify members for *care management* and *disease management*. Integrated information about member eligibility, utilization history, and provider attribution from the data warehouse flows through our HEDIS engine to produce *provider profiles* on quality performance. We distribute these profiles to our network to spur continuous improvement. The data warehouse also supports operational, management, regulatory, and ad hoc reporting.



HEDIS Engine Supplemental Application

Information flows from the data warehouse to our NCQA-certified HEDIS engine to facilitate *HEDIS*,

CMS Child and Adult Core Set, and State-specific measure reporting. Our Quality Management (QM) team tracks and trends our HEDIS and other measures through bi-weekly, monthly, quarterly, and annual reports to multiple departments and quality committees. With this data, we can readily identify opportunities for performance improvement, assess the impact of interventions, and monitor our performance relative to DHHR performance measures. Our reports include a listing of members who are in need of specific services measured by HEDIS, providing a resource that informs member and provider outreach.

Interactive Analytic Insights Platform

Fed by the data warehouse and the HEDIS engine, our *Interactive Analytic Insights* tool provides comprehensive information about QM programs and health plan quality performance. Data that is integrated and analyzed within the tool includes:

- Health plan performance by HEDIS measure against NCQA benchmarks (trended over time)
- Demographic data describing population distribution(s)
- Data about programs implemented to improve HEDIS rates and program effectiveness evaluations
- County-level social determinants of health (SDOH) risks

The tool's analytics capabilities allow our Quality team to drill down to very specific geographic detail by zooming in on particular areas. Our team can also select from a variety of HEDIS measures and examine variables of interest to our health plan and the State such as member age, gender, race, and ethnicity. Based on identified gaps in care, we are able to create 'heat maps' that display concentrated gaps within identified ZIP codes so we can direct attention to areas most in need.

QAPI Reporting

To consistently produce QAPI reports and data, our report generation environment integrates subject matter experts who understand the content and meaning of reports, IT experts who maintain and manage our systems, and analysts who know how to retrieve, associate, and process data to produce accurate,

timely reports, and validate the data is meaningful and actionable. The MIS underpins this integration to improve accuracy, timeliness, and usefulness.

- IM005 1 The Vendor should describe the flexibility of its health information system and processes utilized to develop requirements, configure, and test system changes as per new or modified contract requirements.

Managing System Changes and Enhancements (IM005)

Our Core Services System provides a high degree of automation and data capture with interfaces that optimize information exchanges with other key systems, documenting, and preserving communications as evidence of member care and contacts. The Core Services System is fully configurable, with business rules that guide claims payments, authorization requirements, benefit limits, and reporting requirements.

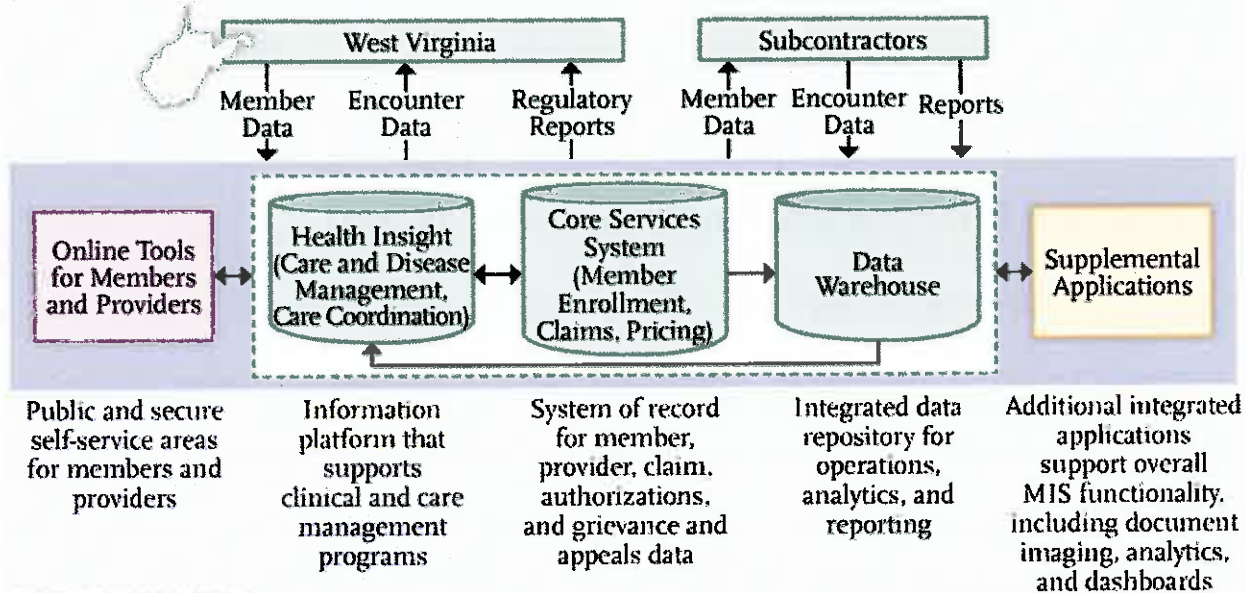
We are confident our systems and technical teams deliver the flexibility needed to support rapid development and deployment of interfaces or new functionality required to interface with DHHR's Medicaid Management Information System. With an average tenure of more than 10 years, our Technology Services team has the deep knowledge, experience, and skills required to build, support, modify, or enhance data exchanges, and systems as needed to meet requirements for all necessary interfaces to support the MHT program. A standard software development life cycle (SDLC) methodology governs the development and testing of all interfaces, including internal unit, and user acceptance testing, followed by interface testing with the DHHR and its vendors.

Component-based Design Provides Flexibility

Modular integration among components is a key design premise of our system. The components interoperate where needed, but are adequately independent to provide specialized functionality to fulfill SPA requirements. This approach protects data integrity and prevents inconsistencies between systems.

Figure 6.12-4. Modular Integration of System Components Supports Specialized Functionality

High-level MIS Overview



The high-level MIS, comprising the following five components, is depicted in Figure 6.12-4:

- **Core Services System.** The system of record for all data for providers, members (including enrollment and eligibility), benefits, contracts, service authorizations, claims, and grievances, and appeals data. All updates to this information will occur through the user interface or through application-specific data loads such as enrollment files received from the State.
- **Health Insight Platform.** Our care management platform shares and aggregates actionable data across systems and organizations, promoting effective, efficient, and collaborative care management — including utilization data for physical health and behavioral health services, clinical data, health risk assessments, and care plans. Health Insight integrates seamlessly with our Core Services System and data warehouse and represents the system of record for member care management information.
- **Data Warehouse.** Our data warehouse is an integrated repository that supports operational processes, analytics, and reporting. To promote data quality, control, and consistency, the data warehouse is fed directly from our Core Services System and Health Insight platform. We also integrate additional information for our members into the data warehouse, including lab results, immunization data, clinical data, and pharmacy data from the State’s fiscal agent to be used for utilization and care management.

- **Supplemental Applications.** Additional integrated supplemental applications support overall functionality, including provider payment, member ID cards, EPSDT, HEDIS, and document imaging. Dashboards, business intelligence, analytic reporting, and other supplemental applications support data analytics and maximize functionality, efficiency, and security.
- **Online Tools for Members and Providers.** We provide a variety of online tools to members and providers, including both public access, and secure self-service areas. We use industry-standard web services as well as content management system technologies to afford users access to all content, features, and functionality regardless of the device they use (desktop/laptop, tablet, or smartphone).

Experience Matters

Michele Carrera
Information Technology Director



Michele has worked extensively with West Virginia and oversees all aspects of information technology for UniCare.

As a best practice to support continuity and streamline solutions, Technology Services will partner with a dedicated IT Director, to work with DHHR, our UniCare operations team, and other Technology Services staff actively engaged in supporting the MHT program. Michele Carrera will serve in this role on an interim basis while we

actively recruit a full-time candidate. Our dedicated IT Director will be an integral part of all technology-based implementations and ongoing operations and will be the single technical point of contact for DHHR and its vendors — both during the implementation and to support day-to-day operations.

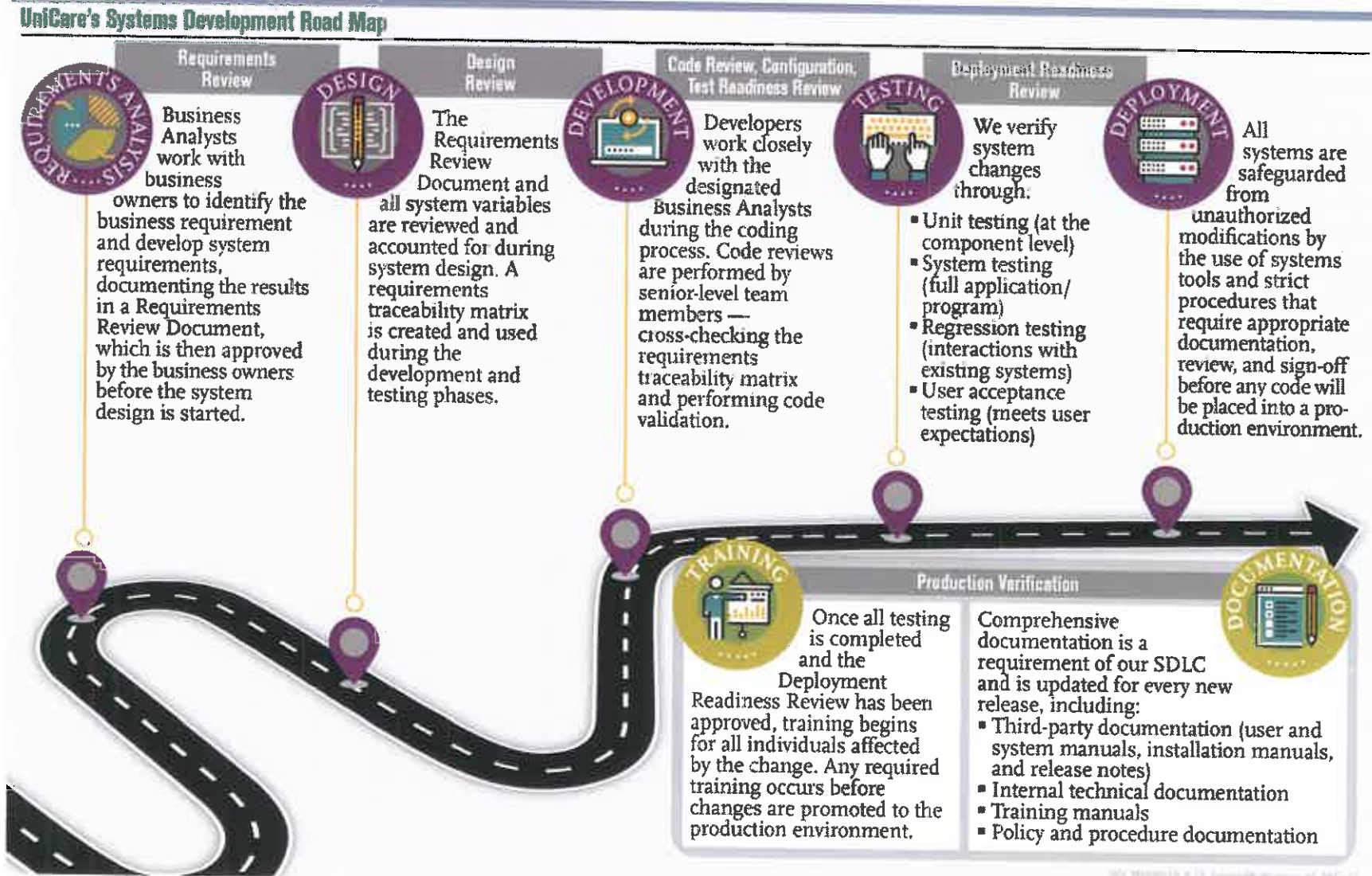
Until a permanent IT Director is hired, Michele will collaborate with DHHR and its vendors on the development of new system interfaces required to support MHT program operations, reviewing all data exchange requirements and meeting with DHHR, designated stakeholders, and other MCOs as needed to discuss technical details including format, transfer method, development timeline, and testing.

Initiation and Coordination of System Changes

Our information systems' change management and version control processes are tightly integrated with our SDLC methodology. For all system changes, including encounter submission, electronic data interchange, clearinghouse, and financial reporting, Technology Services follows formal change

notification policies and procedures that include standards for requirements gathering, analysis, design, tests, and implementation. The SDLC methodology, shown in Figure 6.12-5, can be tailored to include only activities that are appropriate based on project type (new or modified system or configuration change) and whether the system is automated or manual. Technology Services will use either a waterfall development model or the Scaled Agile Framework (SAFe) to manage the life cycle of applications and systems and will maintain procedures, templates, checklists, and processes that enable systems projects to move through iterative cycles, or sprints, of: requirements analysis, design, development, and testing. All change management processes are documented, repeatable, monitored, and subject to continuous process improvement activities.

Figure 6.12-5. UniCare's Change Management Process Is Documented, Monitored, and Repeatable



Change Control and Deployment

Technology Services safeguards all systems from unauthorized modifications with systems tools and strict procedures that require formal process documents for every change or maintenance request, as well as an appropriate review process prior to deployment. All system change requests follow an established process with appropriate review and approval based on level of impact and complexity.

Technology Services maintains a separate group of individuals who have the ability to promote code changes or new code to production libraries. The development group develops and tests the code, obtains approval for the completed product, and plans the implementation strategy. The change control group moves the approved code into a designated staging area. We use a release management tool to monitor and control the entire process. Established procedures do not permit any code to be placed into a production environment without the appropriate documentation and required approvals.

Configuration Changes

UniCare has established policies and procedures regarding the maintenance of all data necessary to support our West Virginia Medicaid operations, including covered benefits, reimbursement rates, and fee schedules. Accurate provider, pricing, and benefit configuration is a critical component of Medicaid managed care operations. Our robust configuration and testing process involves representatives from multiple departments (such as health plan services, claims processing, care management, etc.) in both the configuration and testing process. These representatives ultimately approve the final configuration.

Our Compliance team supports continued compliance with DHHR requirements. On a daily basis, this team monitors DHHR communications for notifications, creating a ticket in our Compliance 360 application and sending alerts to relevant subject matter experts if an update is identified. Notifications concerning covered benefits, reimbursement rates, and fee schedules are sent to the Operations team to

review the alert, determine impact to existing configuration and procedures, and assign tasks to be completed to support the new requirement. This team is comprised of health plan operations staff, as well as key resources from the Pricing and Benefit Configuration teams.

When a regulatory change impacts claims processing, this team documents the necessary change, submits an intake form to the configuration team, and develops, and implements a testing strategy. The Operations team also coordinates appropriate communications, within the required timeframes, to providers, and other partners that may be affected.

We maintain two experienced and specialized configuration teams to execute configuration changes:

- Pricing configuration and fee schedule changes are completed by the Pricing Configuration team with oversight from the Operations team.
- Changes that impact what is covered or how a service is covered (such as benefit limits or copayments) are handled by our Benefit Configuration team. These skilled resources are experts on the benefits offered through West Virginia Medicaid programs and addressing the nuances between different aid categories and cost-sharing groups.

All system changes are reviewed to determine impact to past claims, future claims, and those currently in our queues for processing. Once the change has been made, the relevant configuration team reviews the results to verify the change is working as expected before the change is pushed to production. If the effective date for the change precedes the implementation date for that change, local operations leadership and the configuration team develop a work plan to reprocess any claims that meet the date of service requirements but were processed before the change implementation date.

Coordination of Subcontractor System Modifications

UniCare retains sole responsibility for fulfilling DHHR SPA requirements and works with our subcontractors to identify modifications to their core systems to support operations and comply with

contractual obligations. Modifications to subcontractors' core systems are identified as part of their initial implementation, with additional changes as needed to support State requirements and ongoing operations.

For initial implementation, all system configuration and changes are fully reviewed by appropriate members of the UniCare implementation team before the subcontractor is given approval to begin operations. A project plan is defined with specific milestones and checkpoints for system modifications, integration testing, and readiness review. The scope of system modifications is comprehensive and based on the subcontractors' written agreements.

UniCare's multi-level approach to subcontractor management is overseen by the health plan, but supported by national departments focused on subcontractor management. We maintain an established Subcontractor Oversight Committee that meets regularly with subcontractor representatives and our national Subcontractor Managers. Subcontractor Managers assigned to each subcontractor are responsible for day-to-day management, oversight, and ongoing communication with that subcontractor.

Our Subcontractor Oversight program includes defined processes for making sure that new or changed DHHR policies, data exchanges, and system requirements are clearly and consistently communicated, managed, implemented by our subcontractors, and verified by the Subcontractor Manager.

The Subcontractor Oversight Committee works with UniCare's Compliance team to evaluate the required change and determine if any subcontractors are affected and to what extent. Based on the nature and complexity of the change, the team documents a plan for notification, implementation, and verification. As needed, system design discussions are arranged between the subcontractor, the Subcontractor Oversight Manager, and the Technology Services team to review required changes, establish a timeline for development, and plan for integration, and user acceptance testing as appropriate. Additionally, the subcontractor submits an attestation and documented proof that the change or task was

completed. Oversight and monitoring of subcontractors provides the structure necessary to apply remediation and corrective action if they are not in compliance with contractual requirements.

- IM006 1 The Vendor should provide its business continuity and disaster recovery plan for the technology and infrastructure components of business operations with its bid.

Maintaining Business Continuity and Disaster Recovery Plans (IM006)

UniCare's comprehensive disaster recovery planning and continuous readiness demonstrate how seriously we take our responsibility as a service provider to our members, our provider network, DHHR, and our employees. We maintain detailed disaster recovery plans for our systems, applications, and platforms, as well as business continuity plans for operations related to our systems — combined, these plans make up our business continuity-disaster recovery (BC-DR) plan. The BC-DR plan includes a Crisis Management plan to support overall response, command control, and communication.

Our BC-DR plan, redundant systems and hardware, and data recovery hot site equip us with a swift and effective response capability to anything that could jeopardize processing integrity or temporarily disable or interrupt operations — natural disaster, pandemic, major telecommunications or electrical outage, or a computer virus — with minimal impact on all constituencies. Every component of our BC-DR planning interconnects to create workplace safety for employees, contractors, and visitors; to manage emergency situations effectively; and to facilitate business continuity. *We have the technology and staffing to recover and restore operation of information systems, data, and software to limit service interruptions to 24 hours or less.*

Local Awareness, National Capability

Each of UniCare's national support business units (for example, Claims and Finance) develops and maintains a business continuity plan specific to the operational needs of its stakeholders. To safeguard our West Virginia operations and services and supports for our members and providers, we ask:

- What are absolute essentials that sustain the core functions of the business?
- What triggers the implementation of the BC-DR plan?
- What resources will be required to support recovery and continuing operations and when are they needed?

These questions help us identify business process-critical paths; document the recovery strategies and resources required to support those critical paths; define roles and responsibilities; and link critical path business processes with the resources, systems, and vital records required to support response, recovery, and survival. *Multiple protocols work together to keep all parties aware of the importance of our day-to-day operations and to notice emergent risks as they participate in planning for or responding to disruptive events.*

Our Charleston Business Unit Recovery team evaluates the impact of any unplanned event on business unit functions and implements recovery under the direction of the Corporate Incident Response team. The Business Unit Recovery team is supported by Anthem's Business Continuity team. Anthem's Staff Vice President of Business Continuity directs all policy, implementation, training, testing, and maintenance of the national business continuity program, including the Mobile Recovery solution and its supporting assets, the Virtual Command Center, and the Corporate Incident Response team. The Corporate Incident Response team does not take over for UniCare, but is available to support BC-DR efforts for UniCare and other Anthem affiliates. The staff who make up this team and support our BC-DR plan have significant industry experience and include Certified Business Continuity Professionals, Certified HIPAA Security

Professionals, Certified Business Continuity Management Systems Auditors, and Information Technologists who are ITIL Foundation-certified.

Coverage for Essential Operations

UniCare's contingency plans go into effect immediately with any disruptive event. The Business Unit Recovery team immediately contacts the Corporate Incident Response team to notify them of the situation and its expected duration. They also update the National Employee Emergency Information number so employees at any location can get the most current information related to work and unit functionality. All UniCare and Anthem employees are trained to respond to specific events through the Employee Safety program. The Business Unit Recovery team continues to assess, inform, plan, and implement work continuity during these events.

Our BC-DR plan is scenario-neutral to address any situation that disrupts normal operations. If circumstances require assistance from outside West Virginia, we can reach out to Medicaid affiliates in our Central region or, if necessary, to affiliates in our East or West regions. The President of our Medicaid Central region coordinates with the presidents of the West and East regions. Our national structure and regional organization allow for quick and orderly implementation of contingency plans if there is damage to a facility or a major employee outage.

Identifying Resources Required for Business Functionality

If a local event affects large numbers of employees, the Business Unit Recovery team will determine the resources required for business functionality and try to match business needs to available personnel skill sets. We keep an annually updated list of all employees for this purpose, and we will call to verify who is able to work, evaluate impact and capacity, and determine whether temporary, or permanent staff are required. They will also determine training needs required to fill any gaps in business function. The

Business Unit Recovery team is authorized to develop a backlog reduction program using overtime, interim site capability, work redistribution, or any other appropriate method to manage workloads.

Facility Unavailable

For an event such as a fire, flood, or damage to a building, the Business Unit Recovery team quickly develops messaging for employees and conveys that information to the Corporate Incident Response team. Together, those teams will assess the duration of the facility outage. They will then activate the employee call tree. If necessary, they will compile information about which employees are available to travel to other sites. The primary focus of the Business Unit Recovery team in this scenario is redistribution of employees according to need and skill set, with consideration of what training, lodging, transportation, and work materials may be required at interim locations. Finally, the team will begin planning for return to the permanent work site at the time it is expected to be available again.

Restoration of Daily Operations

Restoring day-to-day operations as quickly as possible is critical. Our BC-DR plan includes access to a substantial workspace recovery capability using a combination of resources, including network redirection of work, our national organization's worksite recovery capacity, mobile recovery resources, and secure satellite connectivity for voice and data.

In the following sections, we describe key components of our BC-DR plan that support restoring day-to-day operations, including information systems contingencies, alternate work locations, communication protocols, continuity of service to members, and employee training, and awareness.

Information System Contingencies

We continually update our BC-DR protocols to align with industry best practices, changing technology and systems environments, and State requirements. Our national Technology Services department

supports data and backup centers with different risk profiles, topography, and vulnerability to natural disasters and physical attacks, as well as off-site storage to assure restoration and recovery. Our BC-DR plan is designed to protect against data loss and facilitate recovery from major unplanned interruptions to computing services. This includes system infrastructure, data, and applications documented in the corresponding Application Recovery and Technical Recovery Guides — each with assigned resources that will execute the plan if a disaster occurs. All plans are reviewed and updated at least annually as part of the annual disaster recovery testing process and after major system changes.

Redundant Systems

We invest in the technology and equipment necessary to support our operational and business continuity needs. We use distributed data centers to host the majority of systems, applications, and technologies that support our West Virginia programs. Each data center has a designated backup site. We maintain complete redundancy for all tiers of our Core Services System, including all surround applications that support claims processing and other key business applications.

High Availability Solution

To provide high availability, we maintain mirror images of files in addition to the production and disaster recovery instances so that if the hardware fails a system can be quickly switched to operate from the recovery environments. This high availability solution is located in our primary data center and can be switched to if there is a non-disaster issue with our Core Services System, allowing operations to continue, uninterrupted, while the production system issue is addressed. Likewise, we back up key hardware and communication lines that enable us to switch operations quickly from one piece of hardware to another.

Disaster Recovery Hot Site

The disaster recovery hot site includes equipment to support our most critical medical management and member/provider contact applications, including the Core Services System, clinical criteria, Fax II/RightFax databases, imaging and workflow document management, and call center workforce management. To keep critical applications and data in sync with production, we maintain continuous real-time replication between the primary data center and the hot site. The facility that hosts our disaster recovery hot site is owned and managed by our parent company. This means we do not need to rely on a vendor for disaster recovery testing or actual recovery of operations. We are in full control of the location, capacity, and resources needed to support a recovery event. In a regional event, this mitigates the risk of competition for shared vendor resources.

The selection of the location for the hot site is based on geographic distribution and different risk profiles, including the topography of the area for vulnerability to natural disasters and malicious physical attack. This state-of-the-art recovery facility has been certified by the Uptime Institute as a Tier III data center, an independent, performance-based assessment that indicates the site infrastructure meets rigorous uptime, and long-term viability requirements. The facility is 102,000 gross square feet, has top-level physical security, and an electrical substation on premises (35,000 kW), including four data halls (10,000 square feet each) allowing for segregation of sensitive environments. Physical security includes a perimeter fence, 24/7 on-site manned security operations, and surveillance cameras. Access to the building, the data center, and individual data halls requires a security key card and entry of a PIN (something you have and something you know). Biometric controls provide additional security to the data center. All personnel movements are logged and tracked.

Disaster Recovery Strategies

Our BC-DR employs different strategies depending on the criticality of the application system. The following are descriptions of strategies currently deployed:

- **Multi-site Active-Active Load Balancing.** Application systems have active configurations in both primary and backup data centers. Global load balancers direct incoming transactions across both sites. If one site fails, transactions are directed to the other.
- **Dedicated Standby.** Our key application systems and surround systems have dedicated standby hardware in a second location that can be quickly activated if the primary site fails. Storage Area Network replication and database log shipping keep database copies at the secondary site synchronized with production.
- **Recovery.** Critical systems not being replicated are recovered at our disaster recovery site. Most data backups are written to virtual tape and replicated to a virtual tape system in an alternate data center, primarily the disaster recovery facility. These would be immediately available for recovery without waiting for off-site tapes to be sent.

Disaster Recovery Team

Technology Services employees are assigned to disaster recovery teams to implement established contingency plans in response to worst-case scenarios. The disaster recovery teams take ownership of business operations recovery by reviewing all documentation, making recommendations, alerting the disaster recovery contingency planners of system changes and upgrades, and participating in Disaster Recovery Plan testing. The comprehensive disaster recovery program contains four major content areas:

- Data center recovery, including environment-specific, and application-specific documentation
- Information systems business unit recovery
- Telecommunications recovery, including voice, and data
- Local communication room recovery

System Backup and Recovery Plans

We maintain backup and recovery plans for the types of events that could interrupt operations or cause a loss of data. Data files, transactions, program libraries, job scripts, operations procedures, and systems documentation are backed up regularly, and copies of key files are maintained in secure off-site locations. Through well-defined processes and procedures, we outline steps for backing out transactions, restarting at certain checkpoints, or completely re-running programs.

A comprehensive backup strategy is a key component of our BC-DR plan and protects from a loss of data due to system or program failures or destruction. We consistently backup systems and databases and store copies of key files in multiple locations, including secure off-site locations. We back up our mission-critical systems at our data recovery hot site data center using near real-time replication. We also perform daily, weekly, and monthly full backups. We employ a 3-2-1 backup strategy: 3 copies, 2 different types of media, and 1 copy stored off-site. This approach maintains the production copy and a replicated copy within the data center. We take a backup of the replicated copy and store it off-site.

Our Technology Services team uses Oracle tools and software with NetApp integration to solve data management challenges, such as workload management, database cloning, and backup, and recovery. NetApp Snapshot technology delivers better performance and efficient use of storage. Maintaining multiple versions of the database allows for faster, near-instantaneous recovery, and supports more frequent testing activities.

Alternative Worksites

The ability to provide continuing business services throughout any occurrence is critical. Our employees can seamlessly access necessary systems remotely to continue operations when their primary work location is unavailable. Using our Citrix Access Gateway, employees can securely use critical applications from any location with internet access.

To supplement worksite recovery, they can access a Mobile Recovery van within 96 hours following an event that results in unavailable network connectivity. The vans have both network and VOIP to support up to 500 call center seats and the following components:

- Two mobile satellite units (including servers, data switches, onboard generator, and HVAC)
- Satellite connectivity for voice and data (bandwidth equivalent to two DS-3s)
- VOIP phone switch (ACD) for 500 seats/1,000 line servers and data switches
- Workstations to use with mobile recovery seat

If the building is unavailable, Mobile Workspace trailers can provide seats for employees and personal computers within 72 hours. The Mobile Workspace trailers can be deployed in conjunction with or separately from our Mobile Recovery vans. To confirm its continued viability, the Mobile Recovery solution is tested every six months. With multiple protocols, our BC-DR plan will support continued operation during a disruption.

Continuity of Services to Members

UniCare maintains specific disaster management operating procedures and guidelines for our most vulnerable members that cover emergency planning, implementing the emergency plan, and considerations for after the emergency. Members who reside in facility settings will follow the facility's emergency and evacuation plans. Care Managers work with members to record and review their personal emergency plans or help them develop one. The emergency plan discussion may include assisting with registration for a county special needs registry/shelter; making sure the member has at least two weeks of medications, shelf-stable food, water, and medical supplies; making a plan for pets; registering with county transportation if going to a shelter; and assessing the member's desire to evacuate to a facility (based on level of care needed).

In an impending emergency, Care Managers will reach out to members on their case load to verify and document location and contact information for the member or their representative. Care Managers will discuss early refill for medications and supply needs the member may have, such as oxygen tanks, and ventilator supplies, diabetic supplies, CPAP, and BiPAP supplies, wound care supplies, or other essential items they need to obtain in advance of the event. Care Managers will advise the member about the on-call process while the event is in progress, reminding them weather conditions may affect providers' ability to deliver services. If the member indicates the existing plan is not going to meet their needs, the Care Manager will help the member make other arrangements. After the crisis has passed, Care Managers will again contact their assigned members to confirm that they are safe and coordinate delivery of services as they are needed.

Communications Continuity

Communicating promptly and effectively is critical in an emergency or service disruption. Our plan provides multiple methods to communicate with staff, suppliers, DHHR, members, providers, and other stakeholders. Our Virtual Command Center, staffed by the Corporate Incident Response team, manages any event-based activity (planned or unplanned) in concert with the local Business Unit Recovery team. To facilitate the flow of information, we issue redundant communication tools to key managers; maintain automated call tree notification and management functionality; have repositories for business continuity documents; store employee, site, subcontractor, external partner, and other mission-critical information; and use collaborative meeting tools such as a teleconference bridge in day-to-day operations. Our National Employee Emergency Information number quickly and effectively informs employees with recorded messages, using a process similar to the message and alert systems that school systems and police departments use nationwide.

Member and Provider Communications

We know communicating promptly and effectively with our members and providers is critical in an emergency or service disruption. Consequently, our plan includes steps to notify members or providers depending on the type of event and what services are unavailable. Our plan emphasizes proactive communication to members and reduced administrative requirements for providers, so they can focus on their own health and safety.

We use numerous methods to notify members and providers of an impending or ongoing emergency and to inform them about accessing services during and immediately after the emergency. Depending on the nature of the disruption and its impact on members and providers, notifications are communicated via:

- **Member and Provider Websites.** We post alerts on our website notifying members and providers of a service disruption and how they can access services.
- **Automated Calls, Text Messages, and Email Messages.** We generate automated telephone calls, text messages, and emails to communicate information to our members and providers.
- **Direct Calls.** We make direct calls to vulnerable members including those in care management.
- **Member and Provider Call Centers.** Our call centers provide up-to-date information to callers regarding how to access services.
- **Social and Local Media.** We may use social media as well as local radio and television to disseminate emergency information to our members and providers.

Regardless of the nature of the emergency, redundant operations for key functions will minimize disruption for West Virginia's members and providers. We can use telecommunications and networking technology among remote sites to reroute member and provider calls to an unaffected worksite.

In the event we cannot operate our local call center in West Virginia, we can leverage Member and Provider Services Representatives in five additional Medicaid call center facilities across the United States. Our telephonic technology circulates calls among them as necessary, creating virtual Member and

Provider Services call centers. In an emergency or service disruption, we can quickly, and seamlessly route calls to another site to continue to serve our members and providers. Using our call center Integrated Desktop and Knowledge Management System, representatives in other facilities have real-time access to covered services, eligibility, and claims data. Access to this technology will allow them to support our West Virginia members and providers in the event of a disruption.

We will also mobilize Care Managers, Member and Provider Services staff, and other clinical staff to assist members with access to information and services before, during, and after a declared incident. Our national support services teams and affiliate health plans can help in the event of a disruption, as they did in 2017, when Florida employees relocated to Kentucky as Category 4 Hurricane Irma hit Florida.

Employee Training and Awareness

Effective and efficient response to any type of emergency or business disruption requires that employees in West Virginia and our national shared services areas understand their roles and responsibilities. Our employees are prepared to:

- Maintain and update the components of our contingency plans
- Perform emergency tasks
- Designate off-site crisis meeting places and implement crisis communications plans

We involve employees and leadership in exercises specific to responding to an emergency. The initial response in any scenario involving employee safety is to inform the Corporate Incident Response team at the Virtual Command Center and the National Employee Emergency Information number. The Business Unit Recovery team assesses the severity and likely duration of the event, and our National Employee Emergency Information number keeps employees updated by phone when events disrupt working hours, operations, or facilities.

The Employee Safety program, Business Continuity Management Plan, and Emergency Management program are available to all employees on our internal website, as are the phone numbers for the Emergency Reporting Hotline, Global Security Operations Center, Corporate Security, Corporate Risk Management, and Corporate Facilities Services. Online courses are available to all employees, including one on employee safety and emergency response procedures, focusing on the actions employees should or should not take in emergency situations. Instructions for evacuations and sheltering in place, managing power failures, fire or smoke, bomb threats or crimes in progress, automated external defibrillator use, suspicious packages, severe weather, and earthquake are available at all times on the employee site and in our in-house Quick Action Guide. In 2019, UniCare held on-site training to educate employees about what to do in a hostile intruder situation, and a video called Run, Hide, Fight is available for employees to view on our internal website.

Our Charleston Safety and Security Director conducts biannual fire drills, with our most recent fire drill occurring in January 2020. The Safety and Security Director also regularly updates contact information for all employees so that it is up-to-date for any needed outreach. Within two hours of an event, the Business Unit Recovery team activates an employee call tree, beginning with remote (work-at-home) employees, to define the impact of the event.

Annual Testing

We test our BC-DR plan annually. We will provide DHHR with a DR after-action report (AAR) if requested. The DR AAR will cover successes and a plan to address the areas identified for improvement. We will make sure DHHR has the information they need at all times for a smooth interface with UniCare and its members in the event of an emergency or disruption.

Plans in Action — Responding to Events of All Shapes and Sizes

From small incidents to catastrophic disasters, the goal is the same — to maintain normal business operations while making sure members are safe and have access to the services they need. Whenever possible, operational continuity should be seamless and completely transparent to members, providers, and our State partner.

For example, in June 2019, our Charleston office experienced a power outage due to a tornado that knocked out a power substation in the local area. As soon as the outage occurred, we took action to reroute all calls to our national call center, minimizing any disruption to our members' access to health plan services. We also implemented call trees to check on employees in the tornado's path and let employees know the local office was closed. Arrangements were made for those unaffected by the tornado to work from home.

In other circumstances, our response to a disaster is less about maintaining physical operations and more about taking action to make sure our members have access to the health care services and equipment they need. During widespread flooding in 2016, our UM and Operations teams worked together to make sure members who had lost essential equipment were able to receive replacements quickly. Because our business continuity plans include workflows to support emergency replacement for durable medical equipment (DME), as well as exception processes to allow authorization requests to be accepted after a service has been rendered, our UM team was able to quickly and efficiently work with local DME providers to facilitate safe delivery of equipment to our members while our Operations team monitored claims processing to make sure that these claims were paid promptly and appropriately. We also maintain procedures for transferring members from their current facility to another participating or out-of-network facility in the event that the current facility is no longer viable.

Maintaining Business Operations During a Catastrophic Disaster

During a widespread, catastrophic event, the focus is on “whatever it takes” – including the use of distributed systems and resources. UniCare has been fortunate to have never had to respond to such an event, such as the one handled by our Florida affiliate in September 2017, when Hurricane Irma caused devastation across Florida, including widespread power outages, flooding, and substantial property damage. While no two disaster events are ever handled in exactly the same way, UniCare’s BC-DR plan addresses enterprise-wide business continuity and recovery in much the same way as our Florida affiliate, including the availability and use of distributed systems and resources to do “whatever it takes” to support members and maintain ongoing operations. Should a catastrophic disaster impact West Virginia, our BC-DR plan would involve activities similar to those highlighted in the following sections, including preparation and providing support to members, providers, subcontractors, and employees.

Preparation

As hurricane tracking models began to predict impact to Florida, our local affiliate began working to make sure members were prepared, activating outreach protocols, and identifying the most vulnerable populations, such as medically complex members and those members residing in areas with anticipated landfall. They initiated twice daily emergency response meetings with senior leadership to review and strategize member and employee contingency planning and coordinate operational communications. They also established daily clinical team meetings to coordinate and address the clinical needs of members. They deployed a 20-person “Go Team” to a non-impacted location in another state to address member and provider needs and concerns until normal business could resume. The “Go Team” provided support across operations, including coordinating eligibility, and payment information to out-of-state providers delivering care for evacuated members.

Supporting Members, Providers, and Subcontractors

The following list is just a sample of the activities performed to support Florida members, providers, and subcontractors as our affiliate prepared for Hurricane Irma:

- The Member Call Center and Care Management teams initiated outreach campaigns to members who:
 - Relied on ventilators or use oxygen to coordinate delivery of portable tanks and refills
 - Were pregnant and near term or high-risk
 - Were undergoing dialysis to assure they had pre-storm and post-storm dialysis treatments coordinated, including transportation, or hospitalization
- Communicated with facilities to confirm they had adequate supplies, generators, caregivers, and evacuation plans in place to protect the well-being of the members
- Suspended many of the edits restricting pharmacy access to reduce member Point of Sale impact, such as refill too soon, prior authorization, and step therapy
- Placed notices on their website and sent a fax blast to all providers that outlined special hurricane protocols regarding authorizations and pharmacy access
- Transportation subcontractors evacuate members to shelters or homes outside of evacuation zone
- Created a hurricane emergency database listing community and state resources such as Federal Emergency Management Agency (FEMA), Red Cross, shelter information, and evacuation orders to assist members with storm-related questions and direct them to the appropriate resources
- Included a Hurricane Irma message on the website to provide members with important storm-specific information and contacts
- Contacted DME providers to understand contingency plans and verify they had adequate supplies, such as oxygen (and the ability to issue portable tanks) and ostomy supplies
- Contacted subcontractors to understand contingency plans in place to minimize member disruption

Supporting Employees

As Florida residents, employees also faced the impact of the hurricane, including evacuation. Our affiliate took steps to address employee safety and security, including communicating the need to begin preparing for office closure and flexible work arrangements. They used a mass notification system to communicate, enabling them to reach each employees through both work and personal channels.

After the Storm

Activities after the hurricane focused on assessing the impact on members, providers, employees, and other stakeholders, and returning to normal operations. They reopened all offices within 48 hours with 85% of staff reporting for work. Twice daily emergency response meetings and daily clinical meetings continued during this time to assess member, provider, and employee needs, and coordinate fulfillment. They also maintained close contact with the state Medicaid agency, providing proactive updates on their activities and member needs.

Our affiliate continued to provide member and provider support 24/7 through their local call center, with additional support from the national call center. Our affiliate conducted extensive outreach after the storm to identify member needs and get them the support they needed. Implementing a “Feet on the Street” approach, they encouraged staff to go into the field to personally deliver needed supplies and assess member needs, including following up on members from the critical populations identified pre-storm and members residing in the hardest hit areas. They supplemented efforts with an automated outreach message to all members that provided key information such as Red Cross and FEMA numbers.

Additional activities during this time included the following:

- Engaging their transportation subcontractor to help evacuated members return home from shelters, access food banks and temporary housing, and access FEMA emergency locations, if needed
- Leveraging their over-the-counter supplier to deliver supplies to impacted members

- Outreach to all 10,000+ providers to confirm they had reopened and rescheduled missed appointments
- Contacting facilities to check on facility and member status and offer assistance
- Working closely with every subcontractor to understand their business resumption status and communicating updates to Member Services and Care Management departments
- Direct outreach by managers to track employee status and assess impact
- Accommodating unique employee needs with flexible work arrangements, including variable work schedules, and work from home
- Providing assistance through a peer-to-peer program in which employees contribute to support peers in their time of need with financial grants. Anthem, Inc.'s foundation matches employee donations made toward disaster relief, increasing the normal 50% match to 200%
- Leveraging the Employee Assistance Program to offer tools and resources to meet the challenges of employees and their families, including provision of on-site counseling in their local offices



13. VALUE-ADDED SERVICES

UniCare proposes 22 Value-Added Services (VAS) to support our West Virginia members (Figure 6.13-1), 13 of which are brand new and developed especially for this contract. Our VAS align with our population health model by providing benefits and resources to help support social cohesion, employment, education, food security, and improved health outcomes. Further, we have expanded our VAS to support CHIP members and address West Virginia's top health priorities, such as decreasing obesity and improving management of key chronic diseases. To develop our VAS, we listen to members about their priorities, monitor utilization data, review local trends, and collaborate with the West Virginia Department of Health and Human Resources (DHHR) to make sure our VAS complement, but never duplicate, existing programs. Our VAS are easy to access and are trackable to monitor effectiveness.

Figure 6.13-1. Value-Added Services to Address Our Members' Needs

UniCare's Unique Value-Added Services Meet Members' SDG Needs			
Maternal & Child Benefits	Physical Activity & Healthy Weight	Whole Person Health	Community & Social Supports
▪ Fresh Fruit and Veggies Program* ▪ Preventive Dental Care for Pregnant Members ▪ Mail Order Diapers* ▪ Safe Sleep Kit* ▪ Convertible Car Seat or Portable Crib ▪ Electric Breast Pump Accessory Kit	▪ Summer Camp Memberships ▪ Youth Club Memberships* ▪ Fitness Coach Program ▪ WW® (formerly known as Weight Watchers®) Memberships	▪ SUD Recovery Support Program* ▪ Healthy Rewards Program ▪ Oral Care Essentials* ▪ Build Your Own Personal Hygiene Box* ▪ Feminine Care Collection* ▪ Healthy Lifestyle Aids*	▪ No-Cost Laptop Benefit* ▪ \$100 Gas Card* ▪ Family Activity Coupon book* ▪ Online Well-Being program* ▪ Lifeline Smart Phone Benefit ▪ Community Resource Link
*New Value-Added Services			

VAS to Support Maternal and Child Benefits



Late or insufficient prenatal care, chronic conditions, inadequate nutrition, and substance use disorder (including opioid use) are factors that negatively impact pregnancy and delivery of a healthy baby. On average, we have more than 3,000 babies delivered by our West Virginia members each year. To help support our youngest members, we offer six VAS that complement our comprehensive maternal child health approach. Together, these programs address major risk factors and help make sure our members have access to supports and services to stay healthy during and beyond pregnancy. What follows are our VAS to support moms and their families.

Fresh Fruit and Veggies Program



To help reduce food insecurity and promote healthy eating, eligible members can receive up to \$100 in fresh produce delivery. Moms-to-be require additional vitamins and minerals to support a healthy pregnancy; this benefit provides healthier food options, which can promote better nutritional habits. **Benefit eligibility/limits:** All pregnant members are eligible. Maximum allowance of \$100 per member, per year.

Preventive Dental Care for Pregnant Members

Oral health plays a crucial role in the well-being of expectant mothers. Research shows a direct correlation between periodontal disease and adverse outcomes in pregnancy, including preterm deliveries, low birth weight babies, and preeclampsia. **Benefit eligibility/limits:** All pregnant members are eligible. Members can receive up to two dental cleanings per pregnancy through six weeks post-partum.

Mail Order Diapers



Eligible members will receive up to \$75 worth of free diapers, mailed right to their doorstep. Diapers are critical to a baby's health and happiness, and without consistent diaper changes, babies run the

risk of infections and other significant health problems that may require medical attention and put additional financial strain on families. **Benefit eligibility/limits:** Maximum allowance of \$75 per member, per year.

Safe Sleep Kit



Eligible members can receive our Safe Sleep kit, which includes a swaddle sleep sack and pacifier as well as an educational brochure that focuses on safe sleep practices to help reduce the risk of Sudden Infant Death Syndrome and other sleep-related causes of infant death. This VAS complements the “Our Babies: Safe and Sound” project, which promotes education for new parents. **Benefit eligibility/limits:** To be eligible, members must have a child under one year old. Limit one kit per child, per pregnancy.

Convertible Car Seat or Portable Crib

To help motivate expectant mothers to complete their prenatal appointments, as well as reduce the financial burden of having to purchase essential safety items, members will receive a convertible car seat or portable crib. **Benefit eligibility/limits:** All members enrolled in case management and complete six prenatal visits are eligible. One per member, per pregnancy.

Electric Breast Pump Accessory Kit

To help new moms nourish their newborns, we offer one accessory kit to complement the electric breast pump members can receive from the Women, Infants, and Children (WIC) program. Our kit includes disposable nursing pads and extra milk storage bags and bottles. This VAS will help new moms conveniently pump and breastfeed longer while working or attending other commitments that would separate them from their infants. Breastfeeding reduces the risk of baby bottle tooth decay, type 2 diabetes

for mom and baby, and obesity. **Benefit eligibility/limits:** Members who recently delivered a baby are eligible to receive one kit per pregnancy.

VAS to Support Physical Activity and Healthy Weight



Healthy, active lifestyles help members avoid common adverse health conditions that can result from obesity and physical inactivity, such as high blood pressure, type 2 diabetes, and heart disease. West Virginia has the highest obesity rate in the nation (37%), and more than two-thirds of West Virginia's adults are overweight or obese¹. Obesity is one of the biggest drivers of preventable chronic diseases in West Virginia. Further, the leading causes of death in the state include heart attack, coronary heart disease, and stroke. The following suite of VAS encourages increased physical activity to help mitigate and manage these chronic conditions and improve health outcomes.

Summer Camp Sponsorships

Our camp sponsorships provide youth with asthma or diabetes the chance to attend camp specially designed to help them manage their condition as well as to build relationships and make friends with other youth who have shared experiences. The camps provide a fun and educational experience, and include supervisory staff who are physicians, nurses, dieticians, pharmacists, and counselors. In combination with physical activities, children learn how to better manage their conditions in a safe and healthy environment. **Benefit eligibility/limits:** Members ages 8 to 13 years with asthma are eligible to attend Camp Catch Your Breath (in Bridgeport), and members ages 7 to 15 years with diabetes are eligible to attend Camp Kno-Koma (in Frankford). We will provide scholarships of up to \$1,000 to attend the weeklong camp.

¹ West Virginia Behavioral Risk Factor Surveillance System Report, 2016

Youth Club Memberships



Eligible members will receive up to \$150 to cover the cost of youth club membership in programs such as the YMCA or Boys and Girls Clubs. These clubs represent a safe place for children and teens to learn and grow in a setting that fosters a sense of belonging. As reported by ChildTrends.org, participation in club activities during middle school is linked to higher academic performance and self-esteem, and older children who attend after-school activities are more likely to attend college, vote, volunteer later in life, and are less likely to skip school and engage in underage drinking. **Benefit eligibility/limits:** Members ages 6 to 18 years are eligible for up to a \$150 maximum allowance per year.

Fitness Coach Program

Our Fitness Coach program offers more than 1,000 physical activity resource materials, including videos and online classes, articles, and self-care tools. Additionally, eligible members can receive a six-month gym membership and access to a Fitness Center network, with locations all around West Virginia.

UniCare is the only MCO offering a gym membership benefit. For members who prefer to exercise at home, a home fitness kit can be requested that includes exercise aids and instructional-use materials.

Benefit eligibility/limits: Limited to six months of gym membership per member, per year, and two home fitness kits per member, per year. All members have access to online fitness classes with no limits.

WW® (Formerly Known as Weight Watchers®) Memberships

Our most used VAS to date, eligible members can receive one WW voucher good for 13 weeks of classes to help them lose weight safely through healthy lifestyle habits. Members who are overweight have a higher risk of high blood pressure, heart disease, stroke, diabetes, cancer, osteoarthritis, and back pain. Members will learn new ways to manage their weight and receive tools and tips to help them reach their weight goals.

Benefit eligibility/limits: Members must be at least 18 years old and have a BMI greater than 30.

VAS to Support Whole-person Health



Providing effective health and wellness VAS is especially important in West Virginia because of high rates of chronic physical and behavioral health conditions, such as diabetes, chronic obstructive pulmonary disease, and substance use disorders (SUD). We designed the following suite of VAS to help provide members more resources to address their needs and goals for achieving wellness, recovery, and resiliency.

SUD Recovery Support Program App



West Virginians have the highest age-adjusted rate of drug overdose deaths involving opioids.² This VAS is a mobile app that provides daily check-in and motivation, peer support via discussion groups and peer-to-peer messages, counselor messaging, care plan reminders, high-risk location alerts, and content to support recovery. This program uses predictive analytics based on relapse and condition-specific data to provide information and access to members right on their smartphones. Our Care Managers monitor member progress, send secure messages, and much more. **Benefit eligibility/limits:** Members diagnosed with SUD are eligible. No other benefit limitations.

Healthy Rewards Program

This VAS aims to increase personal awareness and responsibility by incentivizing members for completing preventive care services. Through a user-friendly platform, they can track their rewards and gain access to interactive digital education sessions, healthy living blogs, and other personalized tools. Members also receive personalized, easy-to-understand, culturally competent health education materials. After completing recommended services (Table 6.13-1), members can redeem rewards delivered

² National Institute on Drug Abuse, 2019

electronically or via mail. **Benefit eligibility/limits:** All members are eligible. Total rewards are limited to \$250 per member annually. Gift card retailers do not sell firearm, alcohol, or tobacco products.

Table 6.13-1. Healthy Rewards Incentives

Eligibility	Measure	Reward	Limits
Pregnant Women	First prenatal checkup within 42 days of enrollment	\$25 for each measure	Once per pregnancy (for each measure)
	Six prenatal checkups		
	Postpartum checkup 21-56 days after delivery		
Infants ages 2 weeks or younger	First well-baby visit	\$25	One-time
Children ages 0-15 months	Six well-baby checkups	\$25	One-time
Children ages 3-6 years	Well-child checkup	\$25	Once every 12 months
Adolescents ages 12-21 years	Wellness checkup	\$25	Once every 12 months
Adolescents up to 13 years	Complete HPV vaccination series	\$50	One-time
Female members age 21 years+	Complete cervical cancer screening	\$50	Once every 12 months
Females members 50-75 years	Complete breast cancer screening	\$50	Once every 12 months
Members 18+ with diabetes	Diabetes blood sugar (HbA1c) screening and kidney test	\$50	Once every 12 months
Members 6 years and older who have been discharged from a hospital for a mental health condition	Outpatient visit with mental health provider within seven days of discharge	\$20	Once per discharge; max of four every 12 months
Adults 18-75 years with diabetes	Diabetes blood sugar (HbA1c) screening and kidney test	\$50	Once every 12 months
Adults ages 18-75 years with diabetes	Diabetes eye exam	\$50	Once every 12 months
Children and adolescents 2-18 years	Complete annual dental visit	\$25	Once every 12 months
Adults ages 18 years+	Complete Health Needs Screener	\$10	One-time
Members age 6-12 years prescribed ADHD medication	Complete follow-up with prescriber (three visits in a 10 month time frame)	\$25	Once every 12 months

Oral Care Essentials



Proper dental care can help prevent the development of serious dental issues, as well as help prevent the exacerbation of other chronic conditions. Eligible members can receive a dental hygiene kit that includes essential oral health products, including an electronic toothbrush, toothpaste, and floss.

Benefit eligibility/limits: All members are eligible. One-time annual benefit.

Build Your Own Personal Hygiene Box



Eligible members will receive a \$50 allowance to purchase items from a hygiene catalogue.

This VAS supports members in maintaining good personal hygiene, helping lower the risk of illness, infection, and the exacerbation of medical conditions. Members can select products that best suit their needs such as shampoos, conditioners, deodorants, toothbrush holders, hair combs/brushes, facial tissues, and more. **Benefit eligibility/limits:** All members are eligible. One-time annual benefit.

Feminine Care Collection



Menstruation can become a barrier to education, as many young women do not have access to feminine hygiene products, which can result in missed school or other daily activities. To help make sure our members have access to these essential products, they will receive up to a \$75 allowance to purchase items from a feminine care catalogue. Items include sanitary napkins, tampons, hygiene wash, discreet carrying bags, panty liners, over-the-counter menstrual-related pain relievers, and more. Our goal is to help our members manage their periods in a healthy manner that enables full participation in school, work, and activities of their daily lives, and promotes increased self-esteem and mental health. **Benefit eligibility/limits:** Female members ages 10-18 years are eligible for this benefit. Maximum allowance of \$75 per year, per member.

Healthy Lifestyle Aids



To support members in achieving healthy lifestyles, this VAS allows them to select up to \$75 in supportive aids to help with mobility and personal comfort. Members can select from a wide variety of options, including digital scales, dexterity products, lumbar pillows, personal fans, clip-on lamps, non-slip socks, large button remotes, diabetic supplies, and more. **Benefit eligibility/limits:** All members are eligible to receive this VAS. This VAS is a one-time benefit.

VAS for Community and Social Supports



This suite of VAS helps promote responsibility and self-management by educating members about locally available services. From providing discounts to local retailers and restaurants so they can engage in their communities, to equipping new graduates with free laptops so they can pursue higher learning, the following VAS support members so they can thrive in their daily lives.

No-cost Laptop Benefit



To help with educational pursuits and make learning processes simpler and more efficient, we will provide a no-cost laptop for members pursuing continuing education. **Benefit eligibility/limits:** To be eligible, members graduating high school must submit a report card showing at least a 3.5 GPA or higher or they must complete and pass TASC/GED. Members must be enrolled with UniCare at the time of graduation or TASC/GED completion. This VAS is a one-time benefit.

\$100 Gas Card



For our members without easy access to transportation, such as those in rural areas, our VAS provides up to \$100 in gas cards to help them and their families with transportation. This benefit helps our members access extracurricular activities, self-help meetings, educational programs, grocery stores, and more. **Benefit eligibility/limits:** All members in case management are eligible, and this benefit is limited to one card per household per year. \$100 maximum allowance (\$25 increments per quarter). CHIP members may use this benefit to access covered medical appointments as well.

Family Activity Coupon Book



This VAS offers a Family Activity Coupon book filled with special discounts for local retailers, restaurants, and entertainment to help offset financial concerns and promote family togetherness.

In-store and online discounts (for select retailers) are available for Shoe Carnival, Famous Footwear,

Family Dollar, Redbox, Barnes and Noble, Advance Auto Parts, Learning Express, and many more.

Benefit eligibility/limits: All members are eligible to receive one coupon book, per household, per year.

Online Well-being Program



Our Online Well-being program helps members manage stress, anxiety, substance use, chronic pain, sleep disruption, and other barriers to health. The VAS includes self-help resources that incorporate cognitive behavioral therapy, motivational interviewing, positive psychology, and mindfulness. It also offers new evidence-based tools to promote tobacco cessation through personalized interventions. The program will also be adding information focused on pregnancy and early parenting.

Benefit eligibility/limits: Members 13 years and older are eligible.

Lifeline Smart Phone Benefit

To supplement the Federal Lifeline program, which offers free cell phones, we offer members 200 bonus minutes at enrollment and 100 bonus minutes during their birthday month. Members can make unlimited calls to our toll-free line. **Benefit eligibility/limits:** Members 18 years and older are eligible.

Community Resource Link

Our online Community Resource Link locates and displays all available local community-based services so members can quickly and easily find options for housing, food, employment, social services, and transportation. This easy-to-use online tool promotes increased personal responsibility and self-management by educating members and families about supplemental supports and services of which they may be unaware. **Benefit eligibility/limits:** All members are eligible.



Vendor Responses to Detailed Specifications

Instructions for Completion of Appendix 1 - Detailed Specifications

1. The Vendor should provide the Section, and Page Number(s) where its detailed narrative response for each specification resides, providing the Department with a crosswalk, ensuring that each specification is addressed. It is up to the Vendor to update the Section, and Page Number(s) columns.
2. Using Tab 3 - Specifications & Responses, the Vendor should provide the Attachment, Section, and Page Number(s) where its detailed narrative response or acknowledgement for each specification resides.
3. Hierarchy Level: The hierarchy level column defines relationships between parent and child specifications. The Department refers to parent specifications as specifications that rely on the content of a subset of related specifications (children) to fully define the scope of the requirement. The Department refers to child specifications as specifications that rely on additional context provided by a higher-level specification (parent) to fully define the scope of the specification. A hierarchy value of 1 denotes the highest level specification. A hierarchy level 2 is a child to the nearest prior hierarchy level 1.
4. When included in a specification, the phrase "for applicable populations" is typically used to delineate between covered services provided for varying populations within the MHT. For example, the Vendor would not be expected to cover the



Vendor Responses to Detailed Specifications

Tabs in this spreadsheet		
1. Worksheet Instructions	Contains instructions for completion of this RFP supplement.	
2. Worksheet Information	Contains information about the contents of this workbook.	
3. Specifications & Responses	Contains the specifications and all related data.	
4. Code Values	Contains coded values for use in the specifications and response tab, and explanations as	
Columns on the Specification & Responses Tab		
Section	Column	Description
Specifications	Req ID #	The unique ID of the specification.
	Hierarchy Level	The hierarchy of the specification.
	Specification Text	The text of the specification.
	Subject Matter Area	How the specification is categorized in the RFP.
Vendor Response Area	Section and Page Reference	Vendor is expected to provide a reference to its RFP response by Section and Page Number where more detailed information about the specification can be found.



Vendor Responses to Detailed Specifications

Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
GE001	1	The Vendor should adhere to page limits, as defined within Section 5 of the Request for Proposal (RFP), and provide responses in 12-point font, single-sided, double-spaced, and with page numbers.	General	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 1. General	1
GE002	1	The Vendor should adhere to templates as indicated within the Request for Proposal (RFP) for the provision of all requested information in Attachment 3: Vendor Qualifications & Experience.	General	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 1. General	1
BA001	1	The Vendor should provide its plan to impose, monitor, and track member co-pays and quarterly household maximums for including, but not limited to, the following:	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	1
BA002	2	Medical Services (includes Physical, Behavioral Health, Dental, and Vision)	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	1
BA003	2	Pharmacy Services	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	1
BA004	1	The Vendor should describe its process for development and revision of Utilization Management (UM) guidelines, as indicated in the Service Provider Agreement (SPA).	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	4
BA005	1	The Vendor should provide its training curriculum for Utilization Management (UM) and clinical staff.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	12

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Vendor Responses to Detailed Specifications

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA006	1	The Vendor should describe its Utilization Management (UM) monitoring guidelines that operate in conjunction with fraud and abuse detection activities, including, but not limited to, the following:	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	16
BA007	2	Ongoing monitoring of Emergency Room (ER) utilization	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	18
BA008	2	Ongoing monitoring of potential abuse or inappropriate utilization of controlled prescription medications	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	21
BA009	2	Reports and other tools that will be used to monitor and manage service utilization	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	23
BA010	1	The Vendor should describe its process for preventing and detecting fraud and abuse related to all administered services including Pharmacy, if applicable.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	25
BA011	1	The Vendor should describe its process for modifying its standard Utilization Management (UM) protocols when reviewing referral and treatment requests for members with special health care needs including, but not limited to, the following:	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	27
BA012	2	Standing referrals	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	29

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Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
BA013	2	Expedited utilization review processes	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	29
BA014	1	The Vendor should describe its process for any condition-specific protocols or standards that will be used to manage members with special health care needs, defined as individuals with complex or serious medical conditions.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	30
BA015	1	The Vendor should describe its process for how condition-specific protocols and conditions will be updated and shared with primary and specialty care providers.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	35
BA016	1	The Vendor should describe its process to honor authorization approvals from previous coverage during the transition period, defined as the period in which members are moving from one Managed Care Organization (MCO) to another or from Fee-for-Service (FFS) to an MCO, or private insurance to an MCO. These processes should include, but are not limited to, the following:	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	37
BA017	2	Medical Services (includes Physical, Behavioral Health, Dental, and Vision)	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	38
BA018	2	Pharmacy	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	40

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Vendor Responses to Detailed Specifications

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA019	1	The Vendor should describe how providers and/or members will be notified regarding the expiration of medical authorizations, and pharmacy authorizations, if applicable.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	41
BA020	1	The Vendor should describe its process for authorizing out-of-network access including, but not limited to, the following:	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	42
BA021	2	Emergency Services, including transportation	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	43
BA022	2	Medically Necessary Travel, for the West Virginia Children's Health Insurance Program (WVCHIP)	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	44
BA023	2	Medical Necessity	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	45
BA024	2	Out-of-State Providers (for example, members who are students, live in proximity to State borders, etc.)	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	45
BA025	1	The Vendor should describe its process for circumstances under which a member might be granted a standing referral to a specialist provider.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	46

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Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
BA026	1	The Vendor should describe the extent to which a specialist provider may refer services.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	47
BA027	1	The Vendor should describe its process for out-of-network referrals, including, but not limited to, the following:	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	48
BA028	2	Members and/or providers requesting out-of-network referrals	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	50
BA029	2	Processes in which a member may continue an existing relationship with an out-of-network provider, or a provider that leaves the Vendor's network, if considered to be in the best medical interest of the member	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	50
BA030	2	Durations permitted for members to see out-of-network providers that refuse to contract with the Vendor for ongoing courses of treatment past the first 90 days of enrollment	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	50
BA031	1	The Vendor should its procedures for ensuring that member information from non-network providers is shared with the member's Primary Care Provider (PCP).	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	52
BA032	1	The Vendor should describe its process to assist in enrolling and pairing the member with an appropriate in-network provider within 90 days of enrollment.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	52

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Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA033	1	The Vendor should describe its process for transferring necessary clinical information to a member's new provider.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	53
BA034	1	The Vendor should describe its process for member access and coverage of Family Planning services.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	55
BA035	1	The Vendor should describe its process for accessing crisis stabilization services.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	59
BA036	1	The Vendor should describe how they will comply with Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program requirements, as indicated by the Centers for Medicare & Medicaid Services (CMS) at https://www.medicare.gov/medicaid/benefits/epsdt/index.html , including its process to ensure that children who are receiving primary care from a specialist receive EPSDT services.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	64
BA037	1	The Vendor should describe its policies and procedures for assisting the State or fiscal agent with the pharmacy rebate resolution process including rejected or disputed physician administered drug claims.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	71
BA038	1	The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when medical service limitations are imposed.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	75

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Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
BA039	1	The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when prescription limits are imposed.	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	80
BA040	1	The Vendor should describe its process for informing Primary Care Providers (PCPs) regarding changes in a member's behavioral health status including, but not limited to, the following:	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	83
BA041	2	What constitutes a change in behavioral health status	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	84
BA042	2	How the member will be assisted to access additional services as a result of a change in behavioral health status	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	86
BA043	1	The Vendor should describe its coordination of care activities between Primary Care Providers (PCPs) and children's dental providers, especially for children with special health care needs (CSHCN).	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	87
BA044	1	The Vendor should describe its mechanisms to remind members of upcoming appointments, including, but not limited to, the following:	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	93
BA045	2	Medical Appointments and Screenings	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	94

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Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA046	2	Dental Appointments and Screenings, including monitoring utilization and interventions if a member has not had a screening in over one year	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	95
BA047	2	Adherence to the periodicity schedule as dictated by the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, as indicated by the Centers for Medicare & Medicaid Services (CMS) at https://www.medicaid.gov/medicaid/benefits/epsdt/index.html	Benefit Administration	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 2. Benefit Administration	96
CM001	1	The Vendor should describe its Care Management program, including, but not limited to, the following:	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	1
CM002	2	Processes to organize its care management department by disease or problem type	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	4
CM003	2	Processes to identify members for participation in the care management program, including screening and timeliness of enrollment, risk levels/tiers, Social Determinants of Health (SDOH)	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	7
CM004	2	Processes and timeframes for assigning members to a care manager	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	11
CM005	2	Processes for identifying candidates for care management, or those receiving high-cost care, who would benefit from care management	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	11

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Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
CM006	2	Processes for how care managers will establish relationships with members, including frequency and timeliness standards after the initial health assessment	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	13
CM007	2	Processes to ensure that members who have specialists as Primary Care Providers (PCPs) are receiving primary care services on an ongoing basis, and interventions if adequate services are not being provided	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	15
CM008	2	Processes to ensure continuity and coordination of care	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	17
CM009	2	Processes to identify pregnant women at enrollment and on an ongoing basis	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	21
CM010	2	Processes to promote "early and often" prenatal care for women identified as being pregnant	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	22
CM011	2	Processes for Supplemental Security Income (SSI) members, if different	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	25
CM012	2	Processes for administering care management for both adults and children	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	28

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CM013	2	Processes for administering care management for members with special health care needs, defined as individuals with complex or serious medical conditions	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	31
CM014	2	Processes for administering care management for children with special health care needs (CSHCN)	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	31
CM015	1	The Vendor should describe strategies to manage members with a history of prescription drug abuse, and processes for monitoring potential abuse or inappropriate utilization of controlled prescription medications.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	36
CM016	1	The Vendor should describe its process for performing screenings or assessments as part of its care management program, including, but not limited to, the following:	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	43
CM017	2	Members with special health care needs, defined as individuals with complex or serious medical conditions	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	44
CM018	2	Children with special health care needs (CSHCN)	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	46
CM019	2	Clinical, social, or other criteria used to determine which members require care management and assignment to care managers	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	47

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		Specification Text	Subject Matter Area	Section	Page #
CM020	2	Performance of health assessments	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	48
CM021	2	Implementation of targeted education programs	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	50
CM022	1	The Vendor should describe its process for creating educational materials and educating members and care management staff.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	51
CM023	1	The Vendor should describe its staff qualification and training requirements for individuals who will be involved in coordinating care, including, but not limited to, any specialized care managers utilized for certain conditions.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	54
CM024	1	The Vendor should describe its process for hiring care management staff including, but not limited to, the following:	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	58
CM025	2	Staff qualifications	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	58
CM026	2	Plan for hiring	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	59

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CM027	2	Timeframe for hiring	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	59
CM028	2	Total number of care managers to be hired	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	60
CM029	2	Maximum case loads and ratios per care manager for Vendor-defined risk tiers	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	60
CM030	1	The Vendor should describe its process for monitoring and evaluating care managers in regard to establishing relationships with members, including, but not limited to, statistics collected and frequency of collection.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	61
CM031	1	The Vendor should describe its protocols for addressing a member that would benefit from a care manager, including alternatives for members that do not want a care manager, members who cannot be reached, and members who have missed medical appointments.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	65
CM032	1	The Vendor should describe its process for identifying members in need of treatment plans, and the development, updating, and implementation of treatment plans wherein service coordination is required.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	68
CM033	1	The Vendor should describe its process for the development of member treatment plans, including, but not limited to, the following:	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	70

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CM034	2	Including Primary Care Providers (PCPs) in the development of treatment plans	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	70
CM035	2	Sharing treatment plans with the member's PCP or other providers, as applicable	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	71
CM036	2	Staff responsible for sharing treatment plans with the member's PCP	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	71
CM037	2	Tracking of completion of treatment plans	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	72
CM038	2	Identification, tracking, and remediation of gaps in care	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	73
CM039	2	Processes for episodic and/or catastrophic care management interventions	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	74
CM040	1	The Vendor should describe its protocols for addressing a provider that does not perform coordination activities that includes, but is not limited to, the following:	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	77

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CM041	2	Identification	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	77
CM042	2	Actions taken to improve coordination	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	80
CM043	1	The Vendor should describe its programs for coordination of care with community resources and social services for members.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	81
CM044	1	The Vendor should describe its approach to address Social Determinants of Health (SDOH).	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	86
CM045	1	The Vendor should describe its care coordination efforts that identify and address member access including, but not limited to, the following:	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	90
CM046	2	Employment	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	90
CM047	2	Food security	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	90

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CM048	2	Housing stability	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	90
CM049	2	Education	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	90
CM050	2	Social cohesion	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	90
CM051	2	Resources that connect members to social supports and healthcare	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	90
CM052	2	Environmental needs	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	90
CM053	1	The Vendor should describe its plan to develop additional programs for Social Determinants of Health (SDOH).	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	94
CM054	1	The Vendor should describe its population health approach including, but not limited to, the following:	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	103

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CM055	2	Engaging members across the entire care continuum	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	105
CM056	2	Promoting and incentivizing healthy behaviors and disease self-management	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	107
CM057	2	Integrating care management	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	109
CM058	2	Advancing evidence-based practices	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	110
CM059	1	The Vendor should describe its process to evaluate the member population and coordinate prevention and wellness programs available to all members.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	113
CM060	1	The Vendor should describe its process to collect and maintain member self-reported demographic, social determinants, and health needs assessment data for aggregate use in, at a minimum, population health management, network adequacy determination, and quality improvement activities.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	116
CM061	1	The Vendor should describe its process to refer all eligible pregnant members to the Bureau for Public Health's (BPH's) Women, Infants, and Children Program (WIC) for nutrition services during and after pregnancy.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	118

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		Specification Text	Subject Matter Area	Section	Page #
CM062	1	The Vendor should describe its process to coordinate with the Bureau for Public Health's (BPH's) Office of Maternal, Child, and Family Health (OMCFH), Office of Nutrition Services (ONS), and Office of Community Health Systems and Health Promotion (OCHSHP) to link members with necessary public health prevention and support services.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	120
CM063	1	The Vendor should describe its protocols to coordinate care for members receiving Social Necessary Services (SNS) through the Specialized Foster Care Administrative Services Organization (ASO).	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	122
CM064	1	The Vendor should describe its process to share information for children enrolled in the Specialized Foster Care Managed Care Organization (MCO) including, but not limited to, authorization data, medical history, claims history, medical records, and other patient information.	Care Management	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 3. Care Management	124
CS001	1	The Vendor should describe its approach to establishing and maintaining relationships with associated Department agencies and State advocacy groups.	Community/Stakeholder Engagement	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 4. Community/Stakeholder Engagement	1
CS002	1	The Vendor should describe its approach to establishing and maintaining relationships with applicable provider and medical associations.	Community/Stakeholder Engagement	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 4. Community/Stakeholder Engagement	7

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CS003	1	The Vendor should describe its approach to establishing and maintaining relationships with applicable professional boards.	Community/Stakeholder Engagement	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 4. Community/Stakeholder Engagement	8
CS004	1	The Vendor should describe its process to coordinate with agencies providing complimentary services to the member.	Community/Stakeholder Engagement	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 4. Community/Stakeholder Engagement	11
MS001	1	The Vendor should describe how they will collaborate with stakeholders to design materials that best meet the needs of the populations being served.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	1
MS002	1	The Vendor should describe how they will leverage information technology (IT) solutions to improve access to member information.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	7
MS003	1	The Vendor should describe its methodology for assigning members to a Primary Care Provider (PCP) including, but not limited to, claims history, proximity, and within contractually defined timeframe.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	10
MS004	1	The Vendor should describe how they will develop protocols to notify members of Primary Care Provider (PCP) assignment.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	14



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Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
MS005	1	The Vendor should describe how they will educate members of the right to change Primary Care Providers (PCPs).	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	15
MS006	1	The Vendor should describe its process for conducting initial and ongoing assessments appropriate for members' circumstances and needs including, but not limited to, the following:	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	16
MS007	2	Methods utilized to complete assessments, and variances by risk level	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	16
MS008	2	Timeline to complete assessments, and variances by risk level	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	16
MS009	2	Identification of the trigger(s) for completion of a comprehensive assessment	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	16
MS010	2	How assessments will be used to develop and update treatment plans and confirm the risk stratification level for each member	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	20
MS011	2	How data from a member's Primary Care Provider (PCP) will be used to prevent duplication of assessment efforts and assist with identification of priorities for the member	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	21

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Specifications				Vendor Response	
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MS012	2	How a member who cannot be reached or who refuse assessments will be handled by the Vendor, including multiple contacts if initial contacts are unsuccessful	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	23
MS013	2	How assessment data will be stored and made available to members of the care team in order to coordinate care	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	25
MS014	2	How assessment data will be shared with a member's other payer(s), as applicable, in order to prevent duplication of efforts	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	25
MS015	1	The Vendor should describe how they will distribute and provide notice of member handbooks on an ongoing basis, according to an established turnaround time, and including, but not limited to, the following:	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	27
MS016	2	Updates to the member handbook	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	28
MS017	2	Handbooks requested ad hoc by a member	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	29
MS018	1	The Vendor should describe its warm transfer protocols for its member services, other internal departments, other entities, and subcontractors, as applicable.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	30



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Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
MS019	1	The Vendor should describe how they will train member services representatives.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	31
MS020	1	The Vendor should describe how they will ensure they are meeting customer use and report to the Department on customer service performance standards including, but not limited to, the following:	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	36
MS021	2	Member-to-representative ratios	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	39
MS022	2	Call answering time, with a minimum of 83% of calls answered in thirty (30) seconds	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	41
MS023	2	Call abandonment rate not to exceed five percent (5%)	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	41
MS024	2	Single contact resolution	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	41
MS025	2	Turnaround time for member requests	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	41

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MS026	2	Remediation strategies for performance issues	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	42
MS027	1	The Vendor should describe its new member enrollment and education process, defined as the time of initial notification of the member's enrollment through the first month of actual enrollment, which includes, but is not limited to, the following:	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	43
MS028	2	Member contact, including welcome calls, welcome letters, and/or home visits	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	44
MS029	2	Outreach to members who are difficult to contact, including disabled members and members without telephones	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	47
MS030	2	Processing and issuing identification cards	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	49
MS031	2	Distributing member handbooks	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	51
MS032	1	The Vendor should describe how they will make information available for members who have Limited English Proficiency (LEP) or limited reading skills, as indicated per 67 Federal Regulation (FR) 41455 (https://www.govinfo.gov/content/pkg/FR-2002-06-18/pdf/02-15207.pdf).	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	51

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MS033	1	The Vendor should describe how they will provide a secure member portal that allows members to log in and access benefit information including, but not limited to, the following:	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	55
MS034	2	Medical records	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	55
MS035	2	Authorization status	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	55
MS036	2	Cost sharing information	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	55
MS037	2	Temporary identification (ID) cards	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	55
MS038	2	Confirmation of Primary Care Provider (PCP)	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	55
MS039	2	Provision of access to guardians	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	55

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MS040	1	The Vendor should describe its process to inform members that program information is available in paper form without charge upon request and available within five (5) business days.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	60
MS041	1	The Vendor should describe how they will make auxiliary aids and services, as well as oral interpretation services, available in all non-English languages to all members and potential members, free of charge, including the top fifteen languages spoken in the State, which are Spanish, Chinese, French, German, Arabic, Vietnamese, Korean, Japanese, Tagalog, Italian, Thai, Nepali, Persian, Russian, and Urdu.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	61
MS042	1	The Vendor should describe how they will notify members that oral interpretation services are available for any language, and that written information is available in prevalent languages and braille, and how to access those services.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	63
MS043	1	The Vendor should describe how they will include taglines in all written materials 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 Text Telephone (TTY)/Telecommunication Device for the Deaf (TDD) telephone number of the Vendor.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	64
MS044	1	The Vendor should describe its policies and procedures related to issuance of member identification cards within contractually defined timeframes.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	65
MS045	1	The Vendor should describe how they will administer a health education program for disease and injury prevention and identification.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	66

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MS046	1	The Vendor should describe its tobacco-cessation program.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	76
MS047	1	The Vendor should describe how they will leverage community events/resources to help improve the health of its member population.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	79
MS048	1	The Vendor should describe how they will foster cultural competency among staff.	Member Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 5. Member Services	87
ED001	1	The Vendor should describe its policies and procedures regarding enrollment of members, including the processing of 834 enrollment files.	Enrollment and Disenrollment	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 6. Enrollment and Disenrollment	1
ED002	1	The Vendor should describe its policies and procedures regarding disenrollment of members, including processes for reconciliation of members against the monthly 820 capitation file.	Enrollment and Disenrollment	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 6. Enrollment and Disenrollment	7
ED003	1	The Vendor should describe its written policies and procedures and protocols for enrolling newborn children of members retroactively to the time of birth, and transferring newborn information to the Department for processing.	Enrollment and Disenrollment	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 6. Enrollment and Disenrollment	8

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ED004	1	The Vendor should describe its protocols to cover newborns even if the mother does not remain enrolled after the newborn's date of birth.	Enrollment and Disenrollment	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 6. Enrollment and Disenrollment	11
ED005	1	The Vendor should describe its written policies and procedures for transferring relevant member information, including medical records and other pertinent materials, when a member is disenrolled from the Vendor and enrolled with another Vendor.	Enrollment and Disenrollment	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 6. Enrollment and Disenrollment	12
ND001	1	The Vendor should describe how they will establish and maintain a provider network that provides statewide access to geographically accessible hospitals, primary care, specialty care, dental providers, and all other required provider types and specialties.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	1
ND002	1	The Vendor should describe how they will establish and maintain a network of accessible, contracted, and credentialed providers for all covered services including supplemental services such as value-add services for, or on behalf of Mountain Health Trust (MHT) members.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	8
ND003	1	The Vendor should describe how they will establish network development and monitoring processes that ensure adequacy of covered services and includes the following considerations, including, but not limited to, the following:	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	10
ND004	2	The anticipated MHT enrollment and the appropriate PCP provider-to-member ratios for adult and pediatric members	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	10
ND005	2	The expected utilization of services for the anticipated MHT populations assigned to the Vendor for care	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	11

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ND006	2	The number of providers not accepting new patients	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	11
ND007	2	The geographic location of providers and members, considering time and distance, and transportation needs	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	12
ND008	2	The location of providers with physical access accommodations for members with disabilities and/or other requirements set forth under the Americans with Disabilities Act (ADA)	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	12
ND009	1	The Vendor should describe how they ensure its provider network will provide culturally competent care to members.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	15
ND010	1	The Vendor should describe how they will develop and maintain a directory of providers that includes provider names, locations with street address, website URLs (as appropriate), and telephone numbers of current contracted providers in the member's service area.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	17
ND011	1	The Vendor should describe its process to ensure its provider network adheres to geographical access standards for all adult and pediatric members.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	19
ND012	1	The Vendor should describe how they will establish provider contracts and include in its provider network all identified comprehensive behavioral health and Psychiatric Residential Treatment Facilities (PRTF), as defined within the Service Provider Agreement (SPA), for both pediatric and adult Mountain Health Trust (MHT) members.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	20

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Vendor Responses to Detailed Specifications

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
ND013	1	The Vendor should describe how its network development and adequacy processes include and assess provider hours of operations, convenience to members, and parity to commercial or Fee-for-Service (FFS) populations.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	23
ND014	1	The Vendor should describe its guidelines and monitoring processes that ensure members have timely access to care per contractual requirements.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	25
ND015	1	The Vendor should describe its process for the selection, credentialing, retention, and maintaining of qualified providers.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	35
ND016	1	The Vendor should describe how they will ensure that its network providers have completed enrollment with the Department as required by Centers for Medicare & Medicaid Services (CMS) Medicaid and Children's Health Insurance Program Medicaid Managed Care Final Rule (https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicare-managed-care-chip-delivered).	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	37
ND017	1	The Vendor should describe how they will establish credentialing and re-credentialing processes that fully comply with West Virginia C.S.R. §114-53-6 (https://www.wvinsurance.gov/Portals/0/pdf/pol_leg/rules/ins/rule_053.pdf?ver=2004-09-14-092000-000) and 42 Code of Federal Regulations (CFR) 455, Subpart B (https://www.govinfo.gov/app/details/CFR-2011-title42-vol4/CFR-2011-title42-vol4-part455-subpartB).	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	38

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Vendor Responses to Detailed Specifications

Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
ND018	1	The Vendor should describe how they will establish site visit criteria and evaluation as part of its credentialing process for Primary Care Providers (PCPs), Obstetrics and Gynecologists (OB/GYNs), Durable Medical Equipment (DME) providers, behavioral health providers, other high risk providers, and other highly utilized specialists.	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	46
ND019	1	The Vendor should describe its process for reimbursement of services that occur during mid-transfer of a treatment, when a recoupment is not available through the original provider (for example, orthodontia).	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	47
ND020	1	The Vendor should describe how they will establish notification processes related to provider network terminations including, but not limited to, the following:	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	48
ND021	2	Notification to the Department and the enrollment broker with advanced written notice of any Primary Care Provider (PCP) network deletions within fourteen calendar days	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	49
ND022	2	Written notification to members, at least thirty calendar days prior to the termination, to allow the opportunity to select a new Primary Care Provider (PCP) before being assigned one	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	49
ND023	2	Immediate notification of a hospital termination to the Department	Network Development	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 7. Network Development	50
PS001	1	The Vendor should provide a description of its Provider Services operating model.	Provider Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 8. Provider Services	1

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Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
PS002	1	The Vendor should describe how its Provider Services Department will provide initial provider orientation, annual training, and support to its provider network.	Provider Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 8. Provider Services	9
PS003	1	The Vendor should describe its process for specialists serving as Primary Care Providers (PCPs), and related monitoring activities.	Provider Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 8. Provider Services	19
PS004	1	The Vendor should describe how its Provider Services Department will provide training to its provider network regarding culturally competent care.	Provider Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 8. Provider Services	21
PS005	1	The Vendor should describe its annual review process of its provider manual, including thirty business days prior notice of any material changes to impacted providers.	Provider Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 8. Provider Services	24
PS006	1	The Vendor should describe how members are held harmless and protected from balance billing for covered services.	Provider Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 8. Provider Services	26
PS007	1	The Vendor should describe how they will develop comprehensive Value-Based Payment (VBP) strategies that link provider payment levels to quality of care outcomes.	Provider Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 8. Provider Services	29



Vendor Responses to Detailed Specifications

Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
PS008	1	The Vendor should describe its process to conduct annual provider satisfaction surveys to evaluate the overall satisfaction of its network providers, including the evaluation of results of satisfaction surveys on an annual basis, and how the Vendor will utilize data to inform quality improvement activities to enhance network satisfaction and availability of services to members.	Provider Services	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 8. Provider Services	43
CE001	1	The Vendor should describe its claims processing guidelines and systems requirements that ensure timely payment of all clean electronic and paper claims for covered services from both in-network and out-of-network providers, within thirty calendar days of receipt for Mountain Health Trust (MHT) members.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	1
CE002	1	The Vendor should describe its claims processing guidelines for contractually obligated services to ensure that claims are paid at no less than 100% of the prevailing rate for Mountain Health Trust (MHT) Medicaid or West Virginia Children's Health Insurance Program (WVCHIP) Fee-for-Service (FFS) rate(s), as applicable.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	10
CE003	1	The Vendor should describe its claims processing guidelines that ensure the denial of claims payment for preventable provider and/or hospital acquired conditions as defined under Section 2702(a) of the Affordable Care Act (ACA) (https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf).	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	12
CE004	1	The Vendor should describe how they will implement rate changes adopted by the Department within thirty calendar days of notification of the rate change.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	14

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Vendor Responses to Detailed Specifications

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CE005	1	The Vendor should describe how its claims processing systems and guidelines uphold payment policies that comport with the National Correct Coding Initiatives (NCCI) edits and/or other claims payment guidance defined by the Centers for Medicare & Medicaid Services (CMS) (https://www.cms.gov/medicare/coding/nationalcorrectcoding/index.html).	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	15
CE006	1	The Vendor should describe its claims processing guidelines and systems requirements that waive member co-payment or cost-sharing obligations for all applicable populations and covered services.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	17
CE007	1	The Vendor should describe its process to evaluate the data quality of its claims/encounters submissions to the Department including, but not limited to, the formatting and all data elements required to complete compliant 837 electronic transactions for medical and dental claims.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	18
CE008	1	The Vendor should describe its encounter certification process that requires its Chief Executive Officer (CEO), Chief Financial Officer (CFO) or other designee to certify the accuracy and completeness of its claims/encounter data information submitted to the Department.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	23
CE009	1	The Vendor should describe its process that ensure complete and accurate encounter data is submitted to the Department on a monthly basis and no later than thirty calendar days after the end of the period in which the service was paid.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	23
CE010	1	The Vendor should describe its process and how they will implement a data accuracy and completeness monitoring program for its encounters that includes delegation oversight of subcontractors, as applicable.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	26



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Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
CE011	1	The Vendor should provide its annual encounter data accuracy and completeness plan with its bid.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	30
CE012	1	The Vendor should describe its process to submit reports to the Department that summarize the encounter activity including, but not limited to, the following:	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	31
CE013	2	A detailed summary of the file submission that includes total claims and dollars by service category	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	31
CE014	2	A detailed change log that includes specifications for any change in the claims processing system that has an impact on the representation of the data in monthly encounter files	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	31
CE015	1	The Vendor should describe its process to reconcile encounter data submitted to the Department with the financial data that it reports on a quarterly basis, including a narrative explaining any difference of five percent (5%) or higher.	Claims and Encounters	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 10. Claims and Encounters	32
QU001	1	The Vendor should describe its Quality Assessment and Performance Improvement (QAPI) Program.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	1
QU002	1	The Vendor should describe how they will coordinate Quality Assessment and Performance Improvement (QAPI) activities with other performance monitoring activities.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	14

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Vendor Responses to Detailed Specifications

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
QU003	1	The Vendor should describe how they will utilize data to identify barriers to care for individuals with special health care needs, and develop policies and procedures for methodologies for collecting and analyzing quality measures for different populations.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	21
QU004	1	The Vendor should describe how they will establish procedures for formal and ongoing communication and collaboration among the Quality Assessment and Performance Improvement (QAPI) policymaking body and other functional areas of the Vendor (for example, health services management and enrollee services).	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	29
QU005	1	The Vendor should describe its approach to having staff and providers receive initial and ongoing training on health equity and Social Determinants of Health (SDOH).	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	33
QU006	1	The Vendor should describe its policies and procedures regarding utilization of reports and data from subcontractors to ensure appropriate oversight and member access, satisfaction, and continuity of care.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	38
QU007	1	The Vendor should describe how they will administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	42
QU008	1	The Vendor should describe its process to administer and utilize the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results to identify and investigate areas of member dissatisfaction, outline action steps to follow up on survey findings, and disseminate findings with providers.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	44
QU009	1	The Vendor should describe how they will gather, report, and utilize audited Healthcare Effectiveness Data and Information Set (HEDIS) measures.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	48

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Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
QU010	1	The Vendor should describe how they will gather and use results for all identified core adult and child quality measures relevant to covered services to identify opportunities to improve member health outcomes, following the technical specifications provided by the Centers for Medicare & Medicaid Services (CMS) (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html), (https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html).	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	56
QU011	1	The Vendor should describe how they will develop standards of performance when providing healthcare and related services to members to meet all goals for performance improvement on specific measures, as established by the Department.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	59
QU012	1	The Vendor should describe its approach to developing performance improvement projects that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. Projects 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.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	61
QU013	1	The Vendor should describe how they will establish and utilize one or more quality indicators that are objective, clearly and unambiguously defined, and based on current knowledge or health services research, to assess its performance.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	67

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Vendor Responses to Detailed Specifications

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
QU014	1	The Vendor should describe how they will use data to identify barriers to care for individuals with special health care needs.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	Removed per Addendum 5 released February 5, 2020
QU015	1	The Vendor should describe its policies and procedures to correct and remediate significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.	Quality	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 9. Quality	69
PI001	1	The Vendor should describe its administrative and management arrangements or procedures that are designed to detect, prevent, investigate, and report potential fraud, waste, and abuse (FWA).	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	1
PI002	1	The Vendor should describe its Special Investigations Unit (SIU) policies and procedures for identifying and investigating potentially or suspected fraudulent behavior, and its criteria for referring such behavior to the Department.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	12
PI003	1	The Vendor should describe its process to work with the Department, the Medicaid Fraud Control Unit (MFCU), the Centers for Medicare & Medicaid Services (CMS), and the Department of Health and Human Services (DHHS), to administer effective fraud, waste, and abuse (FWA) detection and prevention practices.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	16
PI004	1	The Vendor should describe how they will maximize resources for fraud, waste and abuse (FWA) issues.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	17
PI005	1	The Vendor should describe its process for responding to all program integrity and Medicaid Fraud Control Unit (MFCU) requests within the timeframes established by the Department.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	18

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Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
PI006	1	The Vendor should provide its compliance plan with clear goals, timelines, assignments, and measurements as outlined by the Department.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	18
PI007	1	The Vendor should describe its training and education of the compliance officer and the organization's employees, including senior management, on State and federal standards and contract requirements.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	21
PI008	1	The Vendor should describe its disciplinary guidelines and procedures for enforcement of compliance standards.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	23
PI009	1	The Vendor should describe its procedures for routine internal monitoring, auditing, and remediation of compliance risks and identified issues.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	25
PI010	1	The Vendor should describe its oversight and monitoring process for any delegated functions and services, as provided by a subcontractor, in accordance with guidelines defined under the contract.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	28
PI011	1	The Vendor should describe its process for monitoring provider fraud for underutilization of services and member/provider fraud for overutilization of services.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	38
PI012	1	The Vendor should describe its policies and procedures for denying, suspending, nonrenewal, or terminating affiliation with a contracting healthcare professional, including an appeals process, and for reporting serious quality deficiencies to appropriate authorities.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	40

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Vendor Responses to Detailed Specifications

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
PI013	1	The Vendor should describe its policies regarding identification and recoupment of provider overpayments, and processes to coordinate with the Department.	Program Integrity	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 11. Program Integrity	46
IM001	1	The Vendor should describe its written policies and procedures for safeguarding and maintaining the confidentiality of data, including differences for adult and children populations.	Information Management Systems	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 12. Information Management Systems	1
IM002	1	The Vendor should provide its plan for how it will maintain full Health Insurance Portability and Accountability Act (HIPAA) compliance, and maintain this compliance, throughout the life of the contract at no additional cost to the Department.	Information Management Systems	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 12. Information Management Systems	5
IM003	1	The Vendor should describe its policies to ensure that its staff, contracted providers, and all subcontractors that provide cost, quality, or medical appropriateness reviews or coordination of benefits or subrogation maintain the confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI).	Information Management Systems	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 12. Information Management Systems	15
IM004	1	The Vendor should describe how its health information system collects, integrates, analyzes, and reports data necessary to implement and maintain its Quality Assessment and Performance Improvement (QAPI) Program.	Information Management Systems	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 12. Information Management Systems	20
IM005	1	The Vendor should describe the flexibility of its health information system and processes utilized to develop requirements, configure, and test system changes as per new or modified contract requirements.	Information Management Systems	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 12. Information Management Systems	25



Vendor Responses to Detailed Specifications

Req ID #	Hierarchy Level	Specifications		Vendor Response	
		Specification Text	Subject Matter Area	Section	Page #
IM006	1	The Vendor should provide its business continuity and disaster recovery plan for the technology and infrastructure components of business operations with its bid.	Information Management Systems	ATTACHMENT 6: DETAILED SPECIFICATIONS APPROACH 12. Information Management Systems	33

ATTACHMENT 7: TERMS AND CONDITIONS RESPONSE TEMPLATE

1. Instructions

The Vendor should review **Attachment 7: Terms and Conditions Response Template**, signing each provided signature block using blue ink in order to note the Vendor's acknowledgement and intent of compliance. The Vendor should identify any exceptions to the Terms and Conditions. If exceptions are not noted in **Attachment 7: Terms and Conditions Response Template** of the RFP but raised during contract negotiations, the State reserves the right to cancel the negotiation if, at its sole discretion, it deems that to be in the best interests of the State.

2. RFP Terms and Conditions

RFP Terms and Conditions consist of provisions throughout this RFP. Moreover, these provisions encapsulate instructions, State and federal procedures, and the State's expectations of the Vendor when submitting a proposal. The Vendor should understand and strictly adhere to the RFP Terms and Conditions. Failure to follow any instructions within this RFP may, at the State's sole discretion, result in the disqualification of the Vendor's proposal.

Please provide an authorized signature stipulating the Vendor's acknowledgement, understanding, and acceptance of these RFP Terms and Conditions.

TADO HAYNES [Signature] 2/17/20
Printed Name / Signature of Authorized Personnel Date

3. State Customary Terms and Conditions

The selected Vendor will sign a contract with the State to provide the goods and services described in the Vendor's response. The following documents shall be included in any contract(s) resulting from this RFP:

- **Section 3: General Terms and Conditions (attached PDF file
Section_2_Instructions_To_Vendors_Submitting_Bids_and_Section_3_General_Terms_and_Conditions)**
- **Attachment 1: Provisions Required For Federally Funded Procurements**
- **Appendix 3: Service Provider Agreement (SPA)**
- **Business Associate Agreement**

Please provide a signature stipulating the Vendor's acknowledgement and complete review of these documents.

TADO HAYNES [Signature] 2/17/20
Printed Name / Signature of Authorized Personnel Date

If the Vendor is not taking exceptions to any of the State Customary Terms and Conditions, then the Vendor needs to provide a binding signature stipulating its acceptance of these documents.

TADO HAYNES [Signature] 2/17/20
Printed Name / Signature of Authorized Personnel Date

4. Mandatory Requirements and Terms

The following items are Mandatory Terms and Documents. Please be advised, the Vendor **should** provide its affirmative acceptance of these items in order to move forward with consideration under this RFP.

- Attachment 5: Mandatory Requirements (attached Microsoft Excel file, ***Attachment 5 – Mandatory Requirements***).
- Attachment 3, Section 2: Mandatory Qualifications.
- In no event shall the State agree to terms that (a) require indemnification by the State of the Contractor; (b) waive the State's right to a jury trial; (c) establish applicable law anywhere other than the State of West Virginia, or applicable jurisdiction's court of law; (d) designate a governing law other than the laws of the State of West Virginia; (e) constitute an implied or deemed waiver of the immunities, defenses, rights, or actions arising out of the State's sovereign status or under the Eleventh Amendment to the United States Constitution; (f) limit the time within which an action may be brought; (g) require arbitration; (h) require the ability to defend lawsuit without the approval of the Attorney General's Office; or (i) pay attorney fees.
- Business Associate's Agreement.

Vendors that are not able to enter into a contract under these conditions should not submit a bid.

Please provide an authorized signature stipulating the Vendor's acknowledgement, understanding, and acceptance of the Mandatory Requirements and Terms stipulated in this section.

TADO HAYNES [Signature] 2/17/20
Printed Name / Signature of Authorized Personnel Date

5. Exceptions

If a Vendor has any identified exceptions to the State's Terms and Conditions, it must complete the West Virginia Addendum to Vendor's Standard Contractual Forms (WV-96), found at this link: (<http://www.state.wv.us/admin/purchase/vrc/wv96.pdf>).

Any exceptions should include an explanation for the Vendor's inability to comply with such term or condition and, if applicable, alternative language the Vendor would find acceptable. Rejection of the State's Terms and Conditions, in part or in whole, or without any explanation, may be cause for the State's rejection of a Vendor's Proposal. If an exception concerning the Terms and Conditions is not noted in this response template, but raised during contract negotiations, the State reserves the right to cancel the negotiation, at its sole discretion, if it deems that to be in the best interest of the State.

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

Tadd Haynes, Medicaid Plan President, UniCare Health Plan of WV, Inc.
(Name, Title)

Tadd Haynes, Medicaid Plan President, UniCare Health Plan of West Virginia, Inc.

(Printed Name and Title)

200 Association Drive, Suite 200, Charleston, WV 25311

(Address)

Phone Number: (888) 611-9958 / Fax Number: (877) 833-5729

(Phone Number) / (Fax Number)

Tadd.Haynes@Anthem.com

(email address)

CERTIFICATION AND SIGNATURE: By signing below, or submitting documentation through wvOASIS, I certify that I have reviewed this Solicitation in its entirety; that I understand the requirements, terms and conditions, and other information contained herein; that this bid, offer or proposal constitutes an offer to the State that cannot be unilaterally withdrawn; that the product or service proposed meets the mandatory requirements contained in the Solicitation for that product or service, unless otherwise stated herein; that the Vendor accepts the terms and conditions contained in the Solicitation, unless otherwise stated herein; that I am submitting this bid, offer or proposal for review and consideration; that I am authorized by the vendor to execute and submit this bid, offer, or proposal, or any documents related thereto on vendor's behalf; that I am authorized to bind the vendor in a contractual relationship; and that to the best of my knowledge, the vendor has properly registered with any State agency that may require registration.

UniCare Health Plan of West Virginia, Inc.

(Company)

Tadd Haynes, Medicaid Plan President
(Authorized Signature) (Representative Name, Title)

Tadd Haynes, Medicaid Plan President

(Printed Name and Title of Authorized Representative)

2/17/20
(Date)

Phone number: (888) 611-9958 / Fax Number: (877) 833-5729

(Phone Number) (Fax Number)

West Virginia Ethics Commission

**Disclosure of Interested Parties to Contracts**

Pursuant to *W. Va. Code* § 6D-1-2, a state agency may not enter into a contract, or a series of related contracts, that has/have an actual or estimated value of \$1 million or more until the business entity submits to the contracting state agency a Disclosure of Interested Parties to the applicable contract. In addition, the business entity awarded a contract is obligated to submit a supplemental Disclosure of Interested Parties reflecting any new or differing interested parties to the contract within 30 days following the completion or termination of the applicable contract.

For purposes of complying with these requirements, the following definitions apply:

"Business entity" means any entity recognized by law through which business is conducted, including a sole proprietorship, partnership or corporation, but does not include publicly traded companies listed on a national or international stock exchange.

"Interested party" or *"Interested parties"* means:

- (1) A business entity performing work or service pursuant to, or in furtherance of, the applicable contract, including specifically sub-contractors;
- (2) the person(s) who have an ownership interest equal to or greater than 25% in the business entity performing work or service pursuant to, or in furtherance of, the applicable contract. (This subdivision does not apply to a publicly traded company); and
- (3) the person or business entity, if any, that served as a compensated broker or intermediary to actively facilitate the applicable contract or negotiated the terms of the applicable contract with the state agency. (This subdivision does not apply to persons or business entities performing legal services related to the negotiation or drafting of the applicable contract.)

"State agency" means a board, commission, office, department or other agency in the executive, judicial or legislative branch of state government, including publicly funded institutions of higher education: Provided, that for purposes of *W. Va. Code* § 6D-1-2, the West Virginia Investment Management Board shall not be deemed a state agency nor subject to the requirements of that provision.

The contracting business entity must complete this form and submit it to the contracting state agency prior to contract award and to complete another form within 30 days of contract completion or termination.

This form was created by the State of West Virginia Ethics Commission, 210 Brooks Street, Suite 300, Charleston, WV 25301-1804. Telephone: (304)558-0664; fax: (304)558-2169; e-mail: ethics@wv.gov; website: www.ethics.wv.gov.

Revised June 8, 2018

West Virginia Ethics Commission Disclosure of Interested Parties to Contracts

(Required by W. Va. Code § 6D-1-2)

Name of Contracting Business Entity: UniCare Health Plan of West Virginia, Inc Address: 200 Association Drive, Suite 200
Charleston, WV 25311

Name of Authorized Agent: Tadd Haynes Address: 200 Association, Suite 200 Charleston, WV 25311

Contract Number: CRFP 0511 BMS2000000002 Contract Description: MHT Managed Care Procurement

Governmental agency awarding contract: Department of Health and Human Resources

☐ Check here if this is a Supplemental Disclosure

List the Names of Interested Parties to the contract which are known or reasonably anticipated by the contracting business entity for each category below (attach additional pages if necessary):

1. **Subcontractors or other entities performing work or service under the Contract**

☐ Check here if none, otherwise list entity/individual names below.

See Attached

2. **Any person or entity who owns 25% or more of contracting entity (not applicable to publicly traded entities)**

☐ Check here if none, otherwise list entity/individual names below.

UniCare Health Plan of West Virginia is a wholly owned ultimate subsidiary of Anthem, Inc.

3. **Any person or entity that facilitated, or negotiated the terms of, the applicable contract (excluding legal services related to the negotiation or drafting of the applicable contract)**

☒ Check here if none, otherwise list entity/individual names below.

Signature: [Signature]

Date Signed: 1/24/20

Notary Verification

State of VIRGINIA, City of VIRGINIA BEACH

I, TADD HAYNES, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledge that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 24th day of JANUARY, 2020.

[Signature]
Notary Public's Signature

To be completed by State Agency:

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____



Revised June 8, 2018

West Virginia Ethics Commission



Disclosure of Interested Parties to Contracts

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West Virginia Ethics Commission
Disclosure of Interested Parties to Contracts

(Required by W. Va. Code § 6D-1-2)

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☐ Check here if this is a Supplemental Disclosure

List the Names of Interested Parties to the contract which are known or reasonably anticipated by the contracting business entity for each category below (attach additional pages if necessary):

1. Subcontractors or other entities performing work or service under the Contract

☐ Check here if none, otherwise list entity/individual names below.

See Attached

2. Any person or entity who owns 25% or more of contracting entity (not applicable to publicly traded entities)

☐ Check here if none, otherwise list entity/individual names below.

UniCare Health Plan of West Virginia is a wholly owned ultimate subsidiary of Anthem, Inc.

3. Any person or entity that facilitated, or negotiated the terms of, the applicable contract (excluding legal services related to the negotiation or drafting of the applicable contract)

☒ Check here if none, otherwise list entity/individual names below.

Signature: [Signature]

Date Signed: 1/24/20

Notary Verification

State of VIRGINIA, City of VIRGINIA BEACH:

I, TADD HAYNES, the authorized agent of the contracting business entity listed above, being duly sworn, acknowledge that the Disclosure herein is being made under oath and under the penalty of perjury.

Taken, sworn to and subscribed before me this 24th day of JANUARY, 2020.

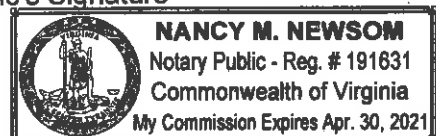
[Signature]
Notary Public's Signature

To be completed by State Agency:

Date Received by State Agency: _____

Date submitted to Ethics Commission: _____

Governmental agency submitting Disclosure: _____



Subcontractor Name	Services Provided by Subcontractor
Adithian, Inc. (Adithian)	Administrative services, including accounting and financial, human resources, leasing and property management, information technology, marketing, actuarial, member services (including eligibility and enrollment), provider contracting, claims administration services, clinical informatics, legal and regulatory
Advanced Medical Reviewers, LLC (AMR)	Utilization management, clinical chart reviews
Exela Technologies, Inc. (Exela)	Paper claims keying, provider correspondence, claims data capture services
IngenioRx, Inc. (IngenioRx)	Pharmacy Benefit Partner managing medical injectable/physician administered prior authorizations and obtaining approval for implementation of clinical programs
SKYGEN USA, LLC (SKYGEN)	Dental Benefits Manager
Symphony Performance Health, Inc. d/b/a SPH Analytics (SPH)	Access and availability provider surveys
Vision Service Plan Insurance Company (VSP)	Vision Benefits Manager
Wipro Limited (Wipro)	Manual adjudication and adjustments for professional, outpatient, and inpatient claims

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

CONSTRUCTION CONTRACTS: Under W. Va. Code § 5-22-1(i), the contracting public entity shall not award a construction contract to any bidder that is known to be in default on any monetary obligation owed to the state or a political subdivision of the state, including, but not limited to, obligations related to payroll taxes, property taxes, sales and use taxes, fire service fees, or other fines or fees.

ALL CONTRACTS: Under W. Va. Code §5A-3-10a, no contract or renewal of any contract may be awarded by the state or any of its political subdivisions to any vendor or prospective vendor when the vendor or prospective vendor or a related party to the vendor or prospective vendor is a debtor and: (1) the debt owed is an amount greater than one thousand dollars in the aggregate; or (2) the debtor is in employer default.

EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

DEFINITIONS:

"Debt" means any assessment, premium, penalty, fine, tax or other amount of money owed to the state or any of its political subdivisions because of a judgment, fine, permit violation, license assessment, defaulted workers' compensation premium, penalty or other assessment presently delinquent or due and required to be paid to the state or any of its political subdivisions, including any interest or additional penalties accrued thereon.

"Employer default" means having an outstanding balance or liability to the old fund or to the uninsured employers' fund or being in policy default, as defined in W. Va. Code § 23-2c-2, failure to maintain mandatory workers' compensation coverage, or failure to fully meet its obligations as a workers' compensation self-insured employer. An employer is not in employer default if it has entered into a repayment agreement with the Insurance Commissioner and remains in compliance with the obligations under the repayment agreement.

"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceeds five percent of the total contract amount.

AFFIRMATION: By signing this form, the vendor's authorized signer affirms and acknowledges under penalty of law for false swearing (W. Va. Code §61-5-3) that: (1) for construction contracts, the vendor is not in default on any monetary obligation owed to the state or a political subdivision of the state, and (2) for all other contracts, that neither vendor nor any related party owe a debt as defined above and that neither vendor nor any related party are in employer default as defined above, unless the debt or employer default is permitted under the exception above.

WITNESS THE FOLLOWING SIGNATURE:

Vendor's Name: UniCare Health Plan of West Virginia, Inc.

Authorized Signature: _____

Date: 1/24/20

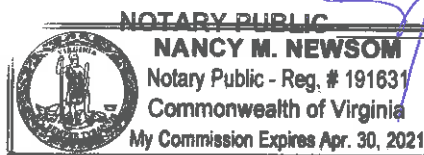
State of VIRGINIA

County of VIRGINIA BEACH, to-wit:

Taken, subscribed, and sworn to before me this 24th day of JANUARY, 2020

My Commission expires 4:30, 2021.

AFFIX SEAL HERE



[Signature]
Purchasing Affidavit (Revised 01/19/2018)

STATE OF WEST VIRGINIA
Purchasing Division

PURCHASING AFFIDAVIT

CONSTRUCTION CONTRACTS: Under W. Va. Code § 5-22-1(i), the contracting public entity shall not award a construction contract to any bidder that is known to be in default on any monetary obligation owed to the state or a political subdivision of the state, including, but not limited to, obligations related to payroll taxes, property taxes, sales and use taxes, fire service fees, or other fines or fees.

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EXCEPTION: The prohibition listed above does not apply where a vendor has contested any tax administered pursuant to chapter eleven of the W. Va. Code, workers' compensation premium, permit fee or environmental fee or assessment and the matter has not become final or where the vendor has entered into a payment plan or agreement and the vendor is not in default of any of the provisions of such plan or agreement.

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"Related party" means a party, whether an individual, corporation, partnership, association, limited liability company or any other form or business association or other entity whatsoever, related to any vendor by blood, marriage, ownership or contract through which the party has a relationship of ownership or other interest with the vendor so that the party will actually or by effect receive or control a portion of the benefit, profit or other consideration from performance of a vendor contract with the party receiving an amount that meets or exceeds five percent of the total contract amount.

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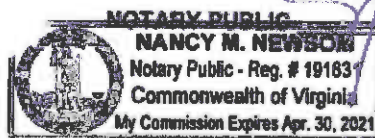
State of VIRGINIA

County of VIRGINIA BEACH, to-wit:

Taken, subscribed, and sworn to before me this 24th day of JANUARY, 2020.

My Commission expires 4.30, 2021.

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Purchasing Affidavit (Revised 01/19/2018)