Technical Proposal

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The HealthPlan

February 18, 2020

Brittany Ingraham, Senior Buyer
Purchasing Division
2019 Washington Street East
Charleston, WV 25305

Dear Ms. Ingraham,

Request Number: RFP CRFP 0511 2000000002

The Health Plan of WV (THP) respectfully submits the attached Request for Proposal related to the Mountain Health Trust (MHT) Managed Care Procurement. We believe we have provided a document which outlines our approach to the Medicaid and CHIP population.

We thank you for the opportunity for The Health Plan of WV to provide DHHR with this proposal. As an incumbent MCO that is based and founded in West Virginia, we are in a unique position to understand and address the needs of the Medicaid and CHIP members. Unlike our competitors, we are committed to delivery of ALL services through our staff based locally in West Virginia.

Please feel free to contact us if we can provide any additional information.

Sincerely,

Jeff Knight
CEO/COO

1110 Main Street, Wheeling, WV 26003-2704 • P: 1.800.624.6961

healthplan.org

Executive Summary

The Health Plan of West Virginia, Inc. (THP) was founded in 1979 as a not-for-profit 501(c)(4) West Virginia corporation. Beginning as a regional plan, we successfully grew our footprint to a statewide entity and have served West Virginia Medicaid members since 1996. As we have grown so, too, has our commitment to West Virginia and its residents. We have and continue to collaborate with the Department of Health and Human Resources (DHHR), Bureau for Medical Services (BMS) and our providers to coordinate the delivery of quality healthcare services for the 94,371 West Virginians we serve in the Mountain Health Trust (MHT) program.

THP's Commitment to Serving and Growing in West Virginia

"WVUHS has long had an excellent relationship with THP in managed care Medicaid. Of all Medicaid Managed Care Organizations ("MCOs") with which we participate, both in West Virginia and surrounding states, THP has always been the easiest and most responsive MCO to work with. [...] Finally, as West Virginia's largest private employer, WVUHS values the importance of other private employers headquartered in West Virginia. From our perspective, THP has demonstrated its commitment to expanding employment opportunities in West Virginia more so than any other payer."

- Albert L. Wright, Jr., President & CEO,
West Virginia University Health System (WVU Medicine), letter of support dated 1/7/2020

Our leadership team includes experts in their fields. The team is skilled at coordinating the delivery of appropriate, medically necessary and quality physical, behavioral and dental health to Medicaid members in West Virginia. Additionally, our team has collaborated with BMS and other stakeholders to implement key initiatives that enhance the delivery of integrated social, behavioral and medical services to MHT members. For example, in spring of 2017, we worked with the Office of Maternal, Child and Family Health at the Bureau for Public Health (BPH) to develop the care coordination workflows around Children with Special Health Care Needs (CSHCN). THP was the only MCO chosen to partner with BPH to develop the workflows and processes for the CSHCN

program. All MCOs in West Virginia now follow the workflows and processes THP developed with BPH.

We are Local – We Live Here. We Give Here.

THP delivers an evidence-based, technology-enhanced, customer-focused program by implementing programs and services that coordinate and improve the health and well-being of our members. We are well-positioned to expand our capabilities and staff to continue meeting the needs of Medicaid members, as well as newly enrolled WVCHIP members. As the only West Virginia-headquartered Medicaid health plan, we are invested in the future of the State:

- Our staff is based in West Virginia, bringing expertise to our members from those who know and understand the culture and healthcare delivery systems.
- As a not-for-profit entity, we are able to ensure that a greater percentage of premium dollars go directly to patient care and not to shareholders.
- As a West Virginia company, we use local services, such as printing, mailing and postal services and financial services.
- We built our new corporate headquarters in Wheeling and employ more than 500 people in West Virginia; we have additional offices in Morgantown and Charleston.

THP's Continuous Evolution to Meet Stakeholder Needs

In the last six months, we conducted a thorough evaluation of our functional areas. The results of that evaluation identified four key areas where THP should make (and has made) significant investments and enhancements to meet the needs of stakeholders:

- Upgraded our clinical platform to overcome communication barriers between the care delivery team, THP and the member.
- Updated our social determinants of health modeling to help connect members to needed resources, services and care.
- Increased our community outreach and presence statewide.
- Improved our member value-added services to empower our members to fully engage in their own health and wellness.

Over the next several pages we outline key areas where THP makes a difference in the lives of West Virginians. Moreover, we highlight our readiness to serve WVCHIP members. These areas set us apart as a community-based organization. This aligns with our company theme: "We are Local – We Live Here. We Give Here."

Enhancing Care Coordination, Reducing Fragmentation and Improving Data Sharing – Our Enhanced Care Management System

We share data and promote collaboration among our care managers, the member's interdisciplinary care team and others involved in the member's care using our enhanced care management system. This system facilitates the delivery of timely, integrated and coordinated services/supports across varied populations and delivery systems. It maintains all information about the member's care and services in their care management record—providing a comprehensive view of their needs and goals and the

services/supports being delivered to them. It provides tools to collaboratively develop a treatment plan that meets each member's needs/goals, monitors the member's progress toward achieving their goals and identifies acute events so we can coordinate relevant and timely interventions.

Improving the Health Outcomes of Members in their Communities through a Community Health Worker Program

In September of 2018, we partnered with Marshall University, Community Care of West Virginia, Inc. and the Claude Worthington Benedum Foundation to implement a community health worker program that incorporates a community health worker into an interdisciplinary team at Community Care. These community health workers interact with our members where they live and are adept at identifying barriers to care, such as lack of transportation, food insecurity and social isolation. On November 1, 2018, we enrolled 40 high-risk THP Medicaid members in the program. As of October 31, 2019, we saw significant improvements for these members:

- Member health risk score ***dropped 8.8%*** from 3.07 to 2.80.
- Number of ER visits ***dropped 23.1%*** from 3.55 to 2.73.
- Number of admissions ***dropped 85.9%*** from 0.64 to 0.09.
- Number of ***prescriptions increased*** from a total of 59 to a total of 80, indicating more members receiving appropriate care.

We will continue this collaborative pilot program for two years and analyze the effectiveness of the program so we can build upon its success at Community Care and elsewhere.

Enhancing Coordination of Care and Access to Services by Engaging High-Risk Members in the Communities Where They Live

We are partnering with Episource to help us locate and engage members who have high risk and may benefit from care management. We are expanding on a successful relationship with Episource, as they currently provide services for our Medicare line of business. Episource leverages technology to build comprehensive member profiles and engage members via multiple channels. Episource clinicians perform face-to-face, in-home visits to understand member needs and connect them to care, including an evaluation of their living conditions and other risks that can be difficult to perceive during office visits or telephonically.

Improving Access to Services/Supports by Engaging in the Community

Coordination with agencies and resources providing social services to members is integral to addressing members' quality of life. As a community partner, we are actively involved in the community and support initiatives to improve the health and well-being of West Virginians. In 2019, our provider engagement team attended nearly 300 community events comprising 18,000+ attendees, including 110 Family Resource Networks meetings in 39 counties. We note our major community engagement initiatives for the MHT program here:

During our most recent survey, NCQA staff stated that we had "remarkable" community involvement and contributions.

- Source: NCQA survey report Fall of 2019

- ***Sponsorship of Project Hope for Women & Children.*** Project Hope provides a stable and supportive environment for women and their children so they can work toward long-term recovery from substance use. We sponsored two apartments

and a playground to help support mothers and their families as they continue their recovery.

- ***Medical and Nursing Student Scholarships.*** In concert with West Virginia University and Marshall University, THP established a scholarship program to promote and sponsor medical and nursing students who intend to stay in West Virginia. To date, over $2.5 million has been awarded to 50 students.

> "The Health Plan scholarship program is great because it helps people like me actually stay in West Virginia and help take care of people who otherwise might not have mental health providers."
>
> - *THP Scholarship Recipient Christian, a medical student from Marshall University beginning his psychiatry residency*

- ***Healthy Grandfamilies Program.*** To help grandparents who find themselves raising one or more of their grandchildren, THP collaborated with the Healthy Grandfamilies program, sponsored by West Virginia State University, to facilitate trainings and establish local coalitions to support member needs. On October 23, 2019, we hosted a Healthy Grandfamilies training session for the Northern Panhandle at our Wheeling headquarters.

Sharing Ideas, Moving Forward

"The Health Plan is willing to share ideas and move forward with implementing those ideas to better West Virginia. One example is the Healthy Grandfamilies program being implemented across the state. Through partnership, we were able to host a training at The Health Plan to more than 30 participants seeking to bring Healthy Grandfamilies to their county [….] Their involvement in the community and assistance with families is valuable…The Health Plan shows compassion and dedication to the citizens of Ohio County and are among the most helpful committee members working to improve West Virginia."

– Claudia Raymer, Executive Director, Ohio County FRN, 12/12/2019 letter

Improving Health Outcomes for Medicaid and WVCHIP Members through Value-added Services

Our value-added services reflect DHHR's goal to improve health outcomes for Medicaid and WVCHIP members. We offer these services at no cost to the MHT members we

serve, and we will include the newly-added WVCHIP members, as well. We will enhance our value-added services as follows:

- Boy Scout memberships provide annual membership for members ages 5-18 to join the Boy Scouts.
- Girl Scout memberships provide annual membership for members ages 5-18 and over the age of 18 who wish to volunteer and mentor to join the Girl Scouts.
- Boys & Girls Clubs memberships provide an annual donation to each of the eight West Virginia Boys & Girls Clubs to be used for membership dues.

Improving Access to Services using Telemedicine

We are offering our members Teladoc, an NCQA-certified telehealth solution that provides free 24/7 member access to medical, behavioral and dermatology care via phone, video or app. Teladoc provides members with alternatives to non-emergent ER utilization and connects them to care most appropriate to their needs. Teladoc physicians are board-certified, state-licensed and enrolled with the fiscal agent, with an average of 25 years of practice.

Ready to Support WVCHIP Members

WVCHIP members entering the MHT program requires onboarding that entails minimal disruption to the member and providers, alike. We have substantial experience making significant program changes and onboarding new members, including:

- Onboarding 10,000 SSI members in 2017.
- Onboarding 35,000 Medicaid expansion members in 2015. We extended the transition period six months, exceeding the 90-day requirement.

- Onboarding 16,000 West Virginia Family Health members from May through July 2019.
- Adding the Substance Use Disorder (SUD) waiver benefit in summer of 2019. From July 1, 2019, through December 31, 2019, we have paid $2.5 million in claims for SUD services.
- Carved-in behavioral health benefits to managed care in 2015 for our entire population, including expansion members. ***We are the only MCO that has contracted with all contractually required comprehensive behavioral health centers.***

Charleston Area Medical Center

501 Morris Street
Post Office Box 1547
Charleston, West Virginia 25326

To Whom It May Concern:

CAMC Health System, Inc. is writing this letter to recommend The Health Plan, to serve as a Medicaid Managed Care Payer in the state of WV. The two companies have worked together for several years, and we look forward to partnering on projects in the coming year to work toward our common goal of improving the quality of care for residents in WV.

Sincerely,

Michelle Coon

Michelle Coon

Vice President of Managed Care, CAMC Health System

President of West Virginia Health Network

VHA
United to Improve America's Health℠

Office of the President
PO Box 8136
One Medical Center Drive
Morgantown, WV 26506
Phone / 304-598-4355
Fax / 304-598-4124

West Virginia Department of Health & Human Resources
Bureau for Medical Services
350 Capitol Street, Room 251
Charleston, WV 25301

January 7, 2020

Re: Support of The Health Plan's Response to Medicaid Request For Proposal

Dear Bureau for Medical Services:

On behalf of West Virginia University Health System's ("WVUHS") eleven (11) member hospitals and nearly 2,500 billing providers, I write to express our strong support of The Health Plan's ("THP") response to West Virginia's Medicaid Managed Care RFP issued December 17, 2019.

WVUHS has long had an excellent relationship with THP in managed care Medicaid. Of all Medicaid Managed Care Organizations ("MCOs") with which we participate, both in West Virginia and surrounding states, THP has always been the easiest and most responsive MCO to work with.

Further, WVUHS and THP continue to partner in ways that benefit West Virginia Medicaid members and the state. WVUHS and THP are now in the second performance year of our innovative Medicaid Shared Savings Program. Under this program, WVUHS and THP collaborate to identify high-risk and rising-risk Medicaid members in order to provide targeted care coordination and other resources to improve quality of care and efficiency. In our first performance year, we succeeded in reducing cost of care of Medicaid members attributed to the program.

Finally, as West Virginia's largest private employer, WVUHS values the importance of other private employers headquartered in West Virginia. From our perspective, THP has demonstrated its commitment to expanding employment opportunities in West Virginia more so than any other payer.

Sincerely,

Albert L. Wright, Jr.
President & CEO
West Virginia University Health System

WHEELING HOSPITAL

A TRADITION OF EXCELLENCE.
A LEGACY OF CARING.

January 23, 2020

The West Virginia Department of Medicaid is committed to using competitive procurement procedures that are designed to deliver the best value in necessary goods and services for the fulfillment of programmatic needs or objectives while maintaining the public's trust through adherence to standards for the maximum practical fair and open competition. As part of this process, the West Virginia Medicaid RFP is vital. Please let this letter serve as my highest recommendation for The Health Plan as they are compiling their response to the WV Medicaid RFP.

As a partner in healthcare with Wheeling Hospital, The Health Plan protects and promotes health and ensures access to medical, preventive, and rehabilitative services for all citizens of the State of West Virginia. Guided by the "Triple Aim", the Health Plan with enrollees, providers, and high performing health entities works to build a care delivery system that improves the health of the population (better health), enhances the experience of care for individuals (better care), and effectively manages Medicaid per capita care costs (lower costs). While working with the Health Plan on several collaborations, Wheeling Hospital, through a population health approach, has been able to maximize enrollee health, advance health equity and began to address priority social determinants of health which include housing, food insecurity, physical safety, and transportation. Through proactive stakeholder meetings, The Health Plan has been able to reduce complexity and administrative burden for providers and enrollees while minimizing wasteful spending through robust utilization review practices.

With the Health Plan, we have been able to share capacity to improve health care quality through data and collaboration. Through partnerships with The Health Plan Pharmacists, Utilization Review, and our Transitional Care Clinic, we have been able to decrease fragmentation and increase integration across providers and care settings. Through partnerships with Provider Outreach and Quality, we have worked together to improve care for the great state of West Virginia by adhering to evidence based practices and bundles. Each day, The Health Plan increases the quality of health care their members receive while also trying to lower costs by setting guidelines on which care is medically necessary. As a team, we attempt to provide clinically effective and efficient care. I highly recommend The Health Plan and its services.

If you have any questions or if you would like additional information, please do not hesitate to contact me at 304-243-8377.

Regards,

Heidi Porter

V.P. of Quality and Regulatory Affairs

West Virginia Department for Health and Human Resources
Mountain Health Trust (MHT) Managed Care Procurement
Request for Proposal
CRFP 0511 BMS2000000002

Title Page

RFP Subject	Mountain Health Trust (MHT) Managed Care Procurement
Number	CRFP 0511 BMS2000000002
Vendor's Name	The Health Plan of West Virginia, Inc.
Business Address	1110 Main Street, Wheeling, WV 26003-2704
Telephone Number	1.800.624.6961
Fax Number	740.695.7581
Contact	Christy Donohue
Email Address	cdonohue@healthplan.org
Signature	
Date	February 12, 2020

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.

The Health Plan of West Virginia, Inc.
(Company)

CEO/COO
(Representative Name, Title)

740-695-7585 (Phone) 740-695-8103 (Fax)
(Contact Phone/Fax Number)

2/11/2020
(Date)

Attachment 3: Vendor Qualifications & Experience

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	The Health Plan of West Virginia, Inc.
Name of Parent Company (If Applicable)	Not applicable
Tax Identification Number	55-0585592
Industry (North American Industry Classification System [NAICS])	524114
Type of Legal Entity	Non-Profit Corporation 501(c)(4), chartered in West Virginia
Company Ownership (e.g., Private/Public, Joint Venture)	Not applicable
Number of Full-Time Employees	540
Last Fiscal Year Company Revenue	$625,021,137 - 2019
Last Fiscal Year Company Net Income	($21,107,412) - 2019
% of Revenue From State Government Clients in the United States	59.9% (2019)
Number of Years in Business	40
Number of Years Vendor Has Been Providing the Type of Services Specified in the RFP	24 years. The Health Plan (THP) enrolled with West Virginia Medicaid in 1996, was certified in all West Virginia counties for Medicaid in 2013 and participated in Medicaid Expansion beginning in 2015. THP has been providing quality, comprehensive and cost-effective healthcare to our members for more than 40 years. Established in 1979, THP is one of the largest locally

Vendor Overview	
	managed care organizations in West Virginia and Ohio, serving over 200,000 covered lives.
Number of Employees Providing the Type of Services Specified in the RFP	THP currently has over 150 employees that work on the West Virginia Medicaid line of business at one of our three West Virginia offices. These positions range from claims analysts, customer service representatives, registered nurses, case and care managers, special investigation unit, behavioral health, social workers, contract liaison, provider engagement representatives and others.
Headquarters in the United States	Wheeling, WV
Headquarters Mailing Address	The Health Plan 1110 Main Street Wheeling, WV 26003
Street Address	1110 Main Street
Telephone Number	800.624.6961
Fax Number	740.695.7581
Locations in the United States	1110 Main Street Wheeling, WV 26003 48 Donley Street, Suite 502 Morgantown, WV 26501 141 Summers Street Charleston, WV 25301 100 Lillian Gish Boulevard, SW #301 Massillon, OH 44647
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 Donohue

- 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.

We intend to continue serving members in all 55 West Virginia counties. We received approval from the West Virginia Offices of the Insurance Commissioner to serve Medicaid in all West Virginia counties in 2013. Our Certificate of Authority (COA) is

provided as Exhibit 1.1 Certificate of Authority and demonstrates that we are in good standing in West Virginia.

Since 2013, we have maintained this approval and will continue to meet the Department's requirements and serve each county.

The 55 West Virginia counties we will continue serving are listed in the following table.

West Virginia Counties that THP will Continue to Serve			
Barbour County	Berkeley County	Boone County	Braxton County
Brooke County	Cabell County	Calhoun County	Clay County
Doddridge County	Fayette County	Gilmer County	Grant County
Greenbrier County	Hampshire County	Hancock County	Hardy County
Harrison County	Jackson County	Jefferson County	Kanawha County
Lewis County	Lincoln County	Logan County	Marion County
Marshall County	Mason County	McDowell County	Mercer County
Mineral County	Mingo County	Monongalia County	Monroe County
Morgan County	Nicholas County	Ohio County	Pendleton County
Pleasants County	Pocahontas County	Preston County	Putnam County
Raleigh County	Randolph County	Ritchie County	Roane County
Summers County	Taylor County	Tucker County	Tyler County
Upshur County	Wayne County	Webster County	Wetzel County
Wirt County	Wood County	Wyoming County	

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

THP is a Non-Profit Corporation 501(c)(4), chartered in West Virginia. We are governed by an independent Board of Directors and do not have a parent company.

- 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.

THP currently administers Medicaid managed care within West Virginia. THP does not currently provide Medicaid services for other states. As of January 1, 2020, THP insured 121,051 members, including 93,820 West Virginia Medicaid members, 3,925 Medicare

members based in West Virginia, 3,160 West Virginia D-SNP members, 5,229 Commercial members based in West Virginia and 14,917 West Virginia PEIA members.

THP currently has active business relationships with the following State, State's Counties and State's local municipalities.

Client Entity	Enrollment (Jan. 1, 2020)
West Virginia Mountain Health Trust (Medicaid) MCO account (since 1996)	93,820 members
PEIA HMO account (since 1981)	14,917 members
West Virginia Medicare/Medicaid D-SNP	3,160 members
West Virginia University Health System	9,250 subscribers, 18,907 members; 7,570 (RX only)
City of Charleston Self-funded managed care account	2,600 members
Marshall County Commission HMO Account	157 subscribers, 401 members
Brooke County Commission POS Account	75 subscribers, 190 members
City of Moundsville HMO Account	80 subscribers, 208 members
City of Benwood HMO Account	19 subscribers, 44 members
City of Wheeling HMO Account	801 members
Morgantown Utility Board POS Account	285 members
City of Mannington	10 subscribers, 21 members
Ohio County Schools	1,160 subscribers, 2,535 members
Village of Bethlehem	14 subscribers, 36 members

- 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.

Not applicable.

  - 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.

Not applicable.

- 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.

Not applicable.

- 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.

Not applicable.

- 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).

Please see the Disclosure of Interested Parties Form in Attachment 7: Acceptance of RFP Terms and Conditions Response Template, submitted with this proposal.

- 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.

We currently have an NCQA accreditation status of "Accredited" across all lines of business, including our Medicaid line of business, in accordance with **MD007**. We initially obtained NCQA accreditation for Medicaid in West Virginia in 2009. Prior to that, we maintained NCQA accreditation in our Medicare and Commercial markets since 1997.

During our fall 2018 Accreditation Survey, we had one area of deficiency in the Utilization Management denial files that was a "Must Pass Element." There was a deficiency in the written notification of healthcare denials provided to the member and his or her treating practitioner. The NCQA auditor concluded the following with respect to our denial notifications:

- Reasons for the denial needed to be more specific and more easily understandable to the member;
- Reference to the benefit provision, guideline, protocol or criterion on which the denial decision was based needed to be more clearly stated; and

- A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or criterion upon request, although included in the notification, needed to be moved to a more prominent location.

During an NCQA survey, three separate categories of Utilization Management written denial notifications (non-behavioral healthcare, behavioral healthcare and pharmacy) are evaluated using the same criteria. Since the same audit procedures are applied to each of these three categories, a deficiency in one category results in a deficiency in all three categories. As a result, three deficiencies were identified related to the "Must Pass Elements" in Utilization Management, resulting in a temporary "Provisional" status. We quickly implemented a corrective action plan that was approved by NCQA and resolved all areas of deficiency.

In September 2019, THP underwent an additional NCQA survey. We were returned to an NCQA status of "Accredited" across all lines of business, with a perfect score of 100% for all areas that were resurveyed. Additionally, NCQA staff identified the following strengths in our program:

- Strong credentialing and behavioral health programs
- Knowledgeable and committed staff
- Evidence of good collaboration with practitioners
- "Remarkable" community involvement and contributions
- Clear and thorough appeal letters
- Well-organized and timely credentialing files
- Well-documented complex case management files
- Highly effective IT system
- Well-organized and timely credentialing, utilization management and complex case management files

Our current NCQA accreditation status is effective through November 2021. This certification demonstrates our commitment to quality management and performance through an established approach to quality.

NCQA Accreditation for Teladoc

Teladoc, our telehealth provider for our value-added services to our members, is the first telehealth provider to receive NCQA certification for its physician credentialing process. Teladoc is the only telehealth provider to receive NCQA certification twice and to pass both certifications with a perfect score of 100 percent. Teladoc physicians are board-certified and state-licensed with an average of 25 years of practice.

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.

The following tables include subcontractor overviews for each proposed subcontractor:

- Episource
- eviCore/Palladian
- Med-Data
- SKYGEN USA
- Superior Vision Benefit Management

Table 6: Subcontractor Overview

Vendor Overview	
Corporate (Legal) Name	Episource
Name of Parent Company (If Applicable)	
Tax Identification Number	20-4761361
Industry (NAICS)	524
Type of Legal Entity	LLC
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	2,500
Last Fiscal Year Company Revenue	$81,191,336
Last Fiscal Year Company Net Income	$16,001,363
% of Revenue From State Government Clients in the United States	Not available
Number of Years in Business	13 years
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	1
Number of Employees Providing the Type of Services Specified in the RFP	17
Headquarters in the United States	Yes
Headquarters Mailing Address	500 W. 190th St. Fourth Floor, Gardena, CA 90248
Street Address	500 W. 190th St. Fourth Floor, Gardena, CA 90248
Telephone Number	714.452.1961
Fax Number	424.268.2221
Locations in the United States	2

Vendor 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	Heather Scott

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.

  - Sishir Reddy – Episource, LLC
  - Harshith Ramesh – Episource, LLC
  - Primary Business Address: 500 W. 190th St. Gardena, CA 90248
  - Business Location: 12332 Race Track Road, Tampa, FL 33626

- 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.

Not applicable.

- 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.

Not applicable.

- 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.

Not applicable.

Vendor Overview	
Corporate (Legal) Name	eviCore healthcare MSI, LLC
Name of Parent Company (If Applicable)	Cigna Corporation (NYSE: CI)
Tax Identification Number	62-1615395
Industry (NAICS)	N/A
Type of Legal Entity	Limited Liability Company
Company Ownership (e.g., Private/Public, Joint Venture)	Public
Number of Full-Time Employees	4,608
Last Fiscal Year Company Revenue	FY18: $2.75B
Last Fiscal Year Company Net Income	FY18: $67.4M
% of Revenue From State Government Clients in the United States	19%
Number of Years in Business	25 years (07/28/1995)
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	25 years
Number of Employees Providing the Type of Services Specified in the RFP	4,608
Headquarters in the United States	Bluffton, South Carolina
Headquarters Mailing Address	400 Buckwalter Place Blvd., Bluffton, SC 29910-5150
Street Address	400 Buckwalter Place Blvd., Bluffton, SC 29910-5150
Telephone Number	800.918.8924
Fax Number	843.815.6580
Locations in the United States	Boston, MA Colorado Springs, CO Franklin, TN Melbourne, FL Plainville, CT St. Louis, MO West Seneca, NY
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	Jeff Kraft

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.

eviCore healthcare MSI, LLC ("eviCore") is a fully owned subsidiary of Cigna Corporation (NYSE: CI) ("Cigna"), a publicly held entity with offices located at 900 Cottage Grove Road, Bloomfield, CT 06002.

- 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.

Cigna Corporation (Tax ID: 82-4991898)

- 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.

Not applicable.

- 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.

eviCore healthcare MSI, LLC ("eviCore") is a fully owned subsidiary of Cigna Corporation (NYSE: CI) ("Cigna"), a publicly held entity. Information regarding Cigna's ownership of other entities is made publicly available through the Cigna and SEC websites.

Vendor Overview	
Corporate (Legal) Name	Med-Data, Incorporated
Name of Parent Company (If Applicable)	MedData Holding Co.
Tax Identification Number	91-1115415
Industry (NAICS)	624190
Type of Legal Entity	Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Private
Number of Full-Time Employees	2,200
Last Fiscal Year Company Revenue	$220M (2018)
Last Fiscal Year Company Net Income	$10M (2018)
% of Revenue From State Government Clients in the United States	<5%
Number of Years in Business	39
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	24
Number of Employees Providing the Type of Services Specified in the RFP	110 employees dedicated to performing disability services
Headquarters in the United States	Yes
Headquarters Mailing Address	25700 Interstate 45 North, Suite 300, Spring, TX 77386
Street Address	25700 Interstate 45 North, Suite 300, Spring, TX 77386
Telephone Number	800.261.0048
Fax Number	None
Locations in the United States	Draper, UT Brecksville, OH Anaheim, CA
Name, Mailing Address, Street Address, Telephone Number, and Fax Number of Business Unit Administering This Bid (If Different From Above)	**Name:** MedData **Mailing Address:** Same as above **Street Address:** Same as above **Telephone Number:** Same as above **Fax Number:** Same as above
Name of Contact Person for Bid	Jonathon Smelley

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.

MedData Holding Co. – 100 percent Owner

25700 Interstate 45 North, Suite 300

Spring, TX 77386

Individuals with control interest:

- Michael Shea, CEO
  25700 Interstate 45 North, Suite 300
  Spring, TX 77386
- Frank Stellato, CFO and Secretary
  25700 Interstate 45 North, Suite 300
  Spring, TX 77386
- Emily Fisher, President and COO
  25700 Interstate 45 North, Suite 300
  Spring, TX 77386

- 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.

FEIN for MedData Holding Co. is 26-1077304

- 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.

Not applicable.

- 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.

All three individuals with a control interest in Med-Data, Incorporated also have a control interest in MedDirect, Inc.

Vendor Overview	
Corporate (Legal) Name	SKYGEN USA, LLC
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	$95,594,000
Last Fiscal Year Company Net Income	$6,324,000
% 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	SKYGEN USA 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	W140 N8981 Lilly Rd Menomonee Falls, WI 53051 N92 W14612 Anthony Avenue Menomonee Falls, WI 53051 1000 W. Donges Bay Road Mequon, WI 53092 10201 N. Port Washington Road Mequon, WI 53092
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:**

Vendor Overview	
	Fax Number:
Name of Contact Person for Bid	Mark Dasek

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.

  - Grambino Technologies, LLC, 37.5 percent ownership interest in SKYGEN USA, LLC, W140N89981 Lilly Rd., Menomonee Falls WI 53051
  - MOA Investments, LLC, 37.5 percent ownership interest in SKYGEN USA, LLC, W140N89981 Lilly Rd., Menomonee Falls WI 53051
  - Scion Holdings, Inc., 25 percent ownership interest in SKYGEN USA, LLC, W140N89981 Lilly Rd., Menomonee Falls WI 53051

- 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, 39-1865244
  - 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

Not applicable.

- 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.

Not applicable.

Vendor Overview	
Corporate (Legal) Name	Superior Vision Benefit Management, Inc.
Name of Parent Company (If Applicable)	Versant Health, Inc.
Tax Identification Number	22-2512930
Industry (NAICS)	N/A
Type of Legal Entity	For-Profit Corporation
Company Ownership (e.g., Private/Public, Joint Venture)	Superior Vision Benefit Management, Inc. is a direct subsidiary of Block Vision Holdings Corporation and an indirect subsidiary of Superior Vision Corporation and Versant Health, Inc.
Number of Full-Time Employees	Versant Health currently employs over 1,300 associates.
Last Fiscal Year Company Revenue	**Proprietary and Confidential** Superior Vision Corporation – 2018 $354 MM
Last Fiscal Year Company Net Income	**Proprietary and Confidential** Superior Vision Corporation – 2018 $13.8 MM
% of Revenue From State Government Clients in the United States	N/A – 0%
Number of Years in Business	26
Number of Years Subcontractor Has Been Providing the Type of Services Specified in the RFP	26
Number of Employees Providing the Type of Services Specified in the RFP	Versant Health currently employs over 1,300 associates. Of that total, approximately 200 employees are dedicated to supporting business on behalf of health plan clients with Medicaid members.
Headquarters in the United States	Yes
Headquarters Mailing Address	939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090
Street Address	939 Elkridge Landing Road, Suite 200 Linthicum, MD 21090
Telephone Number	800.243.1401
Fax Number	410.752.8969
Locations in the United States	Rancho Cordova, CA - 11090 White Rock Road, Suite 175, Rancho Cordova, CA 95670 San Antonio, TX -175 East Houston Street, San Antonio, TX 78205-2255 Latham, NY - 713 Troy Schenectady Road, Latham, NY 12110

Vendor Overview	
	Ft. Worth, TX - 6300 Ridgelea Place, Suite 200, Fort Worth, TX 76116
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	David Dunbar, RVP Health Plan Sales

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.

Superior Vision Benefit Management, Inc. is

- A direct subsidiary of Block Vision Holdings Corporation - 939 Elkridge Landing Rd., Ste. 200, Linthicum, MD 21090 (FEIN: 51-0418587)
- An indirect subsidiary of Superior Vision Corporation - 939 Elkridge Landing Rd., Ste. 200, Linthicum, MD 21090 (FEIN: 80-0769466) and Versant Health, Inc. - 939 Elkridge Landing Rd., Ste. 200 Linthicum, MD 21090 (FEIN: 81-0706365).

- 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.

See above.

- 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.

Not applicable.

- 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.

Not applicable.

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.

The following table identifies the page number(s) in Attachment 3 where we address each mandatory qualification item.

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.	Att. 3, Page 2
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.	Att. 3, Page 5
The Vendor must provide an organizational chart outlining the internal organizational structure for this project.	Att. 4, Pages 10-15
The Vendor must provide a description of the roles, responsibilities, and skill sets associated with each position outlined in the organizational chart.	Att. 4, Page 4
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.	Att. 4, Pages 32-34
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 size and scope is currently being or has been implemented.	Att. 3, Pages 19 and 27-32
The Vendor must demonstrate at least five (5) years' experience in Medicaid.	Att. 3, Page 1
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.	Att. 3, Page 29
The Vendor must have at least three (3) years' experience implementing the proposed approach with an organization similar size and scope to the State, in an MCO capacity.	Att. 3, Page 29

3. Existing Business Relationships

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.

THP currently has active business relationships with the following State, State's Counties and State's local municipalities:

Client Entity	Enrollment (Jan. 1, 2020)
West Virginia Mountain Health Trust (Medicaid) MCO account (since 1996)	93,820 members
PEIA HMO account (since 1981)	14,917 members
West Virginia Medicare/Medicaid D-SNP	3,160 members
West Virginia University Health System	9,250 subscribers, 18,907 members; 7,570 (RX only)
City of Charleston Self-funded managed care account	2,600 members
Marshall County Commission HMO Account	157 subscribers, 401 members
Brooke County Commission POS Account	75 subscribers, 190 members
City of Moundsville HMO Account	80 subscribers, 208 members
City of Benwood HMO Account	19 subscribers, 44 members
City of Wheeling HMO Account	801 members
Morgantown Utility Board POS Account	285 members
City of Mannington	10 subscribers, 21 members
Ohio County Schools	1,160 subscribers, 2,535 members
Village of Bethlehem	14 subscribers, 36 members

Subcontractor Existing Business Relationships

Davis Vision, a subsidiary of Versant Health and an affiliate of Superior Vision, has provided routine vision services for the Highmark West Virginia ACA exchange members since January 1, 2014. In addition, Davis Vision provides vision benefit programs for the Preston County School System in West Virginia. The contract with Preston County School System has been in place since July 1, 2015, and there are currently 1,037 members enrolled in the plan.

THP's other proposed subcontractors do not have existing or recent business relationships with the State, the State's counties and/or the State's local municipalities.

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.

Regulatory Actions and Corrections Within Past Two Years

The Health Plan of West Virginia, Inc. (THP) is committed to maintaining and complying with all regulatory and contract requirements mandated by our State partners. THP has not been the subject of any investigations with respect to our government programs, including Medicaid, in any state within the last two years.

Each year THP is subject to an annual audit by the State's External Quality Review Organization (EQRO) vendor. During our annual EQRO audit for measurement year 2017, THP received one audit finding; this finding related to our SIU Reporting Requirements Policy for verification of service. The established process in place did not include the verification of services for members who did not have a cost-sharing responsibility. We implemented remediation of the audit finding immediately, even though we were not required to complete a formal corrective action plan.

During our annual EQRO audit for measurement year 2018, there were minor findings noted, all of which were remediated in less than 24 hours from completion of EQRO onsite survey. We have included the details and corrective action plan for those findings below. The requirement of a corrective action plan was based solely on verbiage

changes that needed to be made to applicable policies and procedures, as well as the Member Handbook.

Requirement	EQRO Preliminary Findings and Recommendations	Plan of Correction
GAD 6. Timing-Grievance. An enrollee may file a grievance with the MCO, PIHP, or PAHP at any time.	The Member Handbook states, "As a member of The Health Plan, you have the right to file a grievance at any time." The Medicaid Complaint/Grievance policy did not include the language that an enrollee may file a grievance with the MCO at any time. In order to receive a finding of Met in the next review, the Medicaid Complaint/ Grievance policy must be updated to include the language that an enrollee may file a grievance with the MCO at any time.	Corrected - Policy and procedure for Complaints and Grievances was updated to mirror the language of the handbook.
GAD 9. Procedures-Appeal. The enrollee may request an appeal either orally or in writing. Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal.	The Member Handbook states, "you can file an appeal by calling Member Services at 1.888.613.8385 or you can do so in writing." The Medicaid Appeal policy states, "Expedited appeals may be submitted orally or in writing. When submitted orally they do not require written confirmation or the member's written consent to have the practitioner file on behalf of the member." This statement is incorrect, however, because an oral appeal must be followed by a written, signed appeal. To receive a finding of Met in the next review, THP must change the Medicaid Appeal policy to state that oral appeals must be followed by a written, signed appeal.	Corrected - Policy and procedure for Appeals was updated to meet the intent of this requirement.
GAD 17.f. Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements of this section, the enrollee is deemed to have exhausted the MCO's, PHIP's or PAHP's appeals process. The enrollee may	Within the Medicaid Appeals policy, there is no language that includes that if the MCO fails to adhere to the notice and timing requirements of the appeals process, the enrollee is deemed to have exhausted the MCO's appeals process and may initiate a State fair hearing. In order to	GAD 17.f included several elements that needed to be met. Therefore, the Member Handbook, Provider Manual and Appeal extension letters were updated. The policy and procedure for Appeals was updated to meet the intent of this requirement as well.

Requirement	EQRO Preliminary Findings and Recommendations	Plan of Correction
initiate a State fair hearing.	receive a finding of Met in the next review, THP must update the Medicaid Appeals policy to include the language of deemed exhaustion. If THP does not meet the notice and timing requirements of the appeals process, the enrollee may initiate a State fair hearing. This information must also be included in the Member Handbook, Provider Manual and in the Appeal extension letters.	
GAD 23. Deemed exhaustion of appeals processes. In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in §438.408, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.	Within the Medicaid appeals policy, there is no language that indicates that if the MCO fails to adhere to the notice and timing requirements of the appeals process, and may initiate a State fair hearing. In order to receive a finding of Met in the next review, THP must update the Medicaid Appeals policy to include the language of deemed exhaustion. If THP does not meet the notice and timing requirements of the appeals process, the enrollee may initiate a State fair hearing. This information must also be included in the Member Handbook, Provider Manual and in the Appeal extension letters.	GAD 23 included elements that needed to be met within the process. To meet this requirement, the policy and procedure for Appeals was updated. As was the case with GAD 17.f, the Member Handbook, Provider Manual and Appeal extension letters were also updated.

In August 2019, as a result of THP's recent financial performance, the West Virginia Offices of the Insurance Commissioner (WVOIC) requested additional monthly financial reporting. The WVOIC asked THP to provide monthly profit/loss statements by line of business and hold a monthly call to discuss THP's overall business strategy and results of operations. These discussions have given us a meaningful, regular line of communication with our primary regulator, enabling us to have real-time dialogue on any regulatory questions or emerging issues.

As a plan of correction, we established a cost containment focus group consisting of members of finance, provider network/contract management, clinical, operations, information technology, underwriting and actuarial services. The team is focused on contract improvements, payment integrity, clinical enhancements and improved reporting and analytics. The team is engaging outside vendors to drive operational, clinical and financial improvements. It meets weekly and has a project plan that is managed and continuously updated to ensure accountability and achievement of operational and financial goals. We will continue this focus group in 2020.

NCQA Accreditation Status

We currently have an NCQA accreditation status of "Accredited" across all lines of business, including our Medicaid line of business. We initially obtained NCQA accreditation for Medicaid in West Virginia in 2009. Prior to that, we maintained NCQA accreditation in our Medicare and Commercial markets since 1997.

During our fall 2018 Accreditation Survey, we had one area of deficiency in the Utilization Management denial files that was a "Must Pass Element". There was a deficiency in the written notification of healthcare denials provided to the member and his or her treating practitioner. The NCQA auditor concluded the following with respect to our denial notifications:

- Reasons for the denial needed to be more specific and more easily understandable to the member;
- Reference to the benefit provision, guideline, protocol or criterion on which the denial decision was based needed to be more clearly stated; and
- A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or criterion upon request, although included in the notification, needed to be moved to a more prominent location.

During an NCQA survey, three separate categories of Utilization Management written denial notifications (non-behavioral healthcare, behavioral healthcare and pharmacy) are evaluated using the same criteria. Since the same audit procedures are applied to each of these three categories, a deficiency in one category results in a deficiency in all three categories. As a result, three deficiencies were identified related to the "Must Pass Elements" in Utilization Management, resulting in a temporary "Provisional" status. We quickly implemented a corrective action plan that was approved by NCQA and resolved all areas of deficiency.

In September 2019, THP underwent an additional NCQA survey. We were returned to an NCQA status of "Accredited" across all lines of business, with a perfect score of 100% for all areas that were resurveyed. Additionally, NCQA staff identified the following strengths in our program:

- Strong credentialing and behavioral health programs
- Knowledgeable and committed staff
- Evidence of good collaboration with practitioners
- "Remarkable" community involvement and contributions
- Clear and thorough appeal letters
- Well-organized and timely credentialing files
- Well-documented complex case management files
- Highly effective IT system
- Well-organized and timely credentialing, utilization management and complex case management files

Our current NCQA accreditation status is effective through November 2021. This certification demonstrates our commitment to quality management and performance through an established approach to quality.

Termination or Non-Renewal in Past Five Years

In 2015 for the contract year of 2016, THP elected to not renew our contract to provide health benefits for the Federal Employee Health benefit Plan (FEHBP). The plan did not meet our enrollment and financial performance expectations; therefore, THP made the decision not to renew the contract.

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.

Our three references demonstrate our experience as a prime contractor with government entities and other large organizations with unique populations. These references attest to our ability to perform the MHT scope of work. For example, WVCHIP will require premium collections; we have been collecting premiums for City of Charleston active employees and retirees since January 1, 2018, and have established procedures to effectively process them.

Table 8: Vendor References

Vendor Information		
Vendor Name: The Health Plan of West Virginia, Inc.	**Contact Name:**	Christy Donohue
	Contact Phone:	304.720.4923
Customer Information		
Customer Organization: Public Employees Insurance Agency (PEIA)	**Contact Name:**	Ted Cheatham
	Contact Title:	PEIA Director
Customer Address: 601 57th St., SE, Suite 2 Charleston, WV 25304-2345	**Contact Phone:**	304.558.7850 ext 52634
	Contact Email:	Ted.M.Cheatham@wv.gov
Project Information		
Total Vendor Staff:	540 employees	
Project Objectives: THP provides MCO services as an option to State of West Virginia employees who select one of our benefit options through PEIA.		

Project Description: THP offers three different medical/Rx benefit options to public employees, two HMO options and one POS option. All three options have medical and prescription benefits.				
Vendor's Involvement: In addition to processing claims, THP provides utilization management, case management and behavioral health management to PEIA members and retirees. THP also manages and maintains healthcare flexible spending accounts and dependent care accounts for PEIA. THP performs all functions for COBRA administration and collects retiree premium payments on behalf of PEIA.				
Project Benefits: THP provides cost effective medical and prescription drug coverage to our members. Members can choose between three benefit plan options.				
Key Personnel				
Name: Bob Tschappat Jr., Account Manager		Day-to-day contact for PEIA. Attend Open Enrollment meetings, PEIA Finance Board Meetings, Health Fairs and information seminars. Prepare/deliver the annual renewal, etc.		
Name: Ryan Jewell, Assistant VP of Sales and Account Management		Supervisor of PEIA account manager. Responsible for all fully insured accounts at THP.		
Name: Dave Mathieu, Sr. Vice President Underwriting		Provides and calculates annual renewal rates and benefit review.		
Project Measurements:				
Projected Membership of Vendor's Contract: 6,724 subscribers; 14,971 members		**Actual Membership of Vendor's Contract:** 6,724 subscribers; 14,971 members		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	1981	To:	Ongoing
Actual Start and Completion Dates:	From:	1981	To:	Ongoing
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: N/A				

Vendor Information		
Vendor Name: The Health Plan of West Virginia, Inc.	**Contact Name:**	Christy Donohue
	Contact Phone:	304.720.4923

Customer Information		
Customer Organization: West Virginia University Health System dba WVU Medicine	**Contact Name:**	Brian Guyton and Beth Jameson
	Contact Title:	HR Manager
Customer Address: 1 Medical Center Dr #1000, Morgantown, WV 26506	**Contact Phone:**	304.285.7179 (Brian) 412.608.6777 (Beth)
	Contact Email:	brian.guyton@wvumedicine.org elizabeth.jameson@wvumedicine.org

Project Information	
Total Vendor Staff:	540 employees
Project Objectives: THP provides administration services for members who elect the 90% benefit option.	
Project Description: Administration of Medical/Rx and Rx Only plans for their self-funded plan, including claims processing, utilization, case management and customer service.	
Vendor's Involvement: THP provides reporting, claims administration and benefit administration for medical and prescription benefits. THP has provided these administrative services to WVU Medicine previously in 1994 and 2005-2007.	
Project Benefits: THP provides cost effective medical and prescription drug coverage to our members who select them.	

Key Personnel	
Name: Rhonda Kahle, Account Executive 3	Day-to-day contact for WVU Medicine, Enrollment, Finance, Plan documentation, etc.
Name: Richard Legg, Sr. V.P of Benefit Services	Supervisor of Account Executive. Responsible for all self-insured accounts at THP.

Project Measurements:	
Projected Membership of Vendor's Contract: Employees: 9,250 (Medical/Rx), 3,718 (Rx only) Members: 18,907 (Medical/Rx), 7,570 (Rx only)	**Actual Membership of Vendor's Contract:** Employees: 9,250 (Medical/Rx), 3,718 (Rx only) Members: 18,907 (Medical/Rx), 7,570 (Rx only)
Reason(s) for Change in Membership: N/A	

Estimated Start and	From:	1/1/2020	To:	Ongoing

Completion Dates:				
Actual Start and Completion Dates:	From:	1/1/2020	To:	Ongoing
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: N/A				

Vendor Information		
Vendor Name: The Health Plan of West Virginia, Inc.	**Contact Name:**	Christy Donohue
	Contact Phone:	304.720.4923

Customer Information		
Customer Organization: City of Charleston	**Contact Name:**	Maria Church
	Contact Title:	Benefits Manager
Customer Address: 501 Virginia Street East, Suite 308 Charleston, WV 25301	**Contact Phone:**	304.348.8015
	Contact Email:	maria.church@cityofcharleston.org

Project Information	
Total Vendor Staff:	540 employees

Project Objectives:

Provide claims administration, medical management, COBRA services, flexible spending accounts and premium collections for City of Charleston active employees and their dependents and City of Charleston retirees and their dependents.

Project Description:

In addition to processing claims, THP provides utilization management, case management and behavioral health management to City of Charleston employees/retirees and their dependents. THP also manages and maintains healthcare flexible spending accounts and dependent care accounts for the City. THP performs all functions for COBRA administration and collects retiree premium payments on behalf of the City.

Vendor's Involvement:

THP performs all Third Party Administration services for the customer.

Project Benefits:

THP has the flexibility to allow the customer to choose their benefit design. THP offers a wide variety of services and maintains close contact with members via phone or email to ensure adequate care.

Key Personnel	
Name: Jessica Stover, Account Executive	Manages day-to-day operations. Primary contact for the customer. Provides on-demand and renewal reporting.
Name: Richard Legg, Sr. VP Sales and Account Management	Manages all employer group sales and account management staff.

Project Measurements:	
Projected Membership of Vendor's Contract: Employees: 1,200 Total Membership: 2,600	**Actual Membership of Vendor's Contract:** Employees: 1,200 Total Membership: 2,600

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

Estimated Start and	From:	1/1/2018	To:	Ongoing

Completion Dates:				
Actual Start and Completion Dates:	From:	1/1/2018	To:	Ongoing
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: N/A				

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.

The following tables include three references for each proposed subcontractor:

- Episource
- eviCore/Palladian
- Med-Data
- SKYGEN USA
- Superior Vision Benefit Management

Table 9: Subcontractor References

Subcontractor Information		
Vendor Name: Episource, LLC	**Contact Name:**	Heather Scott
	Contact Phone:	805.341.2022
Customer Information		
Customer Organization: Anthem	**Contact Name:**	Shamel Blount
	Contact Title:	Senior Project Manager
Customer Address: 500 Northhampton Blvd Norfolk VA, 23502	**Contact Phone:**	470.371.3684
	Contact Email:	shamel.blount@anthem.com
Project Information		
Total Vendor Staff:	100	
Project Objectives: Medicaid medical chart retrieval and coding throughout various states across the United States.		
Project Description: Episource currently retrieves medical records from the following agreed states: Louisiana (LA), New York (NY), Tennessee (TN), Kentucky, Indiana (IN). Episource provides enough record retrieval personnel and coding specialists to scan and/or review the agreed upon volume of records for each Medicaid State. Episource is also contracted to code these medical records.		
Vendor's Involvement: Episource completes all the medical record retrieval and coding for states identified by Anthem. Episource provides the coding results back to Anthem.		
Project Benefits: Assists with medical record retrieval on behalf of Anthem for a subset of their Medicaid population.		
Key Personnel		
Name: Andrew Perlstein	Vice President, Client Services	

Name: Heather Scott		Manager, Client Services		
Name: Isaac McNulty		Account Manager		
Project Measurements:				
Projected Membership of Vendor's Contract: ~70,000		**Actual Membership of Vendor's Contract:** ~108,000		
Reason(s) for Change in Membership: Episource was able to perform services in additional states since the start of our first project with Anthem.				
Estimated Start and Completion Dates:	From:	7/2018	To:	Present
Actual Start and Completion Dates:	From:	7/2018	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: N/A				

Subcontractor Information		
Vendor Name: Episource, LLC	**Contact Name:**	Heather Scott
	Contact Phone:	805.341.2022
Customer Information		
Customer Organization: Community Health Plan of Washington (CHPW)	**Contact Name:**	Rudy Dominguez
	Contact Title:	Risk Adjustment Supervisor, Population Analytics
Customer Address: 1111 3rd Ave #400 Seattle, WA 98101	**Contact Phone:**	206.613.8918
	Contact Email:	Rodolfo.Dominguez@chpw.org
Project Information		
Total Vendor Staff:	50	
Project Objectives: Medicaid chart retrieval and coding in the state of Washington. Medical chart coding is done using the CDPS model.		
Project Description: Episource retrieves medical records for a list of Medicaid members provided by CHPW. Medical charts are then passed along to the coding team to be processed using the CDPS model. Coding		

results are then passed back to the client for submission.				
Vendor's Involvement: Episource completes the medical record retrieval and coding using the CDPS model.				
Project Benefits: Assistance with retrospective medical chart retrieval and coding.				
Key Personnel				
Name: Andrew Perlstein	Vice President, Client Services			
Name: Scott Roeber	Manager, Client Services			
Project Measurements:				
Projected Membership of Vendor's Contract: ~10,000	**Actual Membership of Vendor's Contract:** ~10,000			
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	01/2018	To:	Present
Actual Start and Completion Dates:	From:	01/2018	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: N/A				

Subcontractor Information		
Vendor Name: Episource, LLC	**Contact Name:**	Heather Scott
	Contact Phone:	805.341.2022
Customer Information		
Customer Organization: Medical Card Systems (MCS)	**Contact Name:**	Brenda Artache Estrada
	Contact Title:	Premium Management SVP
Customer Address: 255 Ave Ponce De Leon San Juan, PR 00917	**Contact Phone:**	787.758.2500 Ext. 5312
	Contact Email:	bartache@medicalcardsystem.com
Project Information		
Total Vendor Staff:	17	

Project Objectives: The overall objective of this project is to submit clean encounter data to Puerto Rico.
Project Description: Episource hosts a web-based application that loads Medicaid encounter data from MCS and submit to Puerto Rico on behalf of MCS. The file submissions are in the format specified by ASES. The response files including 999 and 824 from the state will be loaded back into the application. The Error Management module helps identify errors in submission data and gives MCS the ability to fix the rejections through the intuitive user interface and resubmit them.
Vendor's Involvement: The vendor hosts the web-based submission and error reconciliation platform. The vendor is also responsible to the actual submission of encounter data.
Project Benefits: The benefits of the encounter submission tool are the ease of tracking and correcting all errors identified either prior to submission or post submission. Multiple dashboards and detailed error reports are provided on a regular basis. The error management tool allows for easy identification and correction of errors.

Key Personnel	
Name: Saravanan Rajagopal	Associate Vice President of Products
Name: Sujata Bajaj	Senior Vice President, Products
Name: Heather Scott	Manager Client Services

Project Measurements:	
Projected Membership of Vendor's Contract: ~100,000	**Actual Membership of Vendor's Contract:** ~100,000
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	11/2019	To:	Present
Actual Start and Completion Dates:	From:	11/2019	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: N/A

Subcontractor Information		
Vendor Name: eviCore/Palladian	**Contact Name:**	Jeff Kraft
	Contact Phone:	800.918.8924

Customer Information		
Customer Organization: Emblem Health	**Contact Name:**	Rhonda Robinson
	Contact Title:	VP Vendor Management
Customer Address: 55 Water Street New York, NY 10041	**Contact Phone:**	646.447.7219
	Contact Email:	Rrobinson2@emblemhealth.com

Project Information	
Total Vendor Staff:	4,608
Project Objectives: Ensure services being requested are medically necessary.	
Project Description: Covering procedures for radiology, cardiology, radiation oncology, post-acute care, physical therapy and occupational therapy	
Vendor's Involvement: Utilization management and claims payment integrity services for the above procedures	
Project Benefits: Reduction in medically unnecessary procedures for the above programs leading to better care and program savings	

Key Personnel	
Name: Cayce Awe	VP Strategic Client Relationship Executive. Overall responsibility for the relationship
Name: Adam Ackerman	Director Client Services. Owns the day-to-day operations of the programs

Project Measurements:	
Projected Membership of Vendor's Contract: 1,200,000	**Actual Membership of Vendor's Contract:** 1,200,000
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	1997	To:	Present
Actual Start and Completion Dates:	From:	1997	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: Utilization management and claim payment integrity for radiology, cardiology, post-acute care, radiation oncology, chiropractic, physical therapy and occupational therapy services.

Subcontractor Information		
Vendor Name: eviCore/Palladian	**Contact Name:**	Jeff Kraft
	Contact Phone:	800.918.8924
Customer Information		
Customer Organization: MVP Health Care	**Contact Name:**	Neil O'Brien-Bosselman
	Contact Title:	Sr. Program Manager
Customer Address: 625 State Street Schenectady, NY 12301	**Contact Phone:**	518.386.7249
	Contact Email:	nobrien-bosselman@mvphealthcare.com

Project Information	
Total Vendor Staff:	4,608
Project Objectives: Ensure that services that require prior authorization are medically necessary; ensure that the appropriate guidelines are used based on services authorized.	
Project Description: Radiation therapy, radiology, ClaimsStudio	
Vendor's Involvement: Utilization management of services that require prior authorization	
Project Benefits: Reduce [medically] unnecessary utilization to ensure cost containment and program savings.	

Key Personnel	
Name: Dr. Carl Cameron	Senior Medical Director
Name: Neil O'Brien-Bosselman	Senior Program Manager

Project Measurements:	
Projected Membership of Vendor's Contract: 558,000	**Actual Membership of Vendor's Contract:** 545,383
Reason(s) for Change in Membership: New membership growth for 2020 in the state of Vermont	

Estimated Start and	From:	2012	To:	Present

Completion Dates:				
Actual Start and Completion Dates:	From:	2012	To:	Present
Reason(s) for Difference Between Estimated and Actual Dates: NA				
If the Subcontractor Performed the Work as a Subcontractor, the Subcontractor Should Describe the Scope of Subcontracted Activities: N/A				

Subcontractor Information		
Vendor Name: eviCore/Palladian	**Contact Name:**	Jeff Kraft
	Contact Phone:	800.918.8924
Customer Information		
Customer Organization: YourCare Health Plan	**Contact Name:**	Malinda Sant
	Contact Title:	Director of Clinical Management
Customer Address: 446 Main Street Buffalo, NY 14202	**Contact Phone:**	585.453.8524
	Contact Email:	msant@yourcarehealthplan.com

Project Information	
Total Vendor Staff:	4,608
Project Objectives: **Vendor** (eviCore/Palladian) is to ensure that the service (outlined below) for which the health plan (YourCare) delegates to vendor (eviCore/Palladian) to manage are medically necessary.	
Project Description: Radiology, cardiac implantable devices, radiation oncology, sleep management	
Vendor's Involvement: Medical management of delegated services.	
Project Benefits: Reduction of medically unnecessary services will improve health outcomes and control cost.	

Key Personnel	
Name: Jeff Kraft	VP Client Relationship Executive. Overall responsibility for the relationship
Name: Kristy Over	Director Client Experience. Owns the day-to-day operations of the programs

Project Measurements:	
Projected Membership of Vendor's Contract: 54,000	**Actual Membership of Vendor's Contract:** 54,000

Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	1997	To:	Present
Actual Start and Completion Dates:	From:	1997	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: Utilization management and claim payment integrity for radiology, cardiology, post-acute care, radiation oncology, chiropractic, physical therapy and occupational therapy services.				

Subcontractor Information		
Vendor Name: Med-Data, Inc.	**Contact Name:**	Jonathan Smelley
	Contact Phone:	346.360.1602

Customer Information		
Customer Organization: Cook Children's Health Plan	**Contact Name:**	Crystal O'Reilly, BSN RN
	Contact Title:	AVP, Quality & Care Management Affairs
Customer Address: 7000 Calmont Ave Fort Worth, TX 76116	**Contact Phone:**	682.885.1410
	Contact Email:	Crystal.oreilly@cookchildrens.org

Project Information	
Total Vendor Staff:	107 FTEs
Project Objectives: Med-Data's objective is to assist members in obtaining their SSI benefits.	
Project Description: Med-Data provides full disability services for the providers	
Vendor's Involvement: Med-Data receives referred members from Cook Children's nurse caseworkers and other staff via an electronic disability file download to being the screening process.	
Project Benefits: Med-Data's technology results in 5%-10% more SSI opportunities on average. The program is comprehensive and effective in converting disabled patients to SSI and/or SSDI because they have the legal, technical, and medical capability to identify and pursue disability cases on behalf of the health plan and members.	

Key Personnel	
Name: Jonathan Smelley	Vice President, Disability
Name: Karl Czerny	Director of Operations
Name: Angela Sundquist	Director of Operations

Project Measurements:	
Projected Membership of Vendor's Contract: 130,774	**Actual Membership of Vendor's Contract:** 130,774
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	9/1/2016	To:	Auto-renews
Actual Start and Completion Dates:	From:	9/1/2016	To:	Auto-renews
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

Subcontractor Information		
Vendor Name: Med-Data, Inc.	**Contact Name:**	Jonathan Smelley
	Contact Phone:	346.360.1602
Customer Information		
Customer Organization: NYU Winthrop Hospital	**Contact Name:**	Tim Reilly
	Contact Title:	AVP, Financial Planning and Reimbursement
Customer Address: 700 Hicksville Rd Bethpage, NY 11714	**Contact Phone:**	516.576.1714
	Contact Email:	treilly@nyuwinthrop.org

Project Information	
Total Vendor Staff:	107 FTEs
Project Objectives: Med-Data assists patients to obtain SSI and increases Medicaid, DSH and 340b reimbursements.	
Project Description: Med-Data provides full disability services for the providers.	
Vendor's Involvement: Med-Data receives referred patients from NYU Winthrop Hospital's nurse caseworkers and other staff via an electronic disability file download to begin the screening process.	
Project Benefits: Med-Data's technology results in 5%-10% more SSI opportunities on average. The program is comprehensive and effective in converting disabled patients to SSI and/or SSDI because they have the legal, technical, and medical capability to identify and pursue disability cases on behalf of the hospital and patient.	

Key Personnel	
Name: Jonathan Smelley	Vice President, Disability
Name: Karl Czerny	Director of Operations
Name: Angela Sundquist	Director of Operations

Project Measurements:	
Projected Membership of Vendor's Contract: N/A This is a referral process from the hospital. There is no projected membership for this contract.	**Actual Membership of Vendor's Contract:** N/A This is a referral process from the hospital. There is no projected membership for this contract.

Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	9/1/2016	To:	Present
Actual Start and Completion Dates:	From:	9/1/2016	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: N/A				

Subcontractor Information		
Vendor Name: Med-Data, Inc.	**Contact Name:**	Jonathan Smelley
	Contact Phone:	346.360.1602
Customer Information		
Customer Organization: Select Health	**Contact Name:**	Andrea Neilson
	Contact Title:	Project Coordinator, Medicaid Program
Customer Address: 5381 Green St. Murray, UT 84123	**Contact Phone:**	801.442.9992
	Contact Email:	Andrea.Neilson@selecthealth.org
Project Information		
Total Vendor Staff:	107 FTEs	
Project Objectives: Med-Data's objective is to assist members in obtaining their SSI benefits.		
Project Description: Med-Data provides full disability services for the providers		
Vendor's Involvement: Med-Data receives referred members from Select Health's nurse caseworkers and other staff via an electronic disability file download to being the screening process.		
Project Benefits: Med-Data's technology results in 5%-10% more SSI opportunities on average. The program is comprehensive and effective in converting disabled patients to SSI and/or SSDI because they have the legal, technical, and medical capability to identify and pursue disability cases on behalf of the health plan and members.		
Key Personnel		
Name: Jonathan Smelley	Vice President, Disability	

Name: Karl Czerny		Director of Operations		
Name: Angela Sundquist		Director of Operations		
Project Measurements:				
Projected Membership of Vendor's Contract: 100,000 total members 90,000 Medicaid 10,000 CHIP		**Actual Membership of Vendor's Contract:** 100,000 total members 90,000 Medicaid 10,000 CHIP		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	10/1/2015	To:	Auto-renew
Actual Start and Completion Dates:	From:	10/1/2015	To:	Auto-renew
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				

Subcontractor Information		
Vendor Name: SKYGEN USA	**Contact Name:**	Mark Dasek
	Contact Phone:	262.946.4537
Customer Information		
Customer Organization: Horizon Blue Cross Blue Shield New Jersey	**Contact Name:**	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 (SKYGEN) provides administrative dental services for Horizon's Medicaid members.

Project Description:

SKYGEN performs all services necessary to administer the dental benefit to Horizon NJ Health, including implementation, network development, provider relations, credentialing, member services, member outreach, intensive care management, quality, utilization management, appeals and grievances, and reporting.

In addition to policies and procedures that proactively ensure members receive appropriate services and treatment, SKYGEN has built sophisticated reporting and analytics into its dental benefits software system, the Enterprise System. This system allows SKYGEN to run reports designed specifically for Medicaid dental programs that monitor utilization and member outcomes. Using this data, SKYGEN create interventions, outreach initiatives, and educational campaigns as appropriate for Horizon Blue Cross Blue Shield NJ.

Vendor's Involvement:

SKYGEN USA has managed Horizon Blue Cross Blue Shield of New Jersey's Medicaid members since 2012, with a focus on holistic program integrity and stewardship. To address Horizon Blue Cross Blue Shield of New Jersey's most immediate needs, SKYGEN used a combination of data analytics, fee schedule analysis, and GeoAccess 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
- Fraud, waste and abuse monitoring

Project Benefits:

For Horizon BCBS of NJ, SKYGEN reduced their PMPM costs, resulting in significant saving while

achieving over 80 percent provider satisfaction from 2015 to 2017. SKYGEN also consulted with Horizon BCBS of NJ to improve their providers' performance and helped protect nearly 1 million members by reducing and preventing fraud, waste and abuse.

Key Personnel	
Name: Mark Dasek	Client Experience Executive
Name: Janine Petragnani	Service Manager
Name: Nicole Martins	Account Manager
Name: Lynn Kern	Director of Claims Administration
Name: Marcel Tetzlaff	Vice President, Provider Experience and Dental Benefits Management
Name: Kyle Koltz	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: No change in membership	

Estimated Start and Completion Dates:	From:	12/1/2012	To:	Present
Actual Start and Completion Dates:	From:	12/1/2012	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: All services SKYGEN performs on behalf of Horizon Blue Cross Blue Shield of New Jersey 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 fraud, waste and abuse monitoring.

Subcontractor Information		
Vendor Name: SKYGEN USA	**Contact Name:**	Mark Dasek
	Contact Phone:	262.946.4537
Customer Information		
Customer Organization: United Concordia Dental	**Contact Name:**	Daniel J. Wright
	Contact Title:	SVP Government Business & CFO
Customer Address:	**Contact**	717.260.7182

4401 Deer Path Road Harrisburg, PA 17110	**Phone:**	
	Contact Email:	daniel.wright@highmark.com

Project Information	
Total Vendor Staff:	Approximately 600

Project Objectives:
SKYGEN USA (SKYGEN) provides administrative dental services for United Concordia's Medicaid members.

Project Description:
SKYGEN is a dental administrative services organization. SKYGEN performs 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 ensure members receive appropriate services and treatment, SKYGEN has built sophisticated reporting and analytics into its dental benefits software system, the Enterprise System. This system allows SKYGEN 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, provider payment
- Reporting
- Member services
- Quality assurance
- Reporting
- Member services
- Quality assurance
- Complaints, grievances, and appeals
- Fraud, waste and abuse monitoring

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	Client Experience Executive
Name: Janine Petragnani	Service Manager
Name: Cheryl Lighthart	Account Manager
Name: Lynn Kern	Director of Claims Administration
Name: Kyle Koltz	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: No change in membership				
Estimated Start and Completion Dates:	From:	4/1/2012	To:	Present
Actual Start and Completion Dates:	From:	4/1/2012	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: 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.				

Subcontractor Information		
Vendor Name: SKYGEN USA	**Contact Name:**	Mark Dasek
	Contact Phone:	262.946.4537
Customer Information		
Customer Organization: AmeriHealth Caritas Family of Companies	**Contact Name:**	Dr. Larry Paul
	Contact Title:	Dental Director
Customer Address: 100 Stevens Drive Philadelphia, PA 19113	**Contact Phone:**	215.937.7303
	Contact Email:	lpaul@amerihealthcaritas.com
Project Information		
Total Vendor Staff:	Approximately 600	
Project Objectives: SKYGEN USA (SKYGEN) provides administrative dental services for the AmeriHealth Caritas Family of Companies' approximately 1 million Medicaid members.		
Project Description: SKYGEN is a dental administrative services organization. SKYGEN performs all services necessary to administer the dental benefit to AmeriHealth Caritas in Pennsylvania, Washington D.C., Delaware, and Michigan, including implementation, member services, quality and reporting.		
Vendor's Involvement: SKYGEN has been the dental administrator managing AmeriHealth Caritas's Medicaid members since 2011. SKYGEN performs the following activities for AmeriHealth Caritas:		

- Authorizations
- Claims processing, provider payment
- Reporting
- Call Center
- Member services
- Quality assurance
- Complaints, grievances and appeals

Project Benefits:
SKYGEN USA has effectively managed the dental benefit program for AmeriHealth Caritas, 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	Client Experience Executive
Name: Janine Petragnani	Service Manager
Name: Luke Kaat	Account Manager
Name: Lynn Kern	Director of Claims Administration
Name: Kyle Koltz	Senior VP Third Party Administration Operations

Project Measurements:

Projected Membership of Vendor's Contract: 1 Million	**Actual Membership of Vendor's Contract:** 1 Million

Reason(s) for Change in Membership:
No change in membership

Estimated Start and Completion Dates:	From:	6/1/2011	To:	Present
Actual Start and Completion Dates:	From:	6/1/2011	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:
All services SKYGEN performs on behalf of AmeriHealth Caritas Family of Companies are performed as a subcontractor. This includes authorizations; claims processing; provider payment; reporting; member services; quality assurance; call center; and complaints, grievances and appeals.

Subcontractor Information		
Vendor Name: Versant Health - Superior Vision / Davis Vision	**Contact Name:**	Kim Roell
	Contact Phone:	412.298.1872
Customer Information		
Customer Organization: Highmark WV HCA	**Contact Name:**	Jennifer Braverman
	Contact Title:	Director, Product Management & Development
Customer Address: 1800 Center Street Camp Hill, PA 17011	**Contact Phone:**	412.544.3277
	Contact Email:	Jennifer.braverman@highmark.com

Project Information	
Total Vendor Staff:	2 dedicated client account management staff plus operational staff; 1,400 total employees
Project Objectives: Routine Vision services	
Project Description: Provide routine vision services for ACA exchange program.	
Vendor's Involvement: Delegated vision vendor for claims administration for the covered routine vision benefit.	
Project Benefits: Claims administration for routine vision services.	

Key Personnel	
Name: Paul Montuori	RVP, Client Management
Name: Kim Roell	Senior Client Manager

Project Measurements:				
Projected Membership of Vendor's Contract: 3,546		**Actual Membership of Vendor's Contract:** 3,546		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	1/1/2014	To:	Current
Actual Start and Completion Dates:	From:	1/1/2014	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:				

The scope of services includes delegation for claims administration services associated for all covered routine vision benefits including comprehensive eye exams and eyewear.

Subcontractor Information		
Vendor Name: Versant Health - Superior Vision / Davis Vision	**Contact Name:**	Scott Deas
	Contact Phone:	210.819.7597
Customer Information		
Customer Organization: Horizon BCBS of NJ	**Contact Name:**	Terra Swiggett, CHC
	Contact Title:	Manager, Delegate & Vendor Oversight
Customer Address: 250 Century Parkway Mount Laurel, NJ 08054	**Contact Phone:**	856.638.3377
	Contact Email:	Terra_Swiggett@horizonNJhealth.com

Project Information	
Total Vendor Staff:	3 dedicated client account management staff; 1,400 total employees
Project Objectives: Routine vision services and medical optometry services	
Project Description: Provide routine vision services including eye exams and eyewear. Additional services include medical optometry services which includes diagnostic tests and procedures appropriate for the evaluation, diagnosis and treatment of symptomatic eye conditions.	
Vendor's Involvement: Delegated vision vendor for claims administration, network management, customer service and other areas for the administration of the routine vision and medical optometry services.	
Project Benefits: Provide comprehensive eye care and routine vision services for the health plan and the Medicaid beneficiaries.	

Key Personnel	
Name: Paul Montuori	RVP, Client Management
Name: Scott Deas	Director, Client Management

Project Measurements:	
Projected Membership of Vendor's Contract: 850,000 Medicaid beneficiaries	**Actual Membership of Vendor's Contract:** 850,000 Medicaid beneficiaries
Reason(s) for Change in Membership: N/A	

Estimated Start and Completion Dates:	From:	2003	To:	Current
Actual Start and Completion Dates:	From:	2003	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: The scope of subcontracted activities includes claims administration, provider network management and contracting, customer service for members and providers along with required utilization management services.				

Subcontractor Information		
Vendor Name: Versant Health - Superior Vision / Davis Vision	**Contact Name:**	Paul Montuori
	Contact Phone:	516.827.6792
Customer Information		
Customer Organization: Healthfirst Health Plan	**Contact Name:**	Charlene De Saro-Raimondo
	Contact Title:	AVP, Ancillary/Vendor Engagement
Customer Address: 100 Church Street New York City, NY 10007	**Contact Phone:**	212.729.2187
	Contact Email:	Cdesaro-raimondo@healthfirst.org

Project Information	
Total Vendor Staff:	3 dedicated client account management staff; 1,400 total employees
Project Objectives: Routine vision services and medical optometry services	
Project Description: Provide routine vision services including eye exams and eyewear. Additional services include medical optometry services which includes diagnostic tests and procedures appropriate for the evaluation, diagnosis and treatment of symptomatic eye conditions.	
Vendor's Involvement: Delegated vision vendor for claims administration, network management, customer service and other areas for the administration of the routine vision and medical optometry services.	
Project Benefits: Provide comprehensive eye care and routine vision services for the health plan and the Medicaid, Medicare and ACA Exchange beneficiaries.	
Key Personnel	
Name: Paul Montuori	RVP, Client Management

Name: Scott Deas		Director, Client Management		
Project Measurements:				
Projected Membership of Vendor's Contract: 1.4 million Medicaid, Medicare and ACA Exchange beneficiaries		**Actual Membership of Vendor's Contract:** 1.4 million Medicaid, Medicare and ACA Exchange beneficiaries		
Reason(s) for Change in Membership: N/A				
Estimated Start and Completion Dates:	From:	2003	To:	Current
Actual Start and Completion Dates:	From:	2003	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: The scope of subcontracted activities includes claims administration, provider network management and contracting, customer service for members and providers along with required utilization management services.				

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

THP is financially strong and creditworthy, as demonstrated by our recent D&B ratings.

As of Jan. 17, 2020, our Overall Business Risk is Low, per D&B. D&B's further opinion is that THP is in "very stable condition," with a "high likelihood of continued operations" and "very low potential for severely delinquent payments."

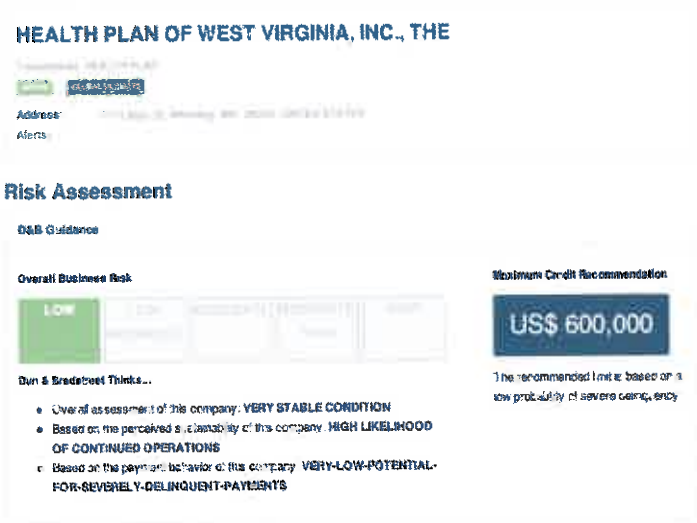


Figure 1: D&B Report. THP's D&B report demonstrates that THP is a very stable organization with a high likelihood of continued operations.

Our D&B measures are:

- ***PAYDEX:*** 73, indicating a low risk of slow pay
- ***Commercial Credit Score Percentile (Delinquency Predictor):*** 94%, with a score of 593

- ***Financial Stress Score:*** 71%, with a score of 1,514
- ***D&B Viability Rating:*** 1
  - Portfolio Comparison Score: 1
  - Viability Score: 2
  - Data Depth Indicator: A
  - Company Profile: G
- ***Bankruptcy Found:*** 0
- ***D&B Rating:*** Low Risk

We have attached the entire D&B report as Exhibit 6.1 Dun & Bradstreet Report.

Additional Third Party Ratings

While D&B has broad use across various industries, the insurance industry generally refers to the Weiss Rating. Specifically, Weiss provides the ratings on virtually all U.S. banks, credit unions and insurance companies; their information is updated semi-annually.

Liquidity and capital are indicators of a company's financial strength. In its most recent publication, Weiss reported:

- ***THP's Liquidity:*** "Good liquidity (6.2) with sufficient resources (cash flows and marketable investments) to handle a spike in claims."
- ***THP's Capital:*** "Strong capitalization index (7.2) based on excellent current risk-adjusted capital (severe loss scenario)."

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.

THP's financial stability is demonstrated through our liquidity and capital.

Liquidity	12/31/2018	3/31/2019	6/30/2019	9/30/2019	12/31/2019
Cash and Investments	$192,118,539	$193,042,664	$224,787,922	$205,553,860	$228,140,641
Unpaid Claims and Admin Expenses	$91,848,308	$94,010,751	$113,191,342	$107,376,320	$115,880,439
Excess Liquidity	$100,270,231	$99,031,913	$111,596,580	$98,177,540	$112,260,202

If needed, we have additional liquidity available in the form of a $13 million line of credit with a $9.6 million available balance. Our investment portfolio is highly liquid with settlement available within one week (within days for equities).

Capital	12/31/2018	3/31/2019	6/30/2019	9/30/2019	12/31/2019
Statutory Capital	$125,973,519	$131,335,739	$105,604,435	$111,565,593	$126,189,964
Risk Based Capital Ratio*	430.6%	448.9%	361.0%	381.3%	431.3%

*Calculated using 12/31/2018 authorized control level capital

THP's capital significantly exceeds regulatory requirements.

We have consistently demonstrated strong financial capacity throughout our 24 years serving the State's Medicaid population. Our financial resources have been able to withstand the adverse selection in our Medicaid population that has occurred since the SFY2016 contract with the implementation of behavioral health and the Medicaid Expansion population. Prior to the departure of West Virginia Family Health from the market, THP's annual risk adjustment was projected to be $6.4 million; after the departure of West Virginia Family Health, it will still be $2.7 million based upon the documents provided by the State's actuary, Navigant.

We maintain excess loss insurance reinsurance with a highly rated reinsurer (PartnerRe) to protect against catastrophic claims. We also maintain continuation of coverage in the event of plan insolvency.

Certificate of Authority

We have consistently maintained a Certificate of Authority (COA) with the West Virginia Offices of the Insurance Commissioner (WVOIC). This COA confirms our good standing with the State and compliance with all financial requirements with the WVOIC. A copy of our COA is provided as Exhibit 1.1 Certificate of Authority.

Credit References

We are pleased to provide the following credit references to verify THP's financial stability.

Table 10: Credit References

INSTITUTION	ADDRESS	PHONE NUMBER
West Virginia Offices of the Insurance Commissioner	West Virginia Lottery Building 900 Pennsylvania Avenue Charleston, WV 25302	304.558.2100
West Virginia University Health System dba WVU Medicine	1 Medical Center Drive Morgantown, WV 26505	Douglas M. Coffman Senior Vice President of Finance/CFO 304.298.7180
Baker Tilly Virchow Krause, LLP	777 East Wisconsin Avenue 32nd Floor Milwaukee, WI 53202	Amar Kothapalli Audit Partner 414.777.5493
WesBanco	1 Bank Plaza Wheeling, WV 26003	Michael Mistovich Senior Vice President of Lending 304.234.9309

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.

Our initial staffing plan, as described on the following pages, ensures that we meet or exceed all requirements and service levels to the Department's satisfaction. After a thorough review of the updated Service Provider Agreement, we enhanced our initial staffing plan to meet or exceed staffing requirements during implementation and throughout the

Serving Members is a Top Priority
In demonstration of our ability to serve MHT members, we exceeded the national average in both "Getting Needed Care" and "Getting Care Quickly" in our 2019 CAHPS Adult Medicaid Survey, with scores of 84 percent vs. 82.6 percent nationally and 84.3 percent vs. 82.2 percent nationally, respectively.

contract term. We are proposing to hire an additional 11 FTEs under the new Service Provider Agreement. These additional FTEs will support WVCHIP members and our enhanced services and programs that we are offering within this proposal. For example, we are hiring an additional enrollment specialist to assist with WVCHIP enrollment and collection of premiums.

Proposed Project Team Knowledge, Skills and Experience

We are pleased to offer a project team of key staff with 198 years of combined Medicaid experience in West Virginia. These key staff are supported by additional leadership and support staff who possess a deep understanding of both Medicaid and how their work matters to our Medicaid and WVCHIP members. All key staff currently work on Medicaid and are familiar with contract requirements.

Our key staff, described in detail in 3.1 below, provide strategic leadership and guidance to make sure that we continually innovate while maintaining fiscal responsibility. Jason Landers, Contract Liaison/MHT Administrator, has 15 years of Medicaid experience in leadership positions, including managing an MCO. Mr. Landers represents our Medicaid product on the THP Executive Management Team. Mr. Landers will be supported by Christy Donohue, VP Medicaid. Ms. Donohue reports directly to Mr. Landers and has more than 15 years of direct, hands-on operational West Virginia Medicaid experience. Both Mr. Landers and Ms. Donohue work closely with all departments within THP to make sure that we deliver on our contractual requirements. Together, they will have overall accountability for the implementation of the new Service Provider Agreement, including preparing the organization for the Readiness Review.

Additional leadership, including seasoned professionals, such as Sheila Kelly, Clinical Psychologist, collaborate with key staff and other team members. For example, Ms. Kelly, a clinical psychologist, works closely with our clinical operations team and Bureau for Medical Services (BMS) to ensure that we are following the behavioral health contractual guidelines. Ms. Kelly is prominent in the community and participates in several organizations, such as the West Virginia Behavioral Healthcare Providers Association. She is a past president of both professional psychology organizations in West Virginia. Ms. Kelly also works closely with BMS; she is currently facilitating the Peer Recovery Support Specialist Services workgroup for the state's Substance Use Disorder waiver.

Finally, our numerous support staff throughout the organization help us deliver high-quality services every day. Whether these support staff are taking member or provider calls, processing claims, enhancing our IT systems, engaging with community stakeholders or other initiatives, they contribute to our Medicaid success.

Below is a brief description of our various support staff assigned to the West Virginia Medicaid contract.

Support Staff Positions	Description
Claims Analyst	Under the direction of the manager of claims, the reviewer performs initial review of claims, including HCFA 1500 and UB 04 claims. Reviewer must meet or exceed production and quality standards and follow documented policies and procedures. There are three levels for this position.
Customer Service Representative (CSR)	The Medicaid CSR is responsible for answering phone calls in a prompt and courteous manner to achieve contractual obligations. Responsible for answering member's and provider's questions related to Medicaid with a quick and accurate response. They are also responsible for timely completion of all correspondence and reporting functions associated with the customer service department.
Medicaid Coordinator	Assist the VP of Medicaid in ensuring all contract requirements are met. Works with BMS on eligibility, capitation rates adjustments, monthly/quarterly

Support Staff Positions	Description
	reporting and is responsible for member appeals and grievances.
Customer Service Manager	The Medicaid customer service manager is responsible for monitoring, educating, training and managing the Medicaid CSR unit. The manager also helps coordinate and assist other departments with special projects; and works with other operations managers with staff education, communication, issues and procedures.
Claims Manager	The Medicaid claims manager is responsible for monitoring, educating, training and managing the Medicaid claims unit. The Medicaid claims manager also will assist other units and the operations directors with claims payment concerns, special projects, staff education, communication issues and procedures.
System Analyst/Programmer	The system analyst/programmer is responsible for design and development of solutions to complete systems. Perform systems management and integration functions. Coordinate data transfers from and to outside systems. Ability to be a technical lead for a programming team.
Nurse Navigators	Responsible to conduct systematic admission, concurrent and retrospective hospital reviews for severity of illness and length of stay, implements discharge planning, and to maintain system census with required data and pertinent clinical information with intervention and follow-up. Coordinates and integrates through review, all services that require pre-authorization including all new technology that requires review by the Transplant & New Technology (T&T) Assessment Committee. Responsible for the navigation and advocacy of identified members. These members require coordinated care and integration. This may include navigation beyond the specific case or situation, providing the member with a wide spectrum of services directed at not only medical or behavioral changes but healthy lifestyles and optimal outcomes assuring quality and continuity within the managed care system. Responsible for those identified members normally on a short-term, episodic or situational basis, or those members with a life-altering illness or injury.
Member Advocates	The member advocate is responsible for completing outreach activities for member engagement into the program. The member advocate is responsible for coordinating administrative functions within the program that may include but not limited to: administering health risk assessments (HRAs), scheduling care team meetings and completing meeting agendas and minutes, performing initial outreach and education, generating documents and reports, conducting mailings and assisting with phone coverage for the nurses.
SIU Investigators	The SIU investigator is responsible for investigating allegations of healthcare fraud, waste and abuse across multiple lines of business. The investigator will conduct full investigations that may include data analysis; research; contract review; medical records review; interviews of patients, witnesses and providers; site visits; consulting with other subject matter experts; coordination with law enforcement or regulatory agencies; and other necessary investigative activities. The investigator will create plans of investigation and determine scope, timing and direction of the investigations, ensuring they are completed timely and in a lawful, ethical and appropriate manner.
Clinical Data Analytics	Clinical data analyst position will gather and analyze healthcare data of the population from multiple sources (e.g. insurance processing, clinical operations, analytical software and other resources) to extract trends and business insights to improve efficiencies and effectiveness of clinical services

Support Staff Positions	Description
	processes.
Nurse Quality Coordinator	Under the direction of the assistant vice president population health, will develop, organize, prioritize and execute assigned population health projects with specific tasks, timelines and processes required to accomplish project goals. Responsible for identifying and quantifying data related to HEDIS, NCQA, CMS and BMS improvement measures, overall utilization of services, investigation areas of opportunity for improvement both internally and externally, evaluating the effectiveness of initiatives, and making further recommendations based upon measurable outcomes.
Provider Engagement Representative	The provider engagement representative provides education, training and guidance for providers in the assigned provider network; responsible for performing on-site reviews of new and re-credentialed providers within their assigned territory; identify and educate providers requiring additional education (performed on-site, via conference call and/or via webinar).
Credentialing Specialist	The credentialing specialist is responsible for credentialing of providers and facilities and associated activities in support of the credentialing process in accordance with established THP credentialing policies following NCQA, Medicare, the state of West Virginia, West Virginia Medicaid and the state of Ohio policies and procedures.
Contract Manager	The manager of pricing and contract compliance oversees the daily operation of pricing and contract compliance as related to claims payment for THP. Ensures fee schedules that are received from BMS are implemented within contract requirements.
Pharmacist	Demonstrates comprehensive knowledge of current pharmacotherapeutic principles, disease state and population management to help ensure the delivery of safe, appropriate and cost-efficient pharmaceutical care to membership.
Pharmacy Technician	A pharmacy technician is responsible in reviewing request from physicians and pharmacies to determine whether medication coverage can be authorized based on benefit plan design, client specifics and clinical criteria. Technicians answer provider and member pharmacy benefit questions with a prompt and accurate response. Technicians research and resolve problems in a timely manner to help others understand and maximize the use of their pharmacy program. Perform other duties as assigned.
Accounts Payable Clerk	The accounts payable clerk is responsible for the accounts payable for THP and all subsidiaries including Medicaid capitation payments.
Social Worker	The social worker collaborates with nurse navigators, medical directors, pharmacists, member advocates and external providers to access resources and address all psychosocial needs and social determinants of health impacting member care and outcomes.
HEDIS Manager	Under the direction of the assistant vice president, population health, is responsible for coordinating all activities related to HEDIS® analytics and reporting; assisting with Stars reporting and initiatives, developing actionable recommendations based on data; overseeing and assisting with identification and follow through of population health projects, throughout the company; assuring compliance with HIPAA privacy standards, Medicare standards, BMS standards and NCQA standards.
Enrollment Specialist	The Medicaid enrollment service representative is responsible for timely processing of enrollments using BMS guidelines and policies. They are also

Support Staff Positions	Description
	responsible for timely completion of all correspondence and enrollment reporting functions associated with the Medicaid unit and have knowledge of how the unit functions affect other plan units and departments. The Medicaid enrollment representative will serve as a backup to customer service by answering phone calls in a prompt and courteous manner (to achieve abandonment standards) and answering member and provider questions with a quick and accurate response.
Compliance Auditor	Under the direction of the compliance officer, the compliance auditor is responsible for conducting auditing and monitoring procedures, analyzing results and providing recommendations to promote compliance with laws, regulations and West Virginia Medicaid contract requirements. The auditor will work collaboratively with other departments to detect, track and report compliance issues. Areas of focus for auditing include, but are not limited to: enrollment, claims, appeals/grievances, provider relations and customer service.

Resources Necessary to Fulfill RFP Requirements for Key and Support Staff

As an existing MHT MCO, our resources currently fulfill the requirements specified in this RFP. Our staffing model is scalable and flexible, as demonstrated through our ability to successfully grow membership in several recent expansion opportunities:

- 2015 Medicaid expansion and behavioral health carve-in representing 35,000 members
- 2017 SSI expansion representing 10,000 members
- 2019 West Virginia Family Health MCO transition representing 16,000 members

We are prepared to leverage our transition processes to accept WVCHIP membership and, as appropriate, additional MHT membership.

Our key staff and support staff responsibilities are aligned with the SOW. Staff responsibilities will flex as SOW requirements evolve to meet changing SOW and member needs. Key and support staff cover all areas of services delivery, including claims processing, customer service, outreach, medical and behavioral health, quality and IT.

Because we serve Commercial and Medicare members in West Virginia, we can supplement Medicaid staff with experienced personnel when needed. For example, during times of high Medicaid call volume, we engage CSRs and pre-authorization staff from our Commercial and Medicare products to serve members. These CSRs and RNs have been cross-trained in Medicaid and can quickly and effectively step in when needed.

Organizational Charts: Narrative

One of the unique benefits of a regional health plan is that our Medicaid experts are embedded within each operational area, where they can leverage expertise and obtain additional support and resources.

Our five organizational charts represent the following areas:

- Operations/Information Systems
- Medical/Pharmacy
- Medicaid/Contracting
- Quality/Compliance/Population Health/Marketing
- Finance

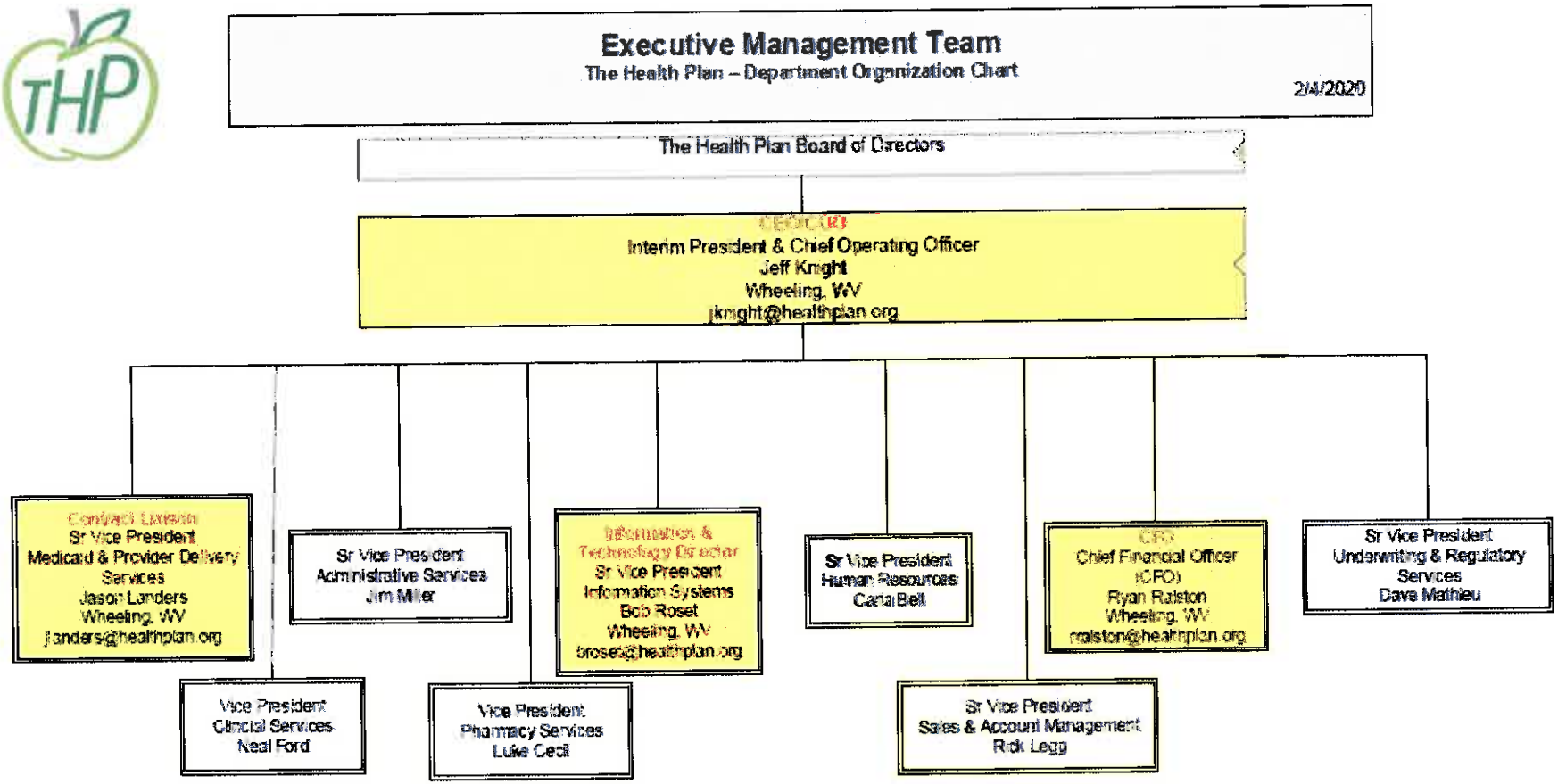
Each organizational chart identifies key staff in yellow boxes. Each key staff name includes their key staff title in red font, their internal titles in black font, then their email contact information and their location. Additional staff to be added to support WVCHIP are highlighted in green in the below organizational charts.

Additionally, our compliance officer reports directly to the CEO/COO, the Corporate Compliance Committee and THP's Board of Directors through the provision of reports to the Audit & Corporate Compliance Committee. This reporting relationship is illustrated in the Quality/Compliance/Population Health/Marketing organizational chart, and complies with Section 8.1.3.1. of the Service Provider Agreement.

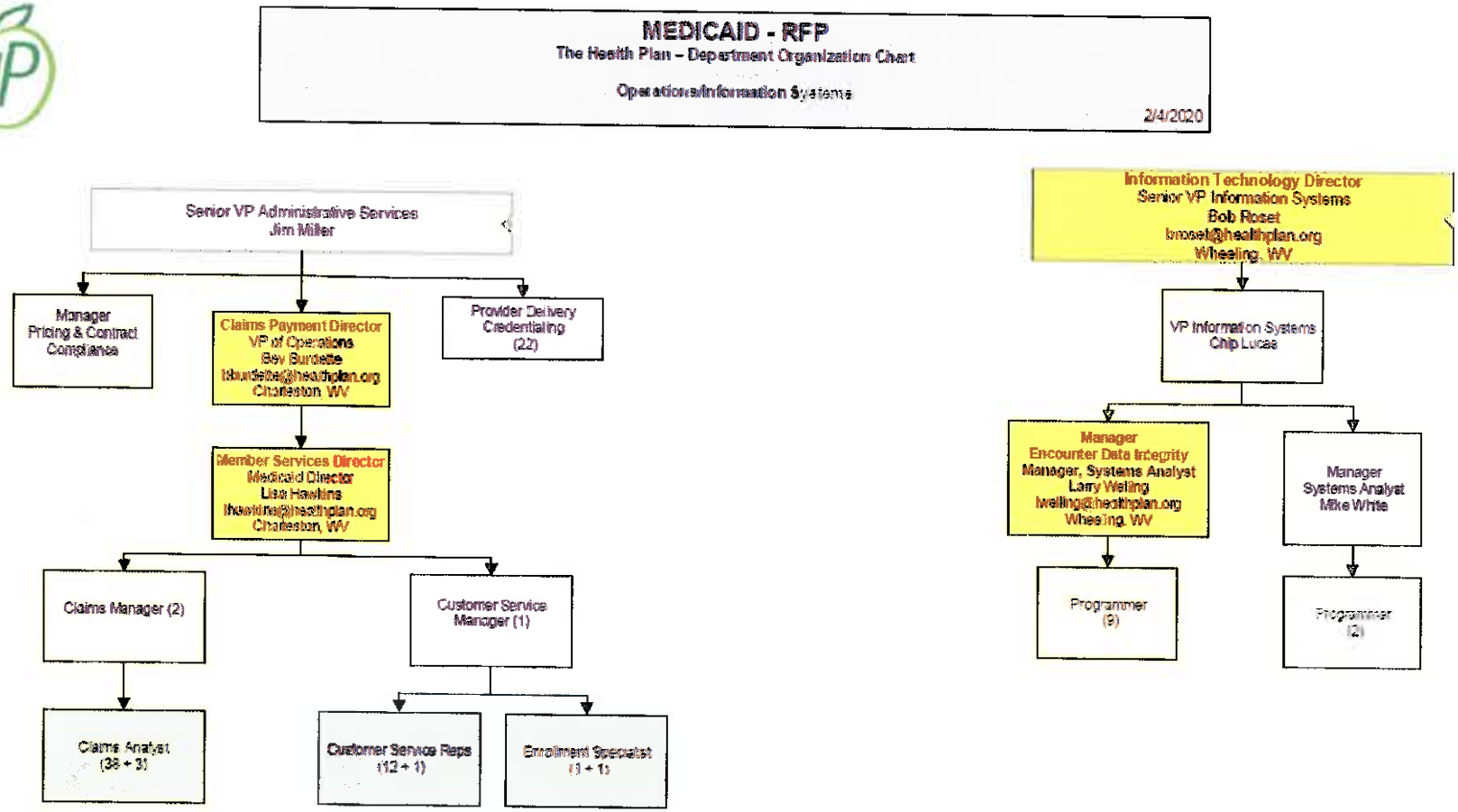
Organizational Chart: Corporate Structure, Lines of Responsibility and Authority

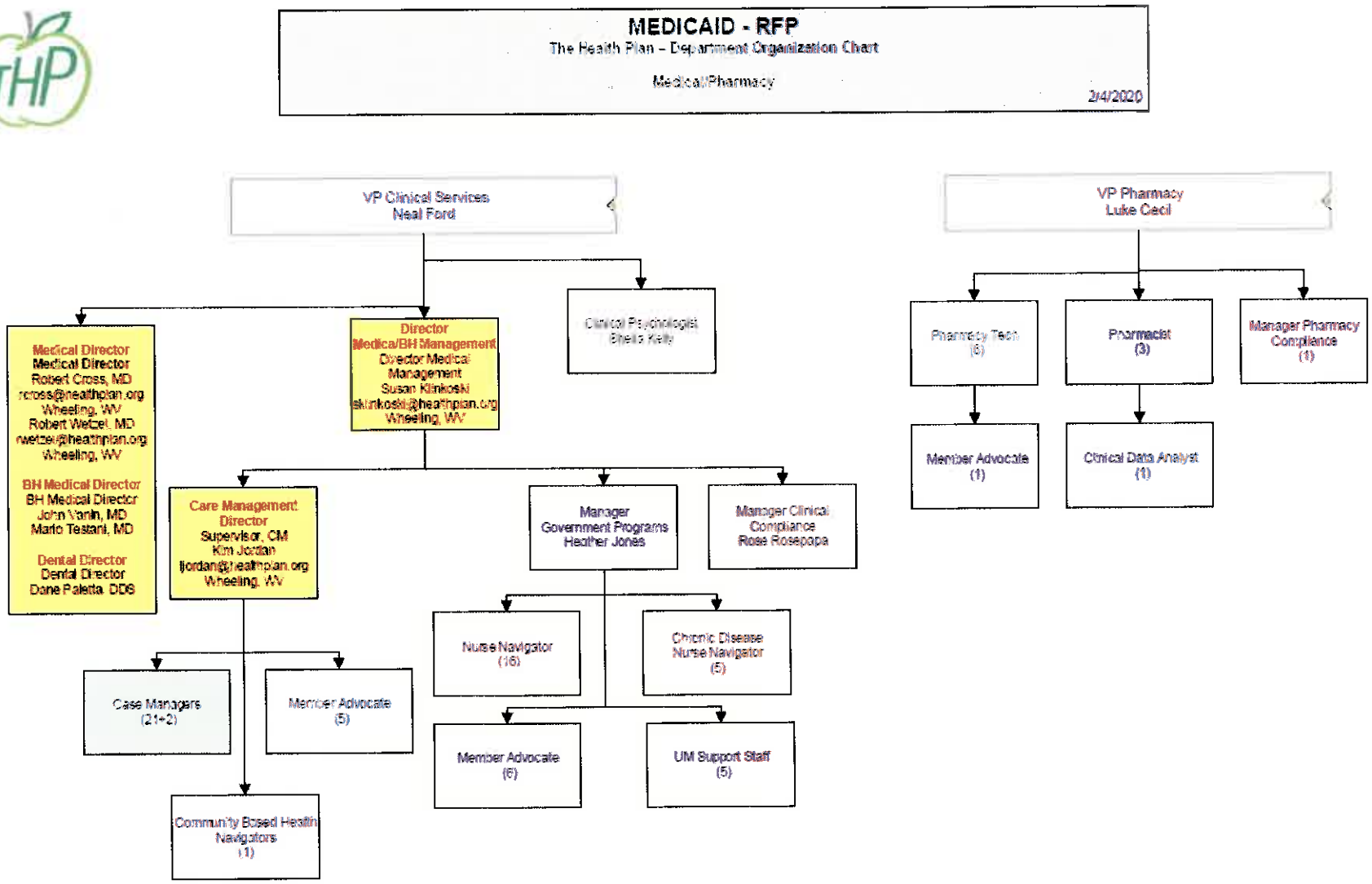
Jeff Knight, CEO/COO, leads THP and has overall accountability for managing the Service Provider Agreement with BMS. Mr. Knight reports directly to THP's Board of Directors.

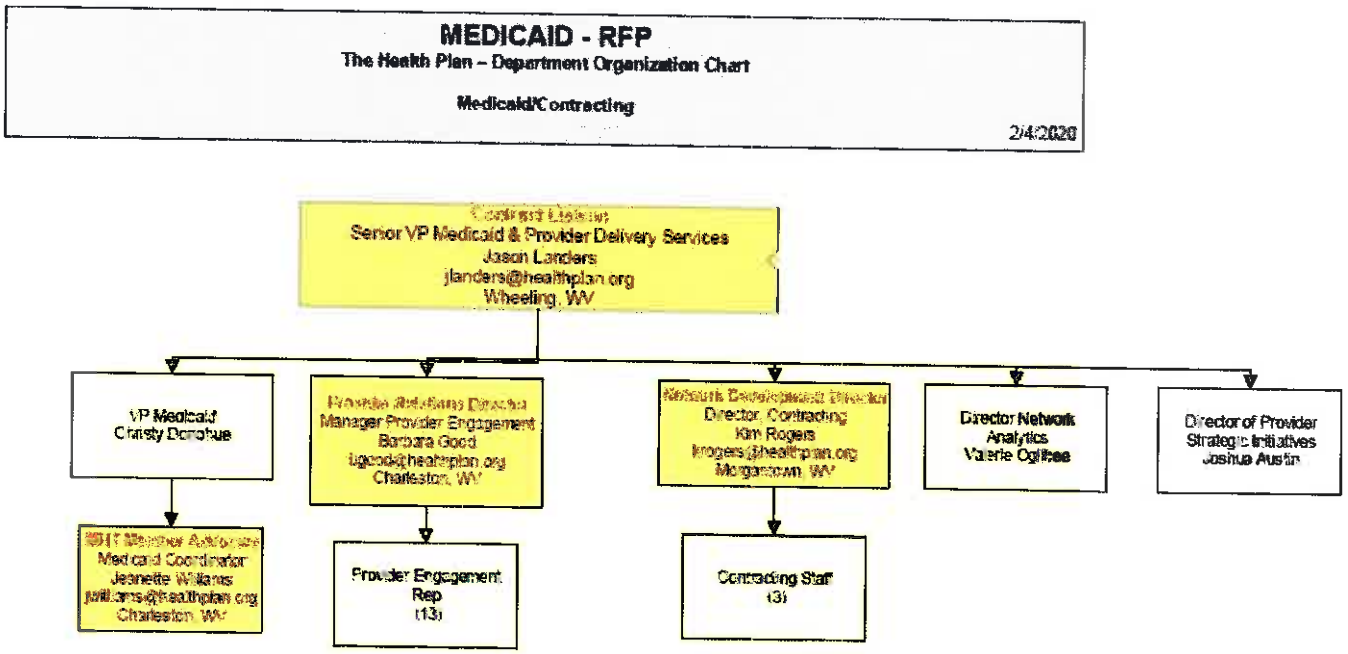
Please see the organizational charts on the following pages.

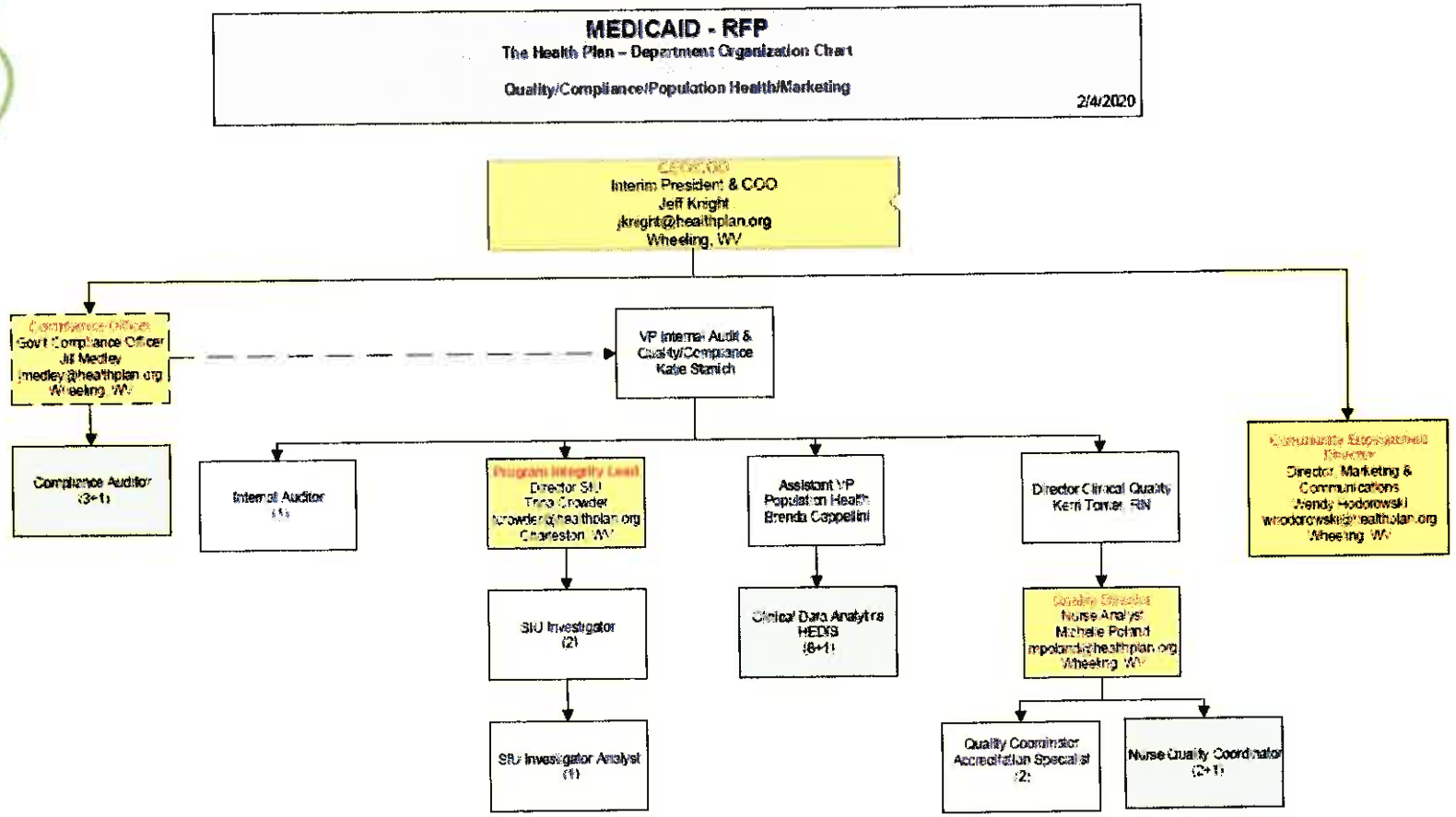

Executive Management Team
The Health Plan – Department Organization Chart
2/4/2020
The Health Plan Board of Directors
CEO/CBI
Interim President & Chief Operating Officer
Jeff Knight
Wheeling, WV
jknight@healthplan.org
Contract Liaison
Sr Vice President
Medicaid & Provider Delivery Services
Jason Landers
Wheeling, WV
jlanders@healthplan.org
Sr Vice President
Administrative Services
Jim Miller
Information & Technology Director
Sr Vice President
Information Systems
Bob Roset
Wheeling, WV
broset@healthplan.org
Sr Vice President
Human Resources
Carla Bell
CFO
Chief Financial Officer (CFO)
Ryan Ralston
Wheeling, WV
rralston@healthplan.org
Sr Vice President
Underwriting & Regulatory Services
Dave Mathieu
Vice President
Clinical Services
Neal Ford
Vice President
Pharmacy Services
Luke Cecil
Sr Vice President
Sales & Account Management
Rick Legg

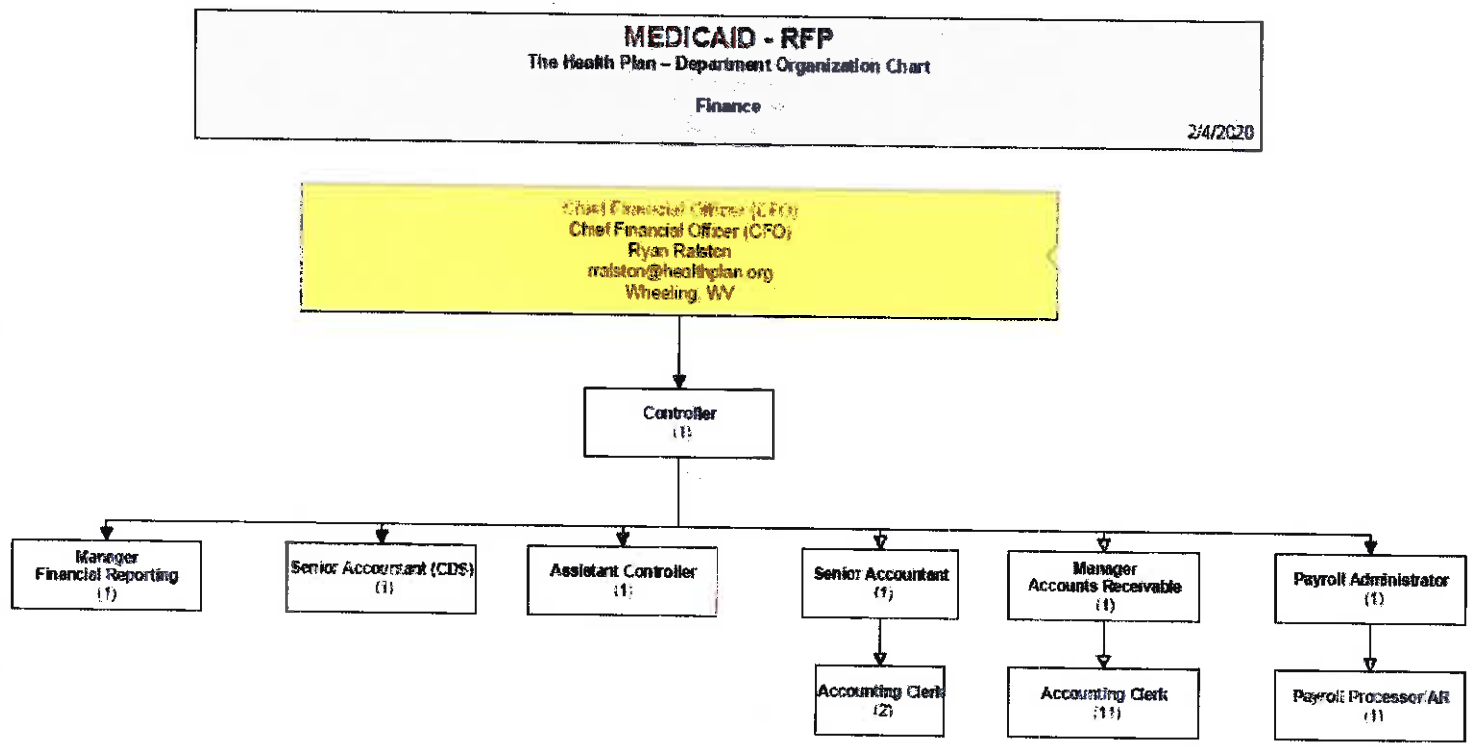
Organizational Charts: Project




MEDICAID - RFP
The Health Plan – Department Organization Chart
Medical/Pharmacy
2/4/2020
VP Clinical Services
Neal Ford
Medical Director
Medical Director
Robert Cross, MD
rcross@healthplan.org
Wheeling, WV
Robert Wetzel, MD
rwetzel@healthplan.org
Wheeling, WV
BH Medical Director
BH Medical Director
John Vanin, MD
Mario Testani, MD
Dental Director
Dental Director
Dane Paletta, DDS
Director
Medical/BH Management
Director Medical Management
Susan Klinkoski
sklinkoski@healthplan.org
Wheeling, WV
Clinical Psychologist
Sheila Kelly
Care Management Director
Supervisor, CM
Kim Jordan
kjordan@healthplan.org
Wheeling, WV
Manager
Government Programs
Heather Jones
Manager Clinical Compliance
Rose Rosepapa
Case Managers
(21+2)
Member Advocate
(5)
Nurse Navigator
(16)
Chronic Disease Nurse Navigator
(5)
Member Advocate
(6)
UM Support Staff
(5)
Community Based Health Navigators
(1)
VP Pharmacy
Luke Cecil
Pharmacy Tech
(6)
Pharmacist
(3)
Manager Pharmacy Compliance
(1)
Member Advocate
(1)
Clinical Data Analyst
(1)


MEDICAID - RFP
The Health Plan – Department Organization Chart
Medicaid/Contracting
2/4/2020
Senior VP Medicaid & Provider Delivery Services
Jason Landers
jlanders@healthplan.org
Wheeling, WV
VP Medicaid
Christy Donahue
Manager Provider Engagement
Barbara Good
bgood@healthplan.org
Charleston, WV
Director, Contracting
Kim Rogers
krogers@healthplan.org
Morgantown, WV
Director Network Analytics
Valerie Ogilbee
Director of Provider Strategic Initiatives
Joshua Austin
Medicaid Coordinator
Jeanette Williams
jwilliams@healthplan.org
Charleston, WV
Provider Engagement Rep
(13)
Contracting Staff
(3)


MEDICAID - RFP
The Health Plan – Department Organization Chart
Quality/Compliance/Population Health/Marketing
2/4/2020
CEO/COO
Interim President & COO
Jeff Knight
jknight@healthplan.org
Wheeling, WV
Compliance Officer
Govt Compliance Officer
Jill Medley
jmedley@healthplan.org
Wheeling, WV
VP Internal Audit & Quality/Compliance
Katie Stanich
Compliance Auditor
(3+1)
Internal Auditor
(1)
Program Integrity Lead
Director SIU
Tricia Crowder
tcrowder@healthplan.org
Charleston, WV
Assistant VP Population Health
Brenda Cappellini
Director Clinical Quality
Kerri Tonner, RN
Director, Marketing & Communications
Wendy Hodorowski
whodorowski@healthplan.org
Wheeling, WV
SIU Investigator
(2)
Clinical Data Analytics
HEDIS
(6+1)
Nurse Analyst
Michele Poland
mpoland@healthplan.org
Wheeling, WV
SIU Investigator Analyst
(1)
Quality Coordinator
Accreditation Specialist
(2)
Nurse Quality Coordinator
(2+1)

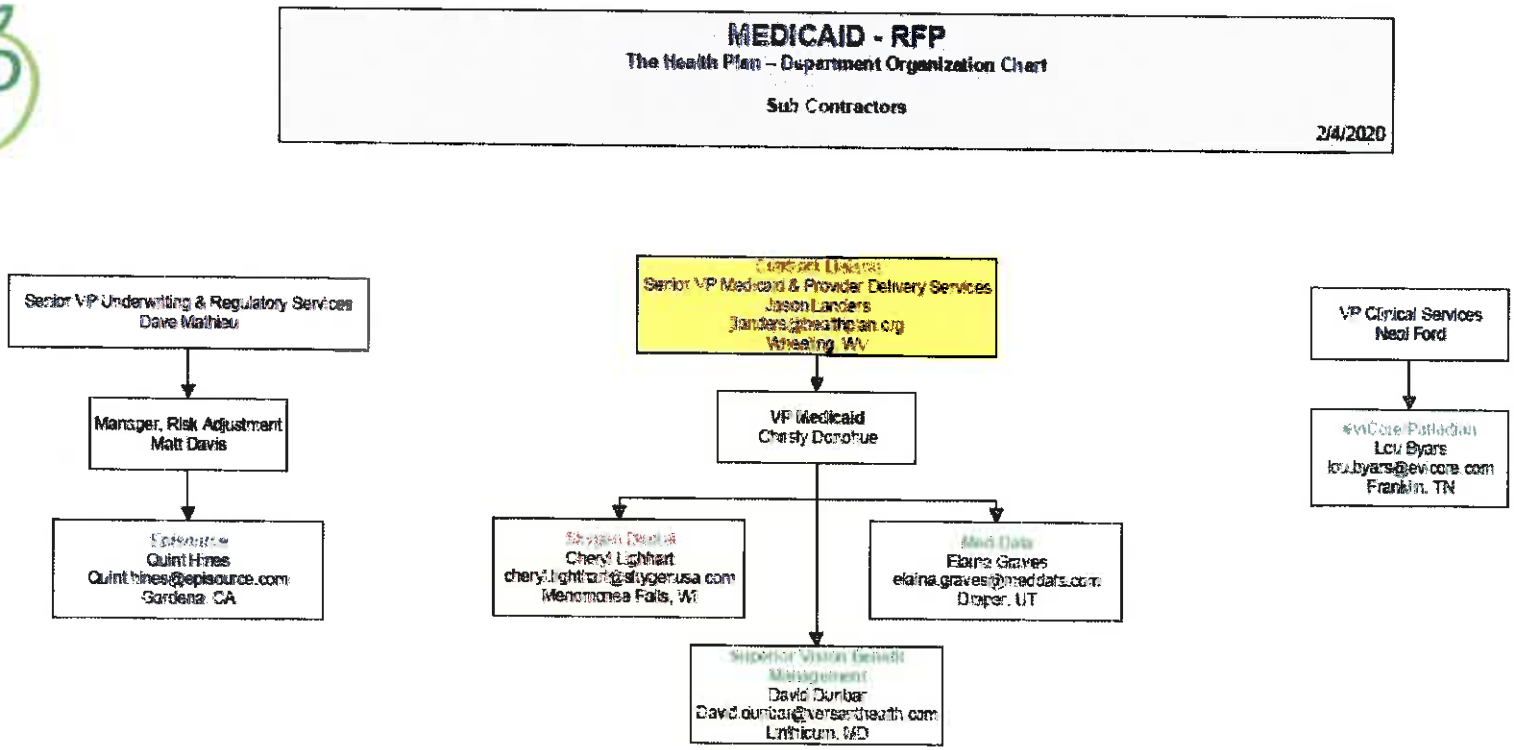

MEDICAID - RFP
The Health Plan – Department Organization Chart
Finance
2/4/2020
Chief Financial Officer (CFO)
Chief Financial Officer (CFO)
Ryan Ralsten
rralston@healthplan.org
Wheeling, WV
Controller
(1)
Manager
Financial Reporting
(1)
Senior Accountant (CDS)
(1)
Assistant Controller
(1)
Senior Accountant
(1)
Manager
Accounts Receivable
(1)
Payroll Administrator
(1)
Accounting Clerk
(2)
Accounting Clerk
(11)
Payroll Processor/AR
(1)

Organizational Chart: Subcontractor Oversight

The following organizational chart illustrates the subcontractor oversight and management within THP for each proposed subcontractor:

- Episource
- eviCore/Palladian
- Med-Data
- SKYGEN USA
- Superior Vision Benefit Management

Each subcontractor is aligned within the operational area with direct knowledge and expertise over their responsibilities. This alignment allows us to closely monitor each subcontractor's performance and to verify that they are consistently delivering high-quality services. Our Subcontractor Monitoring Plan, described in detail below, includes pre-delegation audits, auditing and monitoring processes conducted at various levels of the organization. The Subcontractor Monitoring Plan also includes corrective actions as needed and reporting to a Subcontractor Oversight Committee, THP executives, the executive-level Corporate Compliance Committee (CCC) and the board-level Audit & Corporate Compliance Committee (A&C).


MEDICAID - RFP
The Health Plan – Department Organization Chart
Sub Contractors
2/4/2020
Senior VP Underwriting & Regulatory Services
Dave Mathieu
Manager, Risk Adjustment
Matt Davis
Quint Hines
Quint.hines@episource.com
Gardena, CA
Senior VP Medicaid & Provider Delivery Services
Jason Landers
Wheeling, WV
VP Medicaid
Christy Donohue
Cheryl Lighthart
Menomonee Falls, WI
Elaine Graves
elaine.graves@meddata.com
Draper, UT
David Dunbar
David.dunbar@versanthealth.com
Linthicum, MD
VP Clinical Services
Neal Ford
Lou Byars
lou.byars@evicore.com
Franklin, TN

Tools and Processes to Screen Available Staff to Fill Positions

With offices in Wheeling, Charleston and Morgantown, THP recruits from across the state to hire candidates who are the best match for each position. Our reputation as an employer is well-regarded, as demonstrated by our recent back-to-back awards as a top West Virginia employer.

Top Employer in West Virginia
We are proud to serve West Virginia and its Medicaid members. THP was recognized as a Five Diamond Employer by the West Virginia Chamber of Commerce in 2018 and 2019. This honor is awarded to West Virginia-based companies that exhibit an outstanding commitment to employer development, community service and employee empowerment.

When they become available, we post each position in the Careers section of our website, healthplan.org. We also post positions through outside sources, college job boards and attend job fairs when needed. As part of our commitment to growth and development, we give employees the opportunity to apply for open positions.

Candidates must successfully complete the interview process, along with any other position-specific screening. For example, we require SIU candidates to successfully complete a practical skills/competency assessment during the interview process. This type of additional screening helps to ensure that we find the right candidates for the right positions.

At the conclusion of the interview and screening process, we extend a conditional offer to the selected candidate. All selected candidates are required to pass a pre-employment drug screening and a check of the SAMS and OIG exclusion lists. For some positions (e.g., clinical, finance, SIU), we complete an additional background screening to verify credentials. For example, we contact professional boards (e.g., Boards of Medicine, Nursing, Psychology, Pharmacy) to verify that the candidate has

appropriate licensure. We provide the candidate with a final job offer, including a start date, only after the candidate successfully passes all screening.

Process for Replacing and Backfilling Key Staff

When employee turnover, including that of key staff, occurs, we complete a due diligence process to verify that replacing the position is necessary. For example, if the business needs have changed the scope of work required for the employee, we may consider reclassifying the position or reviewing other opportunities to fill the vacancy.

We understand that we are contractually required to meet the staffing requirements for key staff, including education and experience.

After the due diligence process and once the hiring request is approved, human resources begins the advertising process. We post the position as soon as possible to allow ample time to interview, hire and train an individual.

Developing Talent From Within

It is important to note that we place a high value on developing talent from within, as demonstrated by two programs:

- ***Leadership Education for Advancement and Development (LEAD):*** This is a 12-month leadership development program. We identify future leaders to participate in this program. This program offers a variety of educational and development opportunities including external consultants who train the group on various leadership skills. Our Executive Management Team and the majority of our key staff participated in this program within the past two years.
- ***Top Grading:*** We establish a pool of the highest performers (through annual evaluations) from each department at THP, and we engage in conversations with these employees to determine their future professional and leadership goals. When opportunities arise, we seek to place those high performers in their desired position.

Hiring Plan for Administration of the Contract Awarded Through this Solicitation

THP currently is staffed to handle the existing Medicaid membership. In preparation for the award, we anticipate needing to hire an additional 11 FTE positions that would be required to fulfill the contract requirements, including the addition of WVCHIP and to successfully deliver on the enhanced services that we are offering in our proposal. We also have ascertained that some existing staff, including three key staff (Lisa Hawkins, Member Services Director; Bev Burdette, Claims Payment Director and Jeanette Williams, MHT Member Advocate), have experience serving WVCHIP members with previous employers. We will leverage their past experience and enlist them to assist in the transition of the WVCHIP membership.

Each key staff person is in place and prepared to continue to deliver on our commitments for the MHT program. For those additional support staff, we have initiated the hiring process by completing a thorough assessment of the hiring needs, by department. Additionally, we have existing job descriptions and hiring requisitions for each of these positions. Each of these positions are posted online and we have reviewed our internal team members to identify potential candidates for these positions, especially those with growth potential. We are prepared to make contingent offers as we find the ideal candidates.

With this pre-work completed, we are prepared to quickly execute on our hiring plan. In the unlikely event we are not able to hire/train additional staff prior to go live, we will pull resources from our other lines of business to assist with the operation requirements.

We will obtain BMS approval for all key staff changes, in compliance with **MD019**. With key staff, we will only replace them with persons of equal or greater experience and qualifications.

How Staffing Numbers Reflect Adequate Access

Our staffing methodology focuses on how to effectively meet our members' changing needs in all of our business areas. To determine staffing numbers for the new MHT contract, we carefully reviewed the Service Provider Agreement and considered the program enhancements that we will make prior to the contract effective date. We also reviewed the information that we have gathered about the incoming WVCHIP population, including data from previous meetings with BMS and stakeholders, plus information from our existing staff who previously worked with WVCHIP members. Finally, we met with each internal operational area to vet their staffing methodology to verify that we will meet or exceed the contractual requirements and our commitments.

Our clinical staffing ratios are based upon member lives. For example:

- 1 RN or social worker to every 5,550 members enrolled in a care management program
- 1 RN to every 50 members for members enrolled in the complex case navigation level of care management
- 1 RN or social worker to every 150 members enrolled in the care navigation level of care management

Additional Training or Materials to Support Enrollment

Our comprehensive employee training covers federal, State and contract requirements. Additionally, we require all employees to complete our Cultural Competency (previously Language Access and Non-Discrimination Plan) training. We offer Medicaid University to all employees. Medicaid University is an excellent in-depth resource for a

comprehensive look at Medicaid and how THP meets our contractual requirements.

Selected compliance-related training programs are summarized in the following table.

Compliance Related Training		
Name	**Description**	**Frequency and Target Audience**
Medicaid Service Provider Agreement Training	Summarizes the Service Provider Agreement provisions. Updated annually. Ensures CEO/COO, CFO, senior management and employees are trained on contract provisions. Training is documented by the successful completion of a post-training quiz (at least 80%).	Conducted at hire and every July thereafter. Mandatory for all employees of THP.
Medicaid University	Serves as a resource for all things Medicaid. The presentation is posted on THP's intranet (available to all employees) and includes general contract provisions, Medicaid operations, quality, medical management and member outreach.	All employees who work on the Medicaid line of business.
Compliance & FWA Prevention Training	Covers the seven elements of a compliance program and how to prevent, detect and correct potential non-compliance and FWA. Includes information on relevant healthcare laws such as the Anti-Kickback Statute and the federal False Claims Act (including its qui tam provisions). Training on the federal False Claims Act complies with the requirements of the Deficit Reduction Act of 2005.	Conducted at hire and every November thereafter. Mandatory for all employees of THP and THP board members.
HIPAA Privacy & Security Training	Covers HIPAA requirements, uses and disclosures of PHI and member rights under HIPAA. Training documented by the successful completion of a post-training quiz (at least 80%).	Conducted at hire and every April thereafter. Mandatory for all employees of THP.
Cultural Competency Training	Reviews access for LEP individuals, individuals with disabilities or limited literacy and cultural competency. Training documented by the successful completion of a post-training quiz (at least 80%).	Conducted at hire and every January thereafter Mandatory for all employees of THP.
Claims Analyst/ Customer Service Department Training	This training program is a hands-on program administered in a classroom setting. The trainees begin learning from day one. New hires begin training with a review of the Medicaid contract.	At hire. All Medicaid Claims Analysts and Customer Service Representatives.

Subcontractor Monitoring Plan

THP has developed a subcontractor oversight process that includes pre-delegation audits, auditing and monitoring processes conducted at various levels of the organization, corrective actions as needed and reporting to a Subcontractor Oversight Committee, THP executives, the Corporate Compliance Committee (CCC) and the

Audit & Corporate Compliance Committee (A&C). THP's Subcontractor Monitoring Plan includes the requirements found in Article II Section 8.5 Subcontracts of the Service Provider Agreement. THP accepts the financial, legal, ethical and other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors, and other entities that support or will support THP in the performance of the Medicaid Contract and adherence to (**MD021**).

The figure demonstrates our subcontractor oversight reporting structure within THP.

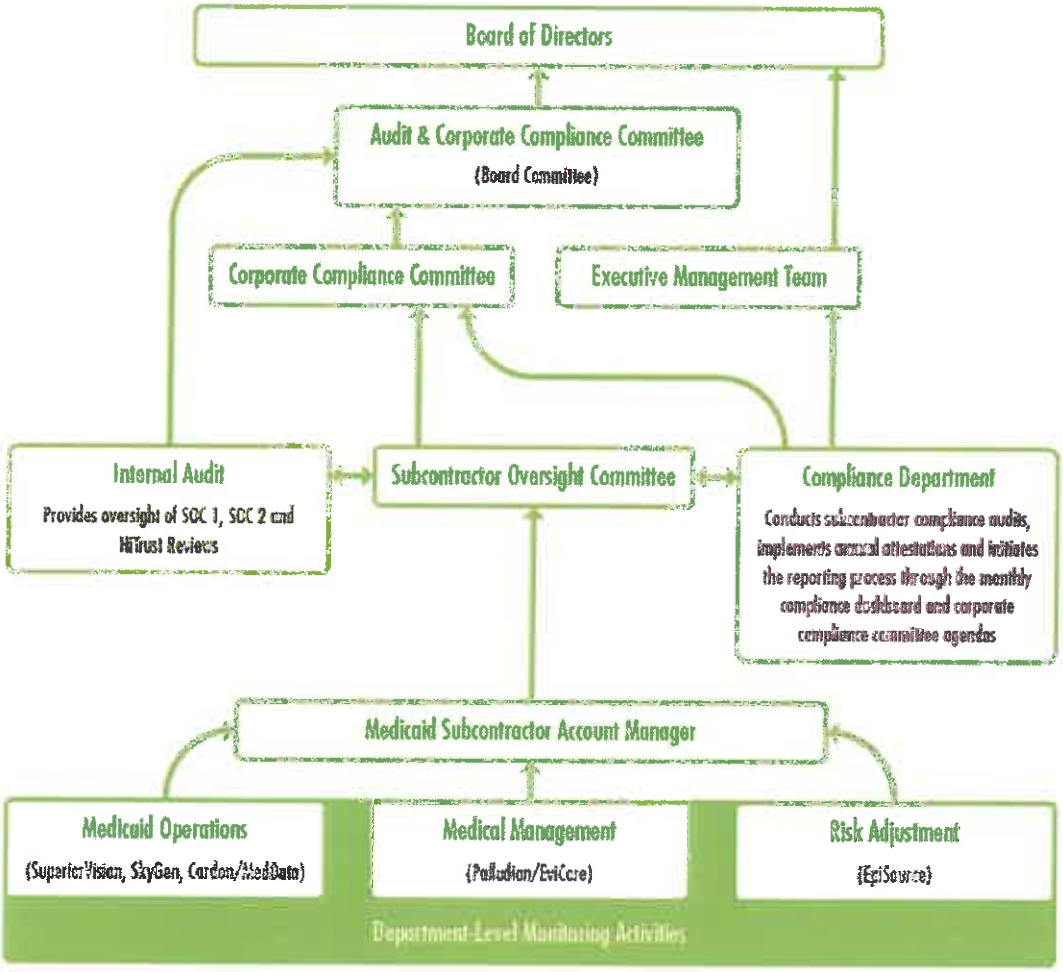


Figure 1: Subcontractor Oversight Reporting Structure. Our subcontractor oversight reporting structure drives visibility to subcontractor performance throughout the organization.

Pre-Delegation Audit

The subcontractor oversight program includes processes to address the continuum of the subcontractor life cycle from pre-delegation audit to termination. The pre-delegation audit is conducted using a team that includes the applicable business owner(s), internal audit and the compliance department. The pre-delegation audit for subcontractors will include an operational readiness review by the applicable business owner, a review of any applicable SOC 1, SOC 2 or HiTrust reports by internal audit, a review of the subcontractor's compliance, privacy and security processes conducted by the compliance department and a list of reports to be received from the subcontractor.

The pre-delegation audit is guided by a checklist and is overseen by the Subcontractor Oversight Committee. The Subcontractor Oversight Committee reviews the findings of the pre-delegation audit of any potential Medicaid subcontractor and makes recommendations based on the results of the audit.

Current THP Subcontractors

THP has experience with its current Medicaid subcontractors through long-standing contractual arrangements as part of its Medicaid program or experience with the subcontractor through THP's other lines of business.

Subcontractor	Services
Episource	Encounter data submissions
eviCore/Palladian	Utilization management including preservice decisions and appeals
Med-Data	Assists Medicaid members in obtaining SSI benefits
SKYGEN USA	Dental benefit administration including network management
Superior Vision Benefit Management	Vision benefit administration including network management

Subcontractor Oversight Committee

The Subcontractor Oversight Committee includes members from Medicaid operations, internal audit, compliance and quality/NCQA.

The Subcontractor Oversight Committee receives reports from the subcontractor account manager on a form designed to capture all auditing and monitoring activities related to each subcontractor. The account manager, Christy Donohue, VP Medicaid, coordinates the monitoring activities associated with all subcontractors.

Regular Monitoring and Auditing Activities
The Subcontractor Oversight Committee regularly reviews the monitoring and auditing activities conducted to ensure the subcontractor performs its delegated duties in a manner consistent with THP's expectations and the requirements of the Service Provider Agreement.

Subcontractor Auditing and Monitoring

Reporting Requirements and Performance Monitoring

Each subcontractor must submit periodic performance reports to THP. The name, purpose and frequency of each report is documented on the applicable Subcontractor Monitoring Form. The applicable business owner provides the day-to-day oversight of THP's Medicaid subcontractors through a review of these reports and ongoing monitoring activities.

Vision and Dental Benefit Administration

THP receives regular reports from its vision and dental benefit subcontractors. Such reports address, as applicable, provider network including network adequacy, provider credentialing, call volume and call center metrics, appeals and grievances, credible allegations of fraud, utilization management and third party recovery.

Encounter Data Submission and Administration

THP will communicate on a weekly basis with its encounter data subcontractor and receive reports related to the percentage and types of encounter data errors. Pertinent information will be captured through documented monitoring metrics that permit the tracking and trending of the subcontractor's performance with respect to the delegated duties.

Utilization Management

Utilization management subcontractors are required to submit performance reports, as applicable, related to standard and expedited pre-service requests, standard and expedited appeals, and grievances. Pertinent information from these reports is captured through documented monitoring metrics that permits the tracking and trending of the subcontractor's performance with respect to its delegated duties.

SSI Disability Advocate

The SSI disability advocate reports members' SSI status on periodic reports submitted to THP. These reports are reviewed for SSI status accuracy.

All subcontractor monitoring activities, including those described above, are reported to Ms. Donohue using the Subcontractor Monitoring Form and subsequently forwarded to the Subcontractor Oversight Committee for review.

Compliance Audits

Compliance audits augment the ongoing monitoring processes previously described. The compliance department uses a risk-based approach to determine the scheduling and frequency of subcontractor compliance audits. Higher risk subcontractors are audited annually or biennially.

Subcontractor audits are scheduled and tracked in the Audit Work Plan (AWP) and documented in Gorman's Online Monitoring Tool (OMT). All subcontractor audits are documented in a final report distributed to the applicable executives and summarized in CCC and A&C meeting agendas. If needed, a corrective action plan (CAP) is implemented. CAPs are documented and tracked in OMT.

Contract Management
THP has a contract management system called iContracts. iContracts is used to house its Medicaid Subcontractor agreements including any applicable delegation agreements and other relevant documents. iContracts provides reminders to the applicable business owner(s) when contracts are coming up for renewal. iContracts is also used to alert business owners when it is time to request updated SOC 1, SOC 2 and/or HITRUST reports from the Subcontractor.

Control Report Reviews

THP requests and reviews its Medicaid subcontractors' applicable SOC 1, SOC 2 and/or HiTRUST reports annually. HiTRUST reports are reviewed by the Compliance Department. SOC 1 and SOC 2 reports are abstracted by the business owner using a structured Excel spreadsheet. The abstraction process reviews the auditor's opinion to determine if the opinion is qualified or unqualified and reviews any control testing exceptions. Follow-up is conducted in the event of a qualified auditor opinion, although this has not been necessary to date. Any applicable complementary user entity controls (CUECs) are reviewed with an emphasis on the identification of THP's corresponding controls. Any exceptions in the reports are evaluated by THP to ensure there is no impact on THP's internal control environment.

Annual Compliance Attestations

In addition to periodic audits, all subcontractors must complete an annual compliance attestation. The annual compliance attestation questionnaire requires subcontractors to confirm compliance with the following program elements:

Compliance Attestation Questionnaire - Compliance Program Elements Queried	
Compliance and FWA Training	Code of Conduct (including annual attestation)
OIG LEIE and GSA/SAM Exclusion Screening	Reporting Mechanisms for compliance issues and potential FWA
Downstream Entities (if applicable)	Access Plan for Enrollees with Limited English Proficiency or Disability

Corrective Actions

The Subcontractor Oversight Committee reviews the results of all subcontractor monitoring, auditing and oversight activities including any identified deficiencies to determine if there is the need for a CAP. Corrective actions may include:

- Documentation of corrective actions (minor or isolated issues)
- Formal CAP (significant or systemic issues)
- Termination of contract (serious deficiencies or no improvement after corrective actions) with notification to BMS within five business days of giving or receiving notice of subcontractor termination or within three business days of a serious breach of contract

Any new subcontractors, including a pharmacy benefit manager if applicable, would be subject to the same oversight process as previously described.

Subcontractor Oversight Reporting

Summary reports of these activities will be reported to the EMT through the monthly Compliance Dashboard and to the CCC and the A&C at regularly scheduled meetings. Significant deficiencies are communicated immediately to the CEO/COO and applicable EMT member.

The figure illustrates our Medicaid subcontractor lifecycle, from pre-delegation audit to termination (if applicable).

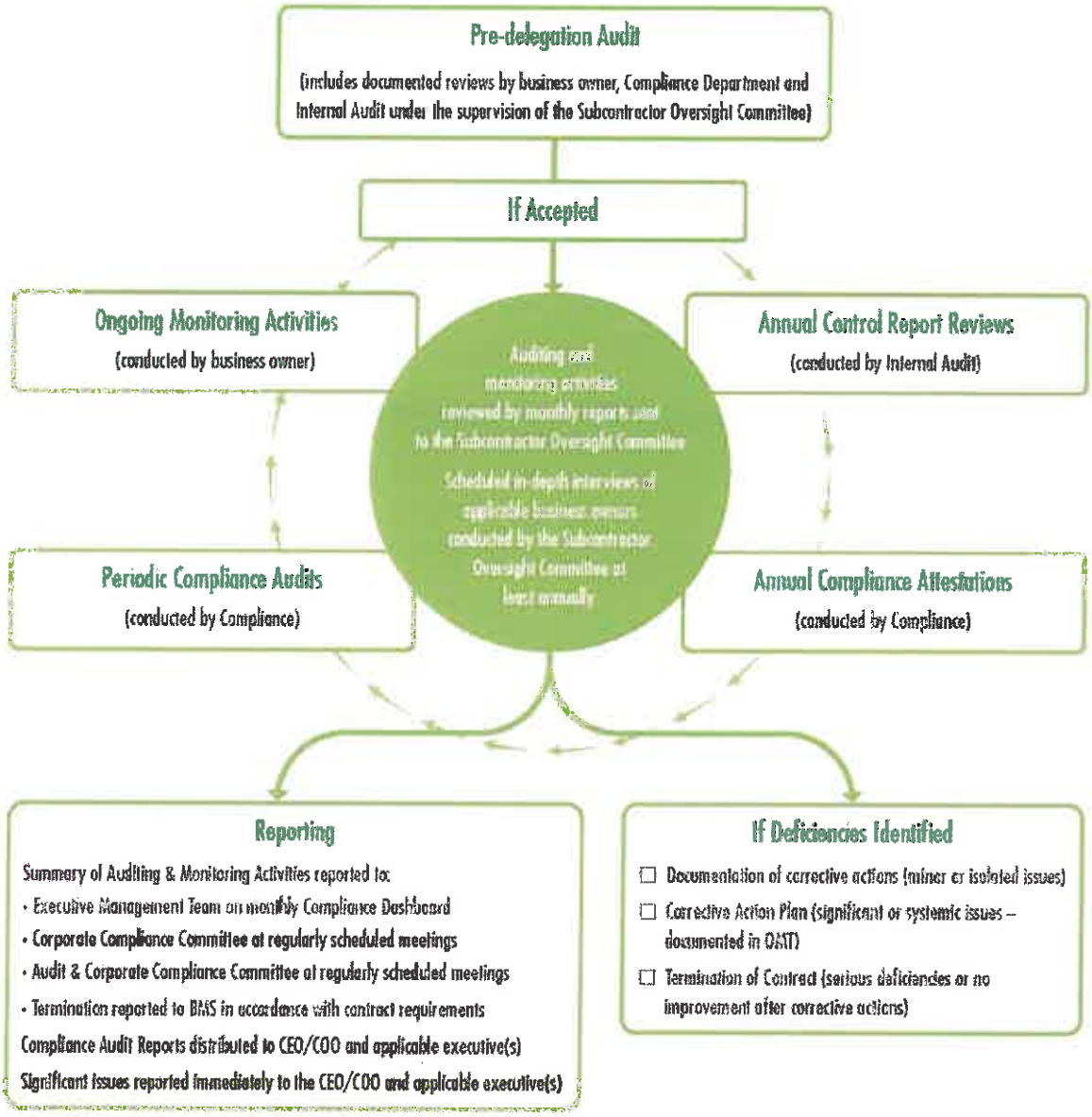


Figure 2: Medicaid Subcontractor Lifecycle. The Medicaid Subcontractor Lifecycle illustrates THP's Subcontractor Monitoring Plan from pre-delegation audit to termination (if applicable). Auditing and monitoring activities are ongoing and subject to the oversight of the Subcontractor Oversight Committee.

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***.

BMS requires experienced and local key staff to ensure that MCOs have a local investment in West Virginia and that the MCO's leaders have decision-making authority. In compliance with **MD020**, our key staff provide leadership for the management and administration of our MHT contract. These dedicated individuals understand the

program requirements and work with BMS, our members and providers to provide high quality service and care. This team also creates standards and processes for the successful implementation, operation and maintenance of the program. As a local non-profit, our leadership is in West Virginia and can efficiently and effectively make decisions; we do not rely on a distant parent organization.

Benefits of our in-place key staff include:

- **No need to recruit:** THP will not need to spend time and resources to recruit expertise needed for the project.
- **Trained on THP systems:** Key staff are already trained on THP systems, Medicaid benefits and other project requirements—allowing them to quickly transition to the new contract.
- **Intimately familiar with project scope:** Key staff were actively involved in responding to the RFP and have begun executing on our new commitments made within this proposal; they are, or will be, ready for the new contract.
- **West Virginia residence and work history:** One hundred percent of key staff have work history in West Virginia and are personally committed to the State and the impact that THP has on the improvement of the lives of adults, children and youth in our communities.

Key Staff Minimum Requirements

We understand the importance of having qualified key staff within our organization and we are pleased that our existing key staff qualifications closely aligned with the BMS key staff requirements.

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.

We are pleased to provide our key staff for BMS consideration. Since all key staff are currently employed and located in West Virginia, we are submitting resumes and not submitting any letters of intent.

Table 11: Resumes for Proposed Key Staff

Name	Proposed Role	Experience in Proposed Role	Currently Employed by the Vendor?
Jeff Knight	Chief Executive Officer/Chief Operating Officer	Jeff Knight has been a leader in the finance area of THP for over 20 years, serving as CFO, and now as THP's President/COO. Mr. Knight is a CPA.	Yes
Jason Landers	Contract Liaison/MHT Administrator	Jason Landers has 15 years of Medicaid experience in leadership positions, including managing an MCO. Mr. Landers represents our Medicaid program on the THP Executive Management Team.	Yes
Ryan Ralston	Chief Financial Officer	Ryan Ralston has been with THP since 2016 and has served in the role of CFO since January 2019. Mr. Ralston is a CPA.	Yes
Jill Medley	Compliance Officer	Jill Medley has been with THP since July 2017 and serves as both the compliance and privacy officer. She previously worked at Ohio Valley Health Services as compliance and privacy officer for six years. Ms. Medley has a master's degree in Health Care Administration.	Yes
Dr. Robert Wetzel	Medical Director	Dr. Robert Wetzel has served as a full-time medical director with THP since 2015. He provides physician oversight for activities related to the company's utilization management, disease management and quality management programs ensuring compliance with NCQA, Medicare, Medicaid and other regulatory entities.	Yes

Susan Klinkoski	Medical Management Director	Susan Klinkoski has been employed in the care management area as a registered nurse with THP for over seven years. Prior to her employment with THP, she worked for over 15 years as a pediatric and nursery nurse in the hospital setting.	Yes
Kim Jordan	Care Management Director	Kim Jordan is a registered nurse with over 40 years of experience, combined, in acute clinical setting and managed care. She has been with THP since 2015 and currently supervises Medicaid, D-SNP and Medicare case management with a staff of 45.	Yes
Dr. John Vanin	Behavioral Health Medical Director	Dr. John Vanin has served as the behavioral health medical director at THP since 2015. During his tenure at West Virginia University, he worked in a number of capacities including provision of student mental health services at the university. He has also worked as a consulting psychiatrist at various Community Mental Health Centers.	Yes
Michelle Poland	Quality Director	Michelle Poland has worked as a clinical nurse for over 37 years, 13 of which have been spent in THP's quality management department. She has a master's degree in nursing from Wheeling University.	Yes
Lisa Hawkins	Member Services Director	Lisa Hawkins has been employed with THP since December 2018 and oversees both claims payment and customer service for THPs Medicaid areas. Prior to employment with THP, Ms. Hawkins worked with HealthSmart and Wells Fargo as a team manager for over 15 years serving both commercial and government contracts.	Yes
Bev Burdette	Claims Payment Director	Beverly Burdette has led operations at THP since 2015. Prior to that, she was with HealthSmart and Wells Fargo TPA where she held the position of VP of operations for 20 years. Ms. Burdette was in charge of an operations center handing claims payment and customer services for over 400 clients with approximately 500,000 members, serving both commercial and government contracts.	Yes
Kim Rogers	Network Development Director	Kim Rogers recently joined THP and brings 20+ years of experience contracting commercial and government lines of business. Ms. Rogers is an RN with an MBA from West Virginia University. She previously worked as director of network development and contracting for MAMSI Health Plans and Coventry/Aetna. Ms. Rogers has several years of experience developing value-based contracts for United Healthcare, Highmark and LabCorp.	Yes

Barbara Good	Provider Relations Director	Barbara Good is responsible for overseeing provider education, training and guidance for the provider network, including having knowledge of contract language and payment methodology. She currently manages the activities of all regional provider education, services and THP's community outreach opportunities.	Yes
Trina Crowder	Program Integrity Lead	Trina Crowder is a Certified Fraud Examiner with over 20 years of experience, including 12 years with the OIG Medicaid Fraud Control Unit, and approximately one year with The Lewin Group as a healthcare fraud subject matter expert advising BMS on strengthening managed care program integrity efforts. She is also a Certified Medical Coder.	Yes
Bob Roset	Information Technology Director	Bob Roset has over 30 years of experience leading the Information systems department at THP.	Yes
Wendy Hodorowski	Community Engagement Director	Wendy Hodorowski has over 10 years of marketing experience. She plans, directs and sets the strategic direction of marketing programs for the entire organization, including marketing communications and public relations activities.	Yes
Larry Welling	Encounter Data Integrity Manager	Larry Welling has over 37 years of experience in planning, developing and implementing cutting-edge EDI solutions that manage the ever-changing health insurance landscape. Mr. Welling has extensive experience at gathering, analyzing and defining business and functional requirement; HIPAA ANSI X-12 transaction; and designing/re-engineering processes, workflows and technology solutions for health insurance systems.	Yes
Jeanette Williams	MHT Member Advocate	Jeanette Williams joined THP in 2016. She is currently responsible for member appeals and grievances, working with BMS on a daily basis with eligibility, capitation, fee schedule and member concerns. Prior to that time, she worked as a customer service representative at HealthSmart.	Yes
Diane Paletta, DDS	Dental Director	Dr. Paletta's 35-plus years in the field of dentistry spurs her passion to help people achieve optimal oral health. Throughout the past three decades, she has not only worked in private practice as a dentist in West Virginia, she has served on numerous boards and as an advocate educating the public on the importance of dentistry and how it impacts overall health.	Yes, currently employed with SKYGEN

JEFF KNIGHT

KEY STAFF TITLE: CEO/COO

PROFILE

Mr. Jeff Knight is an experienced leader with over 22 years of financial experience in healthcare and Medicaid. His many years of experience at The Health Plan (THP) have allowed him to be involved in all aspects of the Medicaid operations.

EDUCATION AND TRAINING

- Bachelor of Science in Business Administration Accounting, West Virginia University; 1995
- Certified Public Accountant; 1997

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan of West Virginia Inc. November 2019 – Present
Internal THP Title: Interim President/COO

As Interim President/COO, Mr. Knight oversees the day-to-day operations of the Company and responsible for directing, administering and achieving the goals and objectives of the Board of Directors. He develops strategic partnerships with providers to improve coordination and care for THP's members. Mr. Knight identifies and embraces strategic initiatives that will improve the member experience and reduce the cost of care.

The Health Plan of West Virginia, Inc. December 2018 – November 2019
Senior Vice President of Finance and Analytics

As Senior VP of Finance and Analytics, Mr. Knight was responsible for compliance, underwriting, and actuarial services, which included business intelligence. He also was responsible for leading a group whose job was to identify cost containment initiatives that lead to improved financial results. Initiatives were developed for claims, medical management and network management. With the growth in Medicaid, this line of business was the primary focus for the team.

The Health Plan, St. Clairsville OH January 2007 – December 2018
Chief Financial Officer

As CFO, Mr. Knight was responsible to the Board of Directors for all accounting and financial matters. He established company-wide objectives, policies, procedures and practices to assure a strong balance sheet to pay future claims. During his time as CFO, he helped manage an investment portfolio that exceeded $200M in market value. The portfolio averaged a 4% return, which was used to keep member premiums down and pay medical claims. The growth of the portfolio and liquidity of the investments was key in managing the unexpected Medicaid Expansion population until rates stabilized. He helped lead the acquisition of Vested Health Plan and the sale of THP's Workers Compensation business. He was instrumental in helping with the transition of CEOs to help maintain continuity within the organization.

The Health Plan, St. Clairsville OH — March 2003 – January 2007
Controller

As Controller, he was responsible for overseeing all financial and accounting activities. These duties included budget management, financial analysis, payroll, accounts payable, accounts receivable and financial reporting. The Controller was also responsible for preparing all quarterly and annual tax returns, including the Form 990s. He was part of the acquisition team that helped with the seamless integration of Hometown Health Plan, HMO in Massillon OH, with The Health Plan. During his time as Controller, he helped THP grow from $40M in capital to $140M.

The Health Plan, St. Clairsville OH — September 1998 – March 2003
Assistant Controller

As Assistant Controller, he was responsible for preparing and consolidating the Corporate financial statements. This included the preparation of the Statutory Basis financial statements for the National Association of Insurance Commissioners and the West Virginia Office of Insurance Commissioner. He was responsible for managing all aspects of the general ledger and compiling the monthly financial statements for management. He also supervised the accounts receivable and accounts payable staff.

Costanzo & Associates, Wheeling WV — December 1995 – September 1998
Staff Accountant

As the staff accountant, he was responsible for preparing and analyzing financial reports for individuals and companies. Audit financial reports for compliance and review company's financial statements for accuracy. Other responsibilities included bookkeeping, preparation of tax returns, and financial planning.

JASON LANDERS

KEY STAFF TITLE: CONTRACT LIAISON/MEDICAID ADMINISTRATOR

PROFILE

Jason Landers has15 years of Medicaid experience in leadership positions. He is the former Market President of West Virginia Family Health (WVFH), a Highmark-owned Medicaid MCO. Successfully managed WVFH from a startup organization through a fiscally difficult period, into profitability. Mr. Landers represents our Medicaid product on the THP Executive Management Team.

EDUCATION AND TRAINING

- MBA., Business Administration; West Virginia University, Morgantown, WV; 2007
- B.A., Business Management; West Virginia Institute of Technology, Montgomery, WV; 1989

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan of West Virginia, Inc. – Wheeling, WV May 2018 – Present
Internal THP Title: Senior Vice President

Currently holds several executive positions, beginning in Strategic Initiatives then Provider Network, Administrative Services, and currently Medicaid and Provider Delivery Systems and Medicaid. Leading the West Virginia Medicaid profit and loss, provides senior and strategic leadership for the THP Medicaid Plan. Reviewed THP infrastructure and made recommendations on best practices for a successful health plan. Developed key vendor relationships for critical cost containment initiatives. Key part of business development team that created back office opportunities for Medicaid unit. Negotiated key hospital contracts that were terminating. Staffed a new division that includes contracting, provider relations and network operations. Recruited several key personnel into leadership positions throughout the organization. Led initiative to collect multi-million dollar overpayments on services. Leading value-based contracting initiatives with key provider stakeholders.

West Virginia Family Health Plan / Highmark December 2014 – May 2018
– Parkersburg, WV - *Vice President/Executive Director/Market President*

Plan President of West Virginia Family Health, an HMO licensed Medicaid MCO in the state of West Virginia. As Plan President, responsible for the day to day management of a growing Medicaid MCO. Responsible for the company's profit and loss. Responsible for Board of Directors relations with an active board that includes external partners. Oversight of complicated matrixed organization that included Highmark, Highmark WV, Beacon, and Gateway Health. Served as Market President and key government contact for Highmark and West Virginia Family Health in West Virginia. Led West Virginia Family Health (WVFH) through a tumultuous period that included multi-million dollar projected losses and little corporate support to a $40 Million turn around. Oversaw conversion from provider ownership utilizing a unique Provider Sponsored Network (PSN) CON to Highmark ownership with an HMO CON. Managed relationships with dozens of provider shareholders, including most FQHCs, and the WV Primary Care

Association. Led WVFH through a critical period of negative audit issues including "going concern provisions", to a clean audit and WV Insurance Commissioner review.

As VP of the Medicaid Market, responsible for the WV Medicaid business line and how it integrates with the other Highmark business lines. Led Highmark WV Medicaid team to successfully grow the Provider Sponsored Network from a start-up organization to 60,000+ members. Created a plan that successfully entered the Medicaid Expansion market. WV Family Health was the plan that was selected by more new expanded Medicaid members than any other plan. Oversaw carve-in of behavioral health services into managed care.

Highmark WV – Parkersburg, WV April 2012 – December 2014
Director of Provider Strategic Initiatives

Camden-Clark Physician Corporation – Parkersburg, WV July 2009 – April 2012
Executive Director

Camden Clark Medical Center – Parkersburg, WV February 2000 - July 2009
Customer Service Supervisor

Anthem Health Plan of WV PrimeONE January 1999 – February 2000
– Charleston,WV - *Director Underwriting*

Anthem Health Plan of WV PrimeONE September 1994 – December 1998
– Charleston,WV - *Manager, Network Development / Reimbursements*

GROUPS

West Virginia University at Parkersburg Board of Governors August 2015 to Present

- Chairman Audit Committee, Executive Committee
- Governor appointed board

WV Association of Health Plans 2016 to 2018, 2019

- Vice Chairman

Parkersburg Rotary Club May 2000 to Present

- President (July 2016), Board of Directors (2005)

National Quality Forum January 2016 to May 2016

- Nominated and selected to serve on a 12-member national committee focusing on the improvement of healthcare quality and cost in rural and low volume practices.

RYAN RALSTON

KEY STAFF TITLE: CHIEF FINANCIAL OFFICER

PROFILE

Mr. Ryan Ralston is an experienced finance professional with over 14 years of financial management experience. He has an extensive financial background in auditing, financial reporting, budgeting and forecasting, internal controls and treasury management. Mr. Ralston is a certified public accountant (CPA) and a member of the American Institute of Certified Public Accountants.

EDUCATION AND TRAINING

- Master of Business Administration, Finance; University of Pittsburgh Joseph M. Katz Graduate School of Business, Pittsburgh, PA; 2011
- Bachelor of Business Administration, Accounting; Ohio University, Athens, OH; 2005

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV — August 2016 – Present
Internal THP Title: Chief Financial Officer, Director of Finance

As the Chief Financial Officer, Mr. Ralston is responsible for leading and managing all aspects of the finance and accounting functions of THP, including all internal and external reporting, treasury and investment management, budgeting and forecasting, internal controls, and the evaluation of new business opportunities. He is a member of the company's executive management team. As a member of that team, Mr. Ralston is responsible for implementing the Company's business strategy and driving the operational and financial performance of the Company. Mr. Ralston was promoted to Chief Financial Officer in December 2018.

Aladdin Food Management Services, LLC, Wheeling, WV - *Vice President of Finance, Controller* — September 2012 – July 2016

As the vice president of finance, Mr. Ralston was responsible for all aspects of the financial management, month-end close and financial reporting, and budgeting functions for four businesses with combined revenues of $140MM and 2,500 employees. He supervised and managed an accounting and finance team consisting of 10 team members. Mr. Ralston served as a strategic partner to the Company's president with responsibility for analyzing the current state of the business, identifying financial and operational areas of improvement, and setting the strategic and financial directions of the business. Mr. Ralston evaluated all new business opportunities from both a strategic and financial perspective to ensure the opportunities aligned with the Company's strategic and financial goals. He also evaluated and approved all capital expenditures, including developing financial models to ensure all investment hurdles were achieved. Mr. Ralston was selected to be a part of the Elior North America (Aladdin's parent company) CEO's leadership and mentoring council. The council was established to further develop high-performing employees with the potential for

significant advancement in the organization; six individuals were selected to the council out of over 10,000 employees.

RTI International Metals, Inc., Pittsburgh, PA July 2011 - September 2012
Manager of Operational Finance

As the manager of operational finance, Mr. Ralston led the integration of all domestic and international acquisitions from a finance and accounting perspective, including all purchase accounting and post-acquisition accounting. The acquisitions ranged in size from $40MM to $185MM. He served as the interim controller of a $70MM manufacturing facility; his responsibilities included the daily oversight and execution of all accounting and finance activities, including the implementation of internal controls as required by the Sarbanes-Oxley Act. He developed and prepared valuation and strategic models to evaluate the financial and strategic fit of subsidiaries and presented significant findings to executive management so they could evaluate potential divestitures. Mr. Ralston also analyzed financial and operational performance to prepare monthly and quarterly financial reporting and analysis for executive management, the Board of Directors, and SEC regulatory filings. He developed a process for systematically evaluating the financial merits of the Company's research and development activities. Mr. Ralston drove reductions in net working capital by implementing policies and procedures related to sales discounts and aged inventory.

KPMG LLP, Columbus, OH September 2005 - July 2010
Audit Manager, Senior Associate, Associate

As the audit manager, Mr. Ralston planned, executed and managed risk-based audit engagements in the industrial products, real estate and retail industries; the engagements ranged from four team members and 1,000 hours to 12 team members and 9,000 hours. He analyzed client financial statements to identify and understand key financial statement relationships and significant areas of risk and designed audit strategies to address all significant risks identified. Mr. Ralston continually searched for and identified redundant or inefficient audit areas to enhance engagement efficiency and profitability. He audited the client's most complex and judgmental accounting and auditing areas, including impairments, derivatives and income taxes.

JILL MEDLEY

KEY STAFF TITLE: COMPLIANCE OFFICER

PROFILE

Ms. Jill Medley is an experienced compliance professional with a demonstrated history of working in various segments of the healthcare industry. Ms. Medley is certified by the Compliance Certification Board (CCB) in both healthcare compliance (CHC) and healthcare privacy compliance (CHPC). Ms. Medley's experience includes successfully navigating a corporate integrity agreement, restructuring a compliance program for a mid-sized healthcare system, implementing HIPAA privacy programs and overseeing compliance for a managed care company that includes both Medicare and Medicaid lines of business. Ms. Medley worked closely with legal counsel to develop Stark-compliant physician arrangements, developed a compliance program to meet the U.S. Department of Health and Human Services Office of Inspector General (OIG) requirements, and worked with Information Systems personnel to develop robust privacy and security programs. Ms. Medley's compliance career has focused on building, evaluating and improving compliance programs to meet regulatory requirements in various healthcare settings.

EDUCATION AND TRAINING

- A.A.S., Associate of Applied Science, Medical Laboratory Technology, West Virginia Northern Community College
- B.S., Bachelor of Science in Health, Health Services Administration, Ohio University
- M.S., Master of Science, Health Care Administration, Capella University

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan of West Virginia — July 2018 – Present
Internal THP Title: Government Compliance Officer

Ms. Medley oversees and manages THP's compliance and privacy program. Ms. Medley regularly communicates with the Centers for Medicare and Medicaid Services (CMS) Plan Manager, reviews and develops general and specialized compliance training, oversees the compliance program's compliance and audit work plan including audits and monitoring metrics targeted to Medicaid contract compliance, and communicates with various internal stakeholders with respect to the organization's compliance functions. Ms. Medley works closely with THP's Special Investigations Unit to prevent, detect and correct non-compliance and fraud, waste and abuse.

As Government Compliance Officer, Ms. Medley developed a compliance dashboard for reporting relevant metrics to the organization's executive management team, enhanced the program's compliance reporting to the Corporate Compliance Committee (executive level) and the organization's Audit and Corporate Compliance Committee (board level). Ms. Medley's responsibilities include the development, implementation and continuous improvement of the organization's compliance program based upon the seven elements of an effective compliance program. Ms. Medley also assists in the coordination of the

organization's enterprise risk management process and the development and implementation of a robust HIPAA privacy program in collaboration with Information Systems.

The Health Plan of West Virginia — July 2017 – June 2018
Assistant Director of Compliance

As Assistant Director of Compliance, Ms. Medley worked on several projects related to the Model Audit Rule that involved developing workflow narratives and mapping corresponding controls. Ms. Medley assisted the Director of Compliance to enhance the organization's compliance and audit work plan and revised the organization's privacy policies to meet HIPAA and Office for Civil Rights requirements. Ms. Medley collaborated with Information Systems to update the organization's security policies and implemented an automated policy tracking software program for the corporation.

Ohio Valley Health Services & Education — 2011 – 2017
Wheeling, WV – *Compliance and Privacy Officer*

As Compliance Officer for a mid-sized healthcare organization, Ms. Medley restructured the organization's compliance program to meet the stringent requirements of the OIG. The compliance program restructuring included developing and implementing an updated Code of Conduct, developing and implementing both general and specialized training, implementing a contract management system to track hospital-physician agreements, working with legal counsel to assess potential compliance issues, communicating with government officials, and preparing for and responding to various compliance audits. In 2014, Ms. Medley assumed the duties of Privacy Officer and worked with the organization's Information Systems department to develop privacy and security policies and procedures, conduct annual HIPAA security risk assessments, and respond to and evaluate reports of potential privacy violations.

During Ms. Medley's tenure at Ohio Valley Health Services & Education, she regularly presented to the organization's Board of Trustees, participated in the 2020 OIG Roundtable on Corporate Integrity Agreements, presented to the Advisory Panel on Hospital Outpatient Payment at CMS headquarters and was a speaker at two Healthcare Financial Management Association (HFMA) meetings on compliance related topics.

Ohio Valley Medical Center — 2005 – 2011
Wheeling, WV – *Laboratory Compliance Officer*

Ohio Valley Medical Center — 1992 – 2005
Laboratory Technician

ROBERT WETZEL, F.A.C.O.G.

KEY STAFF TITLE: MEDICAL DIRECTOR

PROFILE

Dr. Wetzel has 26 years' experience as an Obstetrician and Gynecologist and as such has served as a primary care option for WV Medicaid members. In 2015, he came to THP as a medical director and has served in this capacity for the past 5 years. As the Medical Director at THP, he maintains an active physician license without restriction in Ohio and West Virginia. He provides physician oversight for activities related to the company's Utilization Management, Disease Management and Quality Management programs ensuring compliance with NCQA, Medicare, Medicaid and other regulatory entities. As a medical director, he also works with Network Development staff to develop and coordinate effective provider education/intervention programs including providing input into provider training and education programs, review of provider manuals and direct contact with providers as needed.

CERTIFICATIONS AND LICENSURE

- Fellow American College of Obstetrics and Gynecology (Armed Forces District)
- Diplomatic, Board of Obstetrics and Gynecology [redacted]
- State of West Virginia Board of Medicine [redacted]
- State Medical Board of Ohio #[redacted]
- Certified in NRP (neonatal rescusitation protocol)

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan — 2015 – Present
Internal THP Title: Medical Director

Dr. Wetzel has been employed at THP since 2015 as a Medical Director. As a medical director, he is required to carry out specific functions as outlined by the Quality Management and the Utilization Management Programs.

West Liberty University, West Liberty, WV — 2013 – Present
Teaching Staff

Teaches Women's Health and Clinical Medicine for the PA Master's program at West Liberty University. He has been teaching this program since the program's inception 7 years ago.

East Ohio Regional Hospital, Martins Ferry, OH — 1998 – Present
Obstetrics and Gynecology

Started at East Ohio Regional Hospital as an OB/GYN in 1998. In September 2015, he changed his practice to Gynecology only and currently practices part time. Dr. Wetzel has been the Department Chair/Medical Director of Obstetrics and Gynecology from January 2001 – Present.

Keesler Medical Center, Keesler Air Force Base, MS — 1995 – 1998
Director of Gynecology

Returned to Keesler Medical Center in August 1995, and became part of the teaching staff and Director of Quality Assurance until June 1997. Also during part of this time period, Dr. Wetzel worked as a Medical Law Case Reviewer to the Surgeon General from December 1995 – June 1998. Dr. Wetzel became the Director of Obstetrics and Gynecology and maintained this status from June 1997 – June 1998 when he relocated to the Ohio Valley.

Robbins Medical Center, Robins Air Force Base, GA 1993 – 1995
Chief of Obstetrics and Gynecology

Dr. Wetzel was a staff OB/GYN at the Robins Medical Center located on the Robins Air Force Base from July 1993 – July 1994. Starting July 1994, Dr. Wetzel took on a new role of Chief of Obstetrics and Gynecology until August 1995 when he started his position at Keesler Medical Center. Dr. Wetzel also was a member of the infection Control Committee during his time at Robins Medical Center.

Keesler Medical Center, Keesler Air Force Base, MN 1989 – 1993
Residency

Dr. Wetzel completed his residency at the Keesler Medical Center located on the Keesler Air Force Base.

PROFESSIONAL ORGANIZATIONS AND AWARDS

- American College of Obstetrics and Gynecologists
- Air Force commendation Medal for Excellence in Resident Education
- Committee for Resident Education in Obstetrics and Gynecology, National Teaching Award, 1996-1997
- Outstanding Staff Resident Education Award 1995-1996
- Air Force Commendation Medal for Meritorious Service as Chief of OB/GYN at Robins Air Force Base

SUSAN KLINKOSKI, BSN, RN, CCM

KEY STAFF TITLE: MEDICAL MANAGEMENT DIRECTOR

PROFILE

Ms. Klinkoski is a registered nurse with more than 20 years of clinical experience across a variety of settings. She has direct care clinical experience and supervisory experience in the acute care setting related to neonates, pediatrics and general surgery as well as supervisory experience in the field of behavioral health in both acute and residential settings. Ms. Klinkoski has extensive experience in development of policy and procedure and implementation of workflow process in both clinical and managed care fields. She has served as team leader on multiple projects and successfully implemented many new programs to achieve strategic initiatives. She has successfully run departments with staff in excess of 100 persons and been an innovator for development of staff productivity and quality monitoring. Ms. Klinkoski has demonstrated proven professional communication skills by serving on committees and boards, being an educator in the community for professionals and laypersons on clinical topics as well presenting to potential clients for sales presentations. Ms. Klinkoski is knowledgeable regarding regulatory agencies and compliance and has led her to team through many successful audits.

EDUCATION AND TRAINING

- Bachelor of Science in Nursing from The Ohio State University
- Certified Case Manager 2014 to present by the Commission for Case Manager Certification
- Active RN Licensure in Ohio, West Virginia, Pennsylvania and Kentucky

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan-Wheeling, WV 2012 to Present
Internal THP Title: Director of Medical and Behavioral Management

Ms. Klinkoski began her THP career as a Case Manager with oversight of a member caseload of approximately 200 medically complex members across all lines of business (Medicare, Medicaid, Fully Funded Commercial products and TPA/ASO products). In this role, she developed an internal electronic medical record to meet and maintain NCQA standards. She also developed and integrated related case management reports for reinsurance and group reporting for ASO/TPA clients. She trained and onboarded new registered nurse case managers and developed and implemented quality and productivity monitoring for case management staff. She served as Supervisor of Case Management prior to being promoted Manager of Medicaid Clinical Services in 2017.

As Manager of Medicaid Clinical Services, Ms. Klinkoski was responsible for not only case management, but also all Medicaid utilization management supervising more than 20 medical staff RNs who daily processed service requests for more than 83,000 lives. In this role, she oversaw all aspects of preauthorization for Medicaid including appeals process up to and including state fair hearings. She researched, developed and wrote policy and procedure, including the THP coverage guideline for private duty nursing and

clinical workflows. She participated in weekly MCO meetings in Charleston as the clinical representative and had daily interaction with BMS staff including close interaction with Children with Special Healthcare Needs (CSHCN). She developed and wrote the workflow for all MCO case management interaction with CSHCN during my tenure as Medicaid Manager. Ms. Klinkoski participated in BMS contract evaluation process and in the writing of the Medicaid member handbook.

In 2018, Ms. Klinkoski was promoted to Assistant Director of Medical Management where her responsibility returned to program and staff oversight for all lines of business. She participated in the Medical Director Oversight Committee, Transplant and Technology Committee, Durable Medical Equipment Committee, STARS, Medicaid Operations, Securecare Operations, Continuous Quality Improvement, NCQA Preparation and HEDIS Task Force for direction of policy. As Assistant In Charge of all medical managerial staff, she maintained responsibility for analysis of unit quality, productivity and staffing.

Ms. Klinkoski was promoted to Director of Medical Management in the Fall of 2018 and is currently responsible for the largest unit in the company. She continues to sit on all internal committees mentioned above and serves as liaison to community organizations and providers. She coordinates and presents talks to hospital facilities describing THP programs and how to access them, Transplant Integration and support sales for the TPA/ASO lines of business as needed. She writes policy and procedure, provider manual updates, provider and member newsletter articles and as request for proposals or information. Ms. Klinkoski works closely with THP's Information Technology team to develop and maintain our proprietary UM and CM systems and to integrate our systems with outside systems and software including Change Healthcare (formerly McKesson) for Interqual, Coordinated Care and to develop our CM portal for outside access and integration. In 2019, she additionally assumed responsibility for integration of THP Behavioral Health Unit into a unified Clinical Service model assimilating an additional 27 direct care behavioral health professionals and 2 behavioral health registered nurse managers into a holistic, person centered, care focused unit.

Ohio Valley Medical Center-Wheeling, WV 1998-2012
Staff Nurse and Charge Nurse Pediatrics and Newborn Nursery

Interim Home Health-Bridgeport, OH 2000-2003
Per Diem Private Duty Nurse

Fox Run Hospital-St. Clairsville, Ohio 1997-1998
Evening Shift RN House Supervisor

Heinzerling Foundation-Columbus, OH 1994-1997
Staff Nurse and Relief House Supervisor ICF/MRDD

KIM JORDAN, RN, CCM

KEY STAFF TITLE: CARE MANAGEMENT DIRECTOR

PROFILE

Kim Jordan is a Registered Nurse with over 40 years of experience, combined, in Acute Clinical Settings and Managed Care. Her broad clinical background includes experience in Medical-Surgical Inpatient, Critical Care Inpatient, Emergency Department Nursing, and, most recently, 22 years of Surgical Services Nursing. She has held various positions, including Staff Nurse, Charge Nurse, Head Nurse and House Supervisor. Her managed care experience includes 5 years in Case Management. She was promoted to Supervisor of Complex Case Management for all lines of business, then Supervisor of Governmental Case Management. She currently supervises the Case Management for Medicaid, Medicare, and Dual Eligible (D-SNP) members. Her reporting staff includes RNs, Social Workers, and Member Advocates. Her duties include, but, are not limited to: scheduling and orientation of new staff, development of workflow, coordination and assignment members requesting or eligible for Case Management Programs, staff development and scheduling. Her leadership abilities are used on a day-to-day basis with members and staff, directing care and providing direction.

EDUCATION AND TRAINING

- Associates Degree in Nursing; WV Northern Community College, Wheeling, WV; 1978
- Valid RN license for State of West Virginia
- Advanced Cardiac Life Support Instructor; AHA; 1978-2014
- Trauma Nurse Core Certification; 2007-2015
- Certified Case Management Certification 2017- Present

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan — June 2014- Present
Internal THP Title: Supervisor of Governmental Case Management

Hired as a Care Manager for all lines of business, Ms. Jordan quickly transitioned to Complex Case Management as a Case Manager. THP experienced much growth over the next 2 years, and she was promoted to Supervisor of Complex Case Management, in January of 2017. She received her certification in Case Management through the Commission for Case Management Certification, in April of 2017. After restructuring, Case Management was split into Governmental and Non-Governmental Lines of Business. Ms. Jordan assumed the position of Supervisor of Governmental Case Management. Today, she supervises Medicare, Medicaid, and Dual Eligible (D-SNP) Case Management and a staff of 45. She remains dedicated to providing the best coordination of care and support for THP Members through her team.

OVHS & E May 2000 – June 2014

Lead Nurse – Endovascular Services. Ms. Jordan provided the conscious sedation for procedures while monitoring and administering the ordered medications under the

direction of the surgeon. She was responsible for quality, safety, workflow and coordination of pre-procedure, procedure and follow up. Coordination included scheduling, interaction with provider offices and telephonic patient follow-up. Ms. Jordan was also instrumental in setting up the first Pain Management Service in this area, providing pre-procedure screenings, scheduling, assistance and medication administration for procedures, and patient telephonic follow-up.

Charge Nurse – Surgical Services. In the absence of the manager, her managerial skills came into play, taking over day-to-day running of the OR. Duties included staffing assignments, room assignments of cases (changing with urgent cases), scheduling surgeries, procuring equipment and instruments, and providing needed documentation of data, safety and quality.

Staff Nurse – Surgical Services. Her main duties were Circulating Nurse in the OR for General, Ophthamalogy, Vascular, Plastic and GI Procedures, providing conscious sedation. She continued to instruct ACLS Classes and obtained a certification in TNCC for trauma. Ms. Jordan also was trained to float to Pre and Post Anesthesia care. She was "On-Call" per schedule for emergencies.

Barnesville Hospital Association July 1978 – May 2000

Perioperative Staff Nurse – Changes in staff structuring brought on the opportunity for a whole new aspect of nursing. Ms. Jordan was trained in Circulating, Scrub and Post Anesthesia Care Nursing. The next 20 years of her career would be spent in this field.

House Supervisor – Ms. Jordan managed and supervised staff in all hospital units during scheduled shifts. Duties included, but not limited to, staffing/call-offs, providing clinical direction and support to staff, providing relief and additional hands in critical situations in the Med-Surg Unit, ICU/CCU, OR and sometimes staffing the ER in addition to supervisor duties. She performed administrative duties and decisions on afternoon and night shifts. She developed strong managerial and clinical skills, and developed staff through teaching ACLS and participating in orientation of new staff. Mentoring became her passion during this time.

Head Nurse – Medical Surgical Unit. Directed care, scheduling and staffing of unit, implemented physician orders and plans of care while identifying acute needs of patients through assessment.

Staff Nurse – ICU/CCU. Provided direct care to critical care patients including, but not limited to, ventilator care, cardiac standard and emergent care/resuscitation, including Swanz-Ganz care, and trauma care.

Staff Nurse – Medical Surgical Unit. Provided direct patient assessment, treatments, medication administration, and IV therapy.

JOHN R. VANIN, MD, DLFAPA

KEY STAFF TITLE: BEHAVIORAL HEALTH MEDICAL DIRECTOR

PROFILE

Dr. John Vanin is a board-certified psychiatrist with over 38 years of clinical, teaching and administrative experience. He serves as the Behavioral Health Medical Director for THP, working with the behavioral health and medical staff. Duties include reviewing in-patient censuses, psychological/neuropsychological testing requests and urine drug testing requests. Dr. Vanin serves on the THP Quality Improvement Committee, THP Physician Advisory Board and THP Medical Director Oversight Committee (MDOC).

Dr. Vanin was the Director for Mental Health/Health Education at the West Virginia University (WVU) Student Health Service for over 25 years, overseeing clinical, educational and administrative areas of student mental health. He was Professor of Behavioral Medicine and Psychiatry/Family Medicine at WVU, supervising and teaching psychiatric residents. He is currently Professor Emeritus of Behavioral Medicine and Psychiatry. After obtaining his M.D. degree, and completing residencies in both Psychiatry and Family Practice, Dr. Vanin was a USAF Psychiatrist and served as Chief of Mental Health and as an Attending Psychiatrist/Resident Supervisor. He achieved the rank of Major, received the USAF Commendation Medal for Meritorious Service and is proud to have served as a medical officer in the U.S. military. He is a Distinguished Life Fellow of the American Psychiatric Association and a Past-President of the West Virginia Psychiatric Association.

Dr. Vanin served as a psychiatric consultant during his career, working as a pension and compensation examiner at a Veterans Administration Medical Center and cared for patients at various Community Mental Health Centers. Dr. Vanin has given numerous local, state and national presentations and has published widely on clinical aspects of anxiety disorders, depression, adult ADHD, and psychiatric medications. In addition, he is a co-editor/author of a book titled Anxiety Disorders – A Pocket Guide for Primary Care and also a co-author of NCAA Guidelines for the Treatment of Athletes with ADHD. Dr. Vanin is a long-time member of the West Virginia Drug Utilization Review Board, a DHHR board responsible for the establishment of standards and criteria for drug utilization.

EDUCATION AND TRAINING

- Medical License – West Virginia
- Surgical License – West Virginia

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan 2014-Current
Internal THP Title: Psychiatric/BH Medical Director

Dr. Vanin has served as Behavioral Health Medical Director for THP for the past 5 years. He carries out a variety of functions such as utilization and quality reviews of psychiatric/psychologic services, substance use disorder treatment programs and behavioral health crisis facility stays. He is also active in all other Medical Director

functions including committees (MDOC, T&T, etc.) and Grand Rounds (Internal/External Complex case reviews).

Community Mental Health Centers 2011-2012
Psychiatric Consultant/Staff Psychiatrist

Dr. Vanin served as a staff psychiatrist and psychiatric consultant. He cared for patients at various Community Mental Health Centers.

Louis A. Johnson VA Medical Center Clarksburg, WV 2011-2014
Psychiatric Consultant (Compensation & Pension Exams)

Dr. Vanin served as a psychiatric consultant, working as a pension and compensation examiner at the Veterans Administration Medical Center.

WVU Student Health Service 1985-2011
Director, Mental Health/Health Education

Dr. Vanin was the Director for Mental Health/Health Education at the WVU Student Health Service for over 25 years, overseeing clinical, educational and administrative areas of student mental health.

WVU School of Medicine 1985-2011
Professor, Behavioral Medicine & Psychiatry/Family Medicine

Dr. Vanin was Professor of Behavioral Medicine and Psychiatry/Family Medicine at WVU, supervising and teaching psychiatric residents.

WVU Department Behavioral Medicine and Psychiatry 2011 - Present
Professor Emeritus

Dr. Vanin is currently Professor Emeritus of Behavioral Medicine and Psychiatry.

HONORS AND AWARDS

- USAF Commendation Medal
- Diplomat, American Board of Psychiatry and Neurology
- Distinguished Life Fellow, American Psychiatric Association
- Past-President/Member, West Virginia Psychiatric Association

MICHELLE POLAND

KEY STAFF TITLE: QUALITY DIRECTOR

PROFILE

Michelle Poland is an experienced clinical registered nurse with over 37 years of clinical nursing experience. Her expertise including 13 years in the Quality Improvement Department that encompasses medical record chart reviews, assessment/resolution of members' complaints and dissatisfaction, asthma education, assisting with Medicaid Performance Improvement Projects and with annual documents such as policy/procedures, work plan and evaluation. In October of 2019, she transitioned into the Population Health Department as Clinical Nurse Analyst focusing on HEDIS® to use clinical skills to strategize on initiatives and interventions to improve quality of care to THP members.

EDUCATION AND TRAINING

- M.S.N Nursing Administration/ Wheeling Jesuit University, Wheeling, WV

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan of West Virginia April 2006 – Present
Internal THP Title: Clinical Nurse Quality Improvement

Oversaw and managed quality of care and service complaints, dissatisfaction, and concerns from members, families, and practitioners until the time of her position transitioning in October 2019.

Quality of care and service complaints/dissatisfaction across all healthcare continuum that care or service is being provided. Verbal and written complaints serve as valuable resources for monitoring and improving member safety. Investigations of complaints are thorough and resolved depending upon the findings. Tracking and trending is essential to identify and improve all clinical outcomes.

Medical records are reviewed for quality of care and service provided, HEDIS, guideline compliance reviews and randomly as follow-up to previous concerns or corrective action requested.

Ms. Poland was instrumental in developing a Quality Improvement initiative for adults and children with asthma. The project was designed to educate members, parents/guardians and children regarding the various components of asthma, the importance of taking medications correctly, learning to control their asthma thus reducing emergency room visits, hospitalizations and missed school/work days, and reducing mortality. Ms. Poland provides outreach to members, parents or guardians participating in the asthma initiative to discuss concerns. She assesses current asthma control and provide education as needed. For 13 years, Ms. Poland has been a senior counselor for Camp Catch your Breath, a week-long asthma camp for children, ages eight to 13 years of age. This resulted in THP becoming a major sponsor in Camp Catch Your Breath and offered all children with asthma meeting age criteria to attend camp at no cost to them.

Ms. Poland is part of the Medicaid Performance Improvement Project team that analyzes data to determine barriers to care, identifies opportunities for improvement, and strategizing interventions to improve and sustain quality of care.

Ms. Poland served on the Quality Improvement Committee (QIC) that provides medical expertise in the review of health outcomes and utilization evaluations of patient care. THP's Medical Director serves as chairperson of the committee. The committee includes external practitioners representing both primary and specialty care and integral members of various departments of THP. The QIC provides clinical competence in the review of health outcomes with objective evaluations of patient care and services.

Evidence-based clinical guidelines are valuable to THP for analyzing performance, taking action for quality and demonstrating improvement in performance. Ms. Poland was responsible for ensuring Clinical Practice Guidelines were reviewed at least biennially to ensure practitioners have the most current clinical practices in place for the treatment of THP members.

In October 2019, Ms. Poland transitioned into a nurse analyst role within the Population Health Department to focus efforts on improving HEDIS by using clinical and creative skills to help identify more effective strategies and initiatives to reduce health disparities.

LISA HAWKINS

KEY STAFF TITLE: MEMBER SERVICES DIRECTOR

PROFILE

Ms. Hawkins is an experienced leader in the healthcare industry with over 25 years of experience and proven success with large government programs. She has multifaceted healthcare experience working with self-funded (ERISA) plans, government plans, and consumer driven health plans. Her current position includes working with fully-insured managed care Medicaid plans. Her operations experience across these product lines also brings value-added knowledge and exposure to various claims processing and call center systems and applications.

Ms. Hawkins has extensive experience with large group implementation, planning and staffing. She leads by example, building teams who engage in common goals to achieve success. Her extensive operations experience includes managing all aspects of a large claims operation, call centers, projects and other support functions.

Ms. Hawkins has served in key roles with responsibility for communicating with members, providers, clients, team members and management.

EDUCATION AND TRAINING

- Bachelor of Science, West Virginia Institute of Technology, Major: Business Management|1992

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan — December 2018 – Present
Internal THP Title: Director, Medicaid Operations

Ms. Hawkins is responsible for the Claims and Call Center teams associated with the Medicaid membership currently administered by THP. Ms. Hawkins is responsible for the Medicaid Operations team that includes staff management, inventory management, timeliness of claims processing, call center management, call center service level statistics, oversight of SLAs, enrollment and appeals processing.

Health Smart Benefit Solutions — January 2012- November 2018
Charleston, WV - *Team Manager*

As a Team Manager, Ms. Hawkins was directly responsible for day-to-day management of the Operations team for a large government program consisting of 180,000 members. Ms. Hawkins managed a 2.6 million claims per year inventory with a quality level of greater than 99.5% accuracy. Team management included monitoring the quality and productivity of 60+ team members, drilling down to proactively identify areas of deficiency, and to develop training plans and improvement agreements necessary to ensure contractual requirements were being achieved at all times.

In the Team Manager role, Ms. Hawkins participated in interviewing, selecting, training and developing new employees, was responsible for development of policies and procedures related to the operations functions, and monitored accuracy pertaining to claims pricing methodologies for her team. Multiple pricing methodologies were in use

and Ms. Hawkins' team was responsible for monitoring the periodic updates of RBRVs fees, DRGs, APCs, and other direct contracts fee loads to ensure accuracy of claims payments to providers.

Additionally, Ms. Hawkins managed the call center supporting this program for a period of time. This entailed managing approximately 30 customer service representatives who took approximately 600,000 call per year. Call statistics were measured and managed daily to meet monthly contractual performance requirements. Additional call center responsibilities included tracking and trending member and provider calls pertaining to coverage questions, benefit payments, complaints, appeals, grievances, eligibility and enrollment assistance.

Ms. Hawkins was a primary point of contact for the client, including client auditors and vendors. This required a high level of communication and collaboration with other business units such as medical management, quality assurance, enrollment services, and IT, to provide continuous increase in client satisfaction.

Wells Fargo Benefit Services September 2001-December 2011
Charleston, WV - *Team Manager, Team Leader, Claims Examiner*

In the Team Manager role, Ms. Hawkins was responsible for the day-to-day supervision of approximately 50 team members who processed claims and received telephone calls for various accounts including a large group health plan in Alaska. Management of this account provided many opportunities and challenges primarily due to the time zone differences, and the unique requirements needed for their healthcare delivery system. In this position, she was responsible for the overall management of accounts assigned to her team. She performed staff management including projecting manpower needs, interviewing potential team members, monitoring performance, providing day-to-day mentoring and training to team members. She managed the claims inventory and quality levels to ensure timely and accurate processing of claims, and for planning resource needs based upon claims volumes.

Prior to being promoted into a Team Manager role, Ms. Hawkins was a Team Leader. In this role, Ms. Hawkins supervised a group of claims processors who processed claims for multiple clients. She reviewed high dollar claims for payment and billing accuracy, performed special internal audits, approved and monitored time and attendance, tracked and monitored team members performance measurements, and conducted performance reviews.

In the Claims Examiner role, Ms. Hawkins was responsible for processing medical, dental, vision and flexible spending claims for self-funded clients.

BEVERLY BURDETTE

KEY STAFF TITLE: CLAIMS PAYMENT DIRECTOR

PROFILE

Beverly Burdette has more than 30 years of experience in the insurance/healthcare field, primarily in the administrative/operations areas. Her experience includes implementing several large state and local government healthcare programs. Her expertise encompasses development of operations strategies and processes with emphasis on enrollment, inventory/claims encounters, and call center management, project management, training, quality and cost control. Ms. Burdette's primary responsibilities include hiring, training, directing, coordinating and managing team members to assure positive client, member and provider experiences.

EDUCATION/PROFESSIONAL MEMBERSHIPS

- Magna cum Laude from Mountain State University (now University of Charleston) with a Bachelor of Science degree in Organizational Leadership.

PROFESSIONAL EXPERIENCE

The Health Plan, Wheeling, WV — March 2015 – Present
Internal THP Title: Vice President of Operations

As VP of Operations, Ms. Burdette is responsible for the Operations team that includes claims processing/encounters, customer service, member advocate/outreach and enrollment for Medicaid, Medicare, Commercial, Self-Funded, Consumer Driven Services and Pension Administration. Other areas of responsibility include scanning, data entry and OCR process, COBRA administration, stop loss filings and training. She brings over 30 years of healthcare operations expertise to THP. In her current role, Ms. Burdette leads a team of approximately 100 operations team members who are responsible for multiple product lines.

HealthSmart Benefit Solutions — August 2012 – March 2015
Vice President of Operations

HealthSmart was founded in 1983 and evolved as a leader in the healthcare field. They purchased the Third Party Administration company from Wells Fargo in 2012. HealthSmart had more than 1,100 employees in locations all across the country.

Ms. Burdette was Vice President of Operations for HealthSmart Benefit Solutions. Her responsibilities included overseeing the operational functions pertaining to medical, dental, vision, COBRA, FSA and STD claims administration. Primary responsibilities included:

- Ensuring timely, quality claims processing and call center responsiveness in accordance with the benefits provided by employer group health plans.
- Responsible for implementation of new group health plans and other products.
- Ancillary support teams providing membership updates, provider maintenance, COBRA billing and premium collection, and repricing of network claims.

- Developing transparent processes between customers, members, networks and other vendors, to assure the highest level of customer satisfaction is obtained by the member.
- Assuring our operations teams follow company policies pertaining to HIPAA privacy to assure compliance regulations are met.
- Responsible for operations processing sites located in Charleston, WV, and Fayetteville, NC.

WELLS FARGO - Charleston, WV (Acordia National until 2001) 1990-2011
VP of Operations

Wells Fargo Third Party Administrators was a large TPA owned by Wells Fargo Bank and provided healthcare solutions to over 400 self-insured customers representing over one million members throughout all 50 states. The TPA serviced accounts for a large insurance brokerage owned by Wells Fargo and preferred outside brokers.

Ms. Burdette was the VP of Operations for Well Fargo Third Party Administrators where she was responsible for all aspects of the Claims Operation including, receipt and entry of membership data, plan building, account management, inventory management, claims processing and customer service. Primary responsibilities included:

- Responsible for all aspects of the claims operations and customer service teams in Charleston, WV; Beckley, WV; Newnan, GA; and Fayetteville, NC.
- Ensuring timely and accurate claims adjudication, and a high level of first-call resolution to inquiries.
- Product offerings include healthcare, dental care, vision care, FSAs, HRAs, retiree billing, Concession Telephone Service and COBRA/HIPAA Administration.
- Functional job units under Bev's direction consisted of over 500 team members who were accountable for claims processing, customer service, membership and billing, repricing, plan building, customer account management, Summary Plan Descriptions (SPD) and Plan Documents.
- Regulatory Compliance as it related to the Operations side of the industry. Assuring compliance with government regulations (DOL, CMS) and internal compliance requirements.
- HIPAA Privacy Officer. Includes obtaining and tracking all business associate agreements necessary for customer and vendor relationships.
- Responsible for the implementation of several very large customers (30,000 – 90,000 employee lives) including all product types and plan designs.

McDonough Caperton Insurance Group – Charleston, WV 1979-1990
Claims Analyst – Customer Service Representative – Trainer – Claims Supervisor

PROFESSIONAL MEMBERSHIPS

Member of Society of Professional Benefit Administrators (SPBA)

KIMBERLY ROGERS, MBA, RN

KEY STAFF TITLE: NETWORK DEVELOPMENT DIRECTOR

PROFILE

Resourceful Registered Nurse with proven strengths in Physician, Hospital, Ancillary and Value-based Care Contracting, strategic business planning and tactical execution to assess risks and achieve results in expedited timeframes with practical experience in both clinical and healthcare industry business operations. Thorough understanding of Medicare and Medicaid Contracting, Governmental Healthcare Contracting, Commercial Healthcare Contracting and Healthcare Operations. Skilled in building relationships, leveraging resources, and developing and managing effective cross-functional teams.

EDUCATION AND TRAINING

- Master's in Business Administration (MBA), West Virginia University, Morgantown, WV
- Bachelor of Science in Healthcare Administration, Fairmont State University, Fairmont, WV
- Associate Degree in Nursing, Fairmont State University, Fairmont, WV
- West Virginia Registered Nurses (RN) License Number 042386 (Active)
- West Virginia Property and Casualty License, National Provider Identifier (NPI) [redacted]

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan of West Virginia — November 2019 – Present
Internal THP Title: Director, Contracting

Physician and Hospital contracting for Medicaid, Medicare and Commercial (Fully insured and Self-Funded) lines of business.

Laboratory Corporation of America — March- November 2019
Executive Director, Value Based Care

Oversight of all value-based care contracting activities in the North Central Division with large hospital and healthcare systems, ACOs, IPAs and CINs in an eight-state division. Responsible for maximizing divisional laboratory revenue via contracting for various value-based tools.

UnitedHealthcare Networks, Southeast Region January 2017- March 2019
Regional Director, Accountable Care Strategies

Direct value-based care activities with large hospital and faculty-based providers, ACOs IPAs, and CINs in the eight-state southeast region. Responsible for maximizing Commercial and Medicare growth via contracting for shared savings, shared risk and full risk value-based contracting. Oversight of account managers and the implementation and service of existing value-based partners. Collaborated with product development to contract for product offerings around value-based programs. Collaborated with clinical leadership and Market Medical Directors to set contractual

metrics and improve quality of care and performance of value-based partners. Work closely with regional and national finance to maximize financial efficiencies. Conduit between local network management contracting strategies and national value-based team. Assist Medicaid team with PCMH contracting for TennCare in Tennessee.

Highmark Blue Cross Blue Shield West Virginia 2015-2016
Director, Provider Strategic Initiatives

Directed strategic initiatives with healthcare providers, facilities and delivery systems throughout West Virginia. West Virginia Market Lead for the development and contracting of Patient Centered Medical Home (PCMH) and ACOs, advancing these value-based programs for the expansion and future viability of Highmark West Virginia. Achieved 100% of the 12-month goal for PCMH/value-based contracting in first 6 months of employment. Assumed a leading role in the development and implementation of the provider network and contracting strategies to include Pay for Value Programs in West Virginia. Developed care alert pilot with West Virginia Health Information Network (WVHIN), two hospitals and physicians.

Coventry Healthcare of West Virginia, an Aetna Corporation 2010-2015
Director, Network Management

Developed and implemented complex competitive contractual relationships with physician, ancillary and hospital contracts throughout West Virginia and Southern Ohio, including both fully insured and self-insured commercial products, HMO, PPO, Medicare, Medicaid, lease networks, automobile and worker comp. Led contracting and validation efforts in preparation for West Virginia and Ohio submissions for 2014 Federal Healthcare Exchanges. The project completed in 6 months; initial plan was a 12-18 months. Assisted with design, development, management, and implementation of value-based care/contracting and other strategic network configurations including an ACO, High Performance Network (HPN) and PCMH for West Virginia. Orchestrated both contractual and operational network integration between Coventry Healthcare of West Virginia Inc. and Aetna in West Virginia.

Mountain State Medical Specialties Inc. 2010-2015
Special Projects

Health Partners Network Inc. 2009-2012
Medical Record & Site Review Nurse

Preferred/Regional Integrated Provider Access Corp (PIPAC/RIPAC) 2005-2010
Executive Director

Coventry/Carelink Health Plans -Quality/HEDIS Nurse 2009

Mid Atlantic Medical Services (UnitedHealthcare)–Mgr Provider Netwk 2000-2005

PrimeONE –Senior Provider Relations Representative 1996-2000

Mountain State Blue Cross Blue Shield – Concurrent Review Nurse 1991-1996

Chestnut Ridge Hospital – Staff Nurse/Quality Review Nurse 1989-1991

BARBARA GOOD

KEY STAFF TITLE: PROVIDER RELATIONS DIRECTOR

PROFILE

Ms. Barbara Good is a seasoned professional who has experience in a variety of areas of healthcare. Her background includes pharmaceutical sales, insurance, healthcare management and physician advocacy. Her regional relationships and expertise in the provider delivery system are well known throughout West Virginia. She has served as a speaker and resource for professional associations including the WVMGMA, HFMA and OMA. She has also served on several state initiatives, including the Medical Services Fund and the Uniform Credentialing Committee. She has always been a strong advocate for education and has provided continuous educational opportunities for providers and their staffs.

EDUCATION AND TRAINING

- MA plus Post Graduate Studies, Special Education, Marshall University Graduate College
- BA Degree in Education, Marshall University
- Practice Management Institute—Certified Medical Office Manager, Certified Medical Coder, Certified Medical Compliance Officer, Certified Medical Insurance Specialist
- American Academy of Medical Management—Various Management Courses

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan of West Virginia — March 2018 – Present
Internal THP Title: Provider Engagement Manager

In her role at THP, Ms. Good is responsible for overseeing provider education, training and guidance for the provider network, including having knowledge of contract language and payment methodology. She currently manages the activities of all regional provider education, services and THP's community outreach opportunities. Ms. Good is knowledgeable about details of provider contracts, payment methodologies and provider networks, as well as quality initiatives. She and her team participate in the semi-annual DXC workshops for providers and also in many community activities such as the local FRN meetings.

West Virginia State Medical Association — August 2006 – March 2018
Physician Practice Advocate

As Physician Practice Advocate, Ms. Good served as a liaison between West Virginia physician practices and insurance payers. She provided advocacy for physicians in all areas of practice management, working directly with upper level management and medical directors of insurance companies, both government and commercial. Ms. Good also provided continuous educational opportunities for physicians and staffs, enabling over 500 physicians and staff members to obtain national professional certifications. She produced an online newsletter for physicians and served as a columnist for the

West Virginia Medical Journal. She has won national awards and recognition for her advocacy work, and her contacts enabled her to bring in nationally recognized speakers for physician practice events and conferences. In her role at WVSMA, she worked closely (and continues to work) with the West Virginia Medical Group Management Association, the Office Managers Association, the Healthcare Financial Managers Association and other groups, speaking often and knowledgeably for these groups. She was appointed by then State Senator Evan Jenkins to represent the WVSMA on the West Virginia Uniform Credentialing Committee, the West Virginia Medical Services Fund and also Palmetto GBA's Contractor Advisory Committee.

Fresenius Dialysis Services, Charleston, WV July 2005 – August 2006
Area Manager

As Area Manager, Ms. Good managed the daily operations for five dialysis facilities, with 100+ employees. She also was instrumental in obtaining a CON and initial preparations to open a new dialysis facility in Ripley, WV. She provided leadership for customer service, quality patient care, marketing and financial management.

First Physicians Network, Charleston, WV June 2001- May 2005
Executive Director

In this position, Ms. Good served as the liaison for physicians with insurance payers and managed care plans. She also conducted the network's messenger model contracting. She helped physicians as they started new practices or joined other practices. Ms. Good ensured that all member physician practices were kept current of payer issues and also provided monthly educational offerings for physicians/staff. She worked closely with the Board of Directors to ensure quality services for network physicians.

Carelink Health Plans, Charleston WV June 1995 – June 2001
Provider Relations Supervisor

As the provider relations supervisor, Ms. Good managed the basic operations of the Provider Relations Department. She developed and stabilized networks for the plan's Commercial, PEIA and Medicaid products. She negotiated contracts and fee schedules for physicians and ensured compliance with Carelink HMO policies and procedures.

Syntex Laboratories, Charleston, WV October 1986 – June 1995
Professional Medical Representative

In this role, Ms. Good managed her territory as she promoted pharmaceutical products to physicians and hospitals throughout West Virginia. She consistently increased sales in her territory and was selected as District Trainer. While working for Syntex, she was awarded District Representative of the Year and given other outstanding achievement awards. The knowledge and relationships she developed and has maintained with physician practices has enabled her to continue her career in healthcare through the various positions she has held.

TRINA CROWDER

PROGRAM INTEGRITY LEAD

PROFILE

Ms. Crowder is a results-driven senior manager with over 20 years of experience investigating complex financial crimes. During her 12 years with the OIG's Medicaid Fraud Control Unit (MFCU), she served as Investigator, Chief Investigator and Director. In those roles, she was responsible for investigating healthcare fraud cases, managing a team of investigators, nurses, auditors and attorneys, creating and delivering training, creating policies and procedures, ensuring compliance with state and federal regulations, setting and achieving goals, and creating the vision for the unit.

EDUCATION AND TRAINING

- Master of Legal Studies, West Virginia University
- B.S. Business Administration (Cum Laude), Fairmont State College
- Certified Fraud Examiner, Association of Certified Fraud Examiners
- Certified Medical Coder, Practice Management Institute

SKILLS

- Certified Fraud Examiner
- Certified Medical Coder
- Healthcare Fraud Subject Matter Expert
- Interviewing and Interrogation
- Deception Detection
- Investigative Report Writing
- Leadership
- Policy Writing
- Training Creation and Delivery
- Grant Compliance

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Charleston, WV — March 2019 – Present
Internal THP Title: Director of SIU

Ms. Crowder is responsible for leading the Special Investigations Unit (SIU) charged with preventing, detecting and investigating allegations of fraud, waste and abuse across all lines of business including West Virginia Medicaid. She creates policies and procedures to facilitate the execution of these responsibilities, oversees all investigations and program integrity activities, and is responsible for setting SIU goals, measurements and milestones.

The Lewin Group, Falls Church, VA — April 2018 – March 2019
Senior Consultant/Medicaid Program Integrity Analyst

Ms. Crowder served as the healthcare fraud subject matter expert, assisting the West Virginia Bureau for Medical Services in the administration of the West Virginia Medicaid Managed Care Program. She worked with the Office of Managed Care and the Office of Program Integrity in a collaborative effort to strengthen program integrity practices in the managed care universe. She was responsible for recommending and drafting policies, procedures, and contract language, creating and delivering training and assisting with CMS audits.

WVDHHR, OIG, Medicaid Fraud Control Unit April 2006 – March 2018
Charleston, WV - *Investigator (2006-2007); Chief Investigator (2007-2011); Director (2011-2018)*

Ms. Crowder joined the MFCU as an investigator responsible for conducting criminal and civil investigations of Medicaid fraud. Responsibilities included obtaining, analyzing and synthesizing evidence; identifying, locating and interviewing witnesses; interviewing and interrogating suspects; conducting undercover operations including covert surveillance; and training new investigators. As Chief Investigator and Director, she was responsible for directing and evaluating the work of investigators, auditors, nurses and attorneys, which included reviewing and approving plans of investigation, operations plans and reports of investigation. She developed training curricula, policies, procedures and internal controls, and ensured compliance with all state and federal regulations. Served multiple years on the Executive Committee of the National Association of Medicaid Fraud Control Units as Eastern Regional Representative, representing seven states and DC. As Director, she expanded the Unit and increased active investigations by 100% in five years. Led the Unit to two of its most successful years on record (2013 & 2016), and other team successes including receipt of the *United States Attorney Award for Distinguished Service* for outstanding investigative work on a healthcare fraud case in 2013, and a record-breaking healthcare fraud settlement in 2014.

WVDHHR, OIG, Investigations & Fraud Management August 1998 – March 2006
Charleston, WV - *Welfare Fraud Investigator (1998-2001); Internal Affairs Investigator (2001-2006)*

Ms. Crowder conducted recipient fraud investigations for over 60 public assistance programs, including Medicaid. She also investigated allegations of employee misconduct, both administrative and criminal, in an agency with over 5,000 employees.

ROBERT JAMES ROSET

KEY STAFF TITLE: INFORMATION TECHNOLOGY DIRECTOR

PROFILE

Mr. Robert Roset is a goal-oriented IT Senior Executive with over 32 years in planning, developing and implementing cutting-edge information solutions that manage the ever-changing health insurance landscape. Mr. Roset has extensive experience at gathering, analyzing and defining business and functional requirements; leading data-modeling and process-mapping initiatives; data integrity, and designing/re-engineering processes, workflows and technology solutions for health insurance systems and networks. His leadership and technology skills are used on a day-to-day basis to lead implementations and deliver technical solutions improving revenues, margins and workplace productivity.

EDUCATION AND TRAINING

- Associates Degree in Computer Science; West Virginia Northern Community College, Wheeling, WV; 1985
- Bachelor of Science in Business Management; Wheeling Jesuit University, Wheeling, WV; 1995

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV

Internal THP Title: Sr. VP, Information Systems	2004 – Present
Director MIS	1992 – 2003
System Manager	1990 – 1991
Programmer	1988 – 1990
Computer Operator	1986 – 1988

Mr. Roset advanced to Senior VP, Information Systems leadership for THP while helping the company grow to over $800 Million in yearly revenue through in-house developed core business systems. The Health Plan has grown from a small regional MCO to covering lives across the United States with 4 office locations. Mr. Roset manages large-scale enterprise migration projects, systems conversions and performance tuning and monitoring of applications/systems. Mr. Roset is responsible for ensuring data integrity and setting long-range technical direction and capacity plans.

Information Imaging, Wheeling, WV 1995 – 2002
Owner, Programmer

Mr. Roset provided consulting and programming solutions for several different clients. Some of Mr. Roset's clients were:

- The Berwyn Group – A consulting firm in Ohio. (Marketing/Sales system)
- Wheeling Health Right – A low income clinic in Wheeling. (Patient Tracking/Scheduling system)
- Kacsmar & Company – An accounting firm in Ohio. (Oil/Gas Tracking system)

Security National Bank & Trust, Wheeling, WV 1986
Computer Operator

Mr. Roset performed all functions related to back-end banking operations.

WENDY HODOROWSKI

KEY STAFF TITLE: COMMUNITY ENGAGEMENT DIRECTOR

PROFILE

Promoted to Marketing Director in 2010 after serving as graphic/web designer, Wendy Hodorowski reports directly to Mr. Knight. With over 10 years' experience, she plans, directs and sets the strategic direction of marketing programs for the entire organization, including marketing communications and public relations activities, both internal and external. Her leadership abilities are used on a day-to-day basis and she has excellent written and oral communication skills. She is experienced in writing press releases, making presentations and negotiating with the media. Ms. Hodorowski has extensive experience with planning and executing both large and small scale corporate events and sponsorships. Throughout her career, Ms. Hodorowski has been responsible for creating and overseeing the design and production of print materials, publications, and websites. She effectively communicates on a daily basis with healthcare providers, government agencies, brokers, businesses, vendors, staff and members.

EDUCATION AND TRAINING

- B.S., Graphic Design; West Liberty State College, West Liberty, WV; 1997
- Minor in Business Administration
- Wheeling Leadership Class of 2018
- Wheeling Chamber of Commerce Board Member, 2016 to present
- Wheeling Heritage Board Member, 2018 to present

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV
Internal THP Title: Marketing Director — Sept. 2010 – Present
Graphic/Web Designer — Oct. 2005 – Sept. 2010

Ms. Hodorowski oversees the development and implementation of support materials and services for various departments. She works with the organization's marketing partners to establish yearly marketing campaigns/goals, in addition to keeping the organization's branding current and fresh. Ms. Hodorowski assisted in establishing new branding and logo identity – introducing graphic standards that are used across the organization today. She monitors marketing trends to remain competitive and meet the organization's overall objectives. Ms. Hodorowski has numerous healthy relationships with organization stakeholders, vendors, brokers and other key business individuals. Ms. Hodorowski is involved in all lines of the organization's business, including Medicare and Medicaid, developing and adhering to all state and federal regulations. She develops and distributes the educational and informational materials to the community engagement team for various outreach events. She successfully plans and executes numerous corporate events, ranging from a large-scale healthcare symposium to more intimate sponsorship events, conferences, golf tournaments, and groundbreakings. Ms. Hodorowski was instrumental in creating and maintaining the organization's website as a graphic/web designer and has continued to play a major

role in its enhancements and redesign today. She also created a Medicare D-SNP direct mail campaign that resulted in an increase of D-SNP sales. Ms. Hodorowski collaborates with executive staff to develop digital and print media for enhancing and promoting the brand, increase member awareness, and optimize online presence.

@home web design, Bellaire, OH Sept. 2001 – Oct. 2005
President; Web/Graphic Designer

Ms. Hodorowski started her own business, using her many years of experience with layout and design, typesetting and proofing. She created websites and marketing materials for clients such as East Richland Christian Schools, St. Clairsville, OH; Home for Men, Wheeling, WV; Wheeling Academy of Law & Science, Wheeling, WV; and the Wheeling Vintage Raceboat Regatta, Wheeling, WV.

HGO Technology, Inc., Wheeling, WV Sept. 1999 – Sept. 2001
Multimedia Specialist

As multimedia specialist, Ms. Hodorowski was responsible for website concept development, design, and implementation and e-commerce solutions for the organization's various clients. She also designed promotional materials for clients including brochures, newsletters, program books, press releases, calendars, booklets and newspaper ads.

LARRY LEE WELLING

KEY STAFF TITLE: ENCOUNTER DATA INTEGRITY MANAGER

PROFILE

Larry Welling is an IT professional with over 37 years in planning, developing, and implementing cutting edge EDI solutions that manage the ever-changing health insurance landscape. He has extensive experience at gathering, analyzing and defining business and functional requirements; HIPAA ANSI X-12 transactions; encounter processing and designing/re-engineering processes, workflows and technology solutions for health insurance systems.

EDUCATION AND TRAINING

- Associates Degree in Computer Science; West Virginia Northern Community College, Wheeling, WV; 1983
- Associates Degree in Business Administration; West Virginia Northern Community College, Wheeling, WV; 1984
- Bachelor of Science in Accounting; Wheeling Jesuit University, Wheeling, WV; 1985

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Wheeling, WV
Internal THP Title: EDI Manager, System Analyst — 2015 – Present
Programmer – EDI, Senior — 1997 – 2015

Manage EDI projects including encounter submissions to the MMIS system, system conversions and performance tuning and monitoring of applications/systems. Mr. Welling designs and codes key business critical modules to ensure coding skills are fresh and deadlines are met. He is a lead programmer/project manager on major projects such as the EDIFECS, ClaimsXten and eviCore Authorization integrations. Mr. Welling has been a key player over the years with BMS/MMIS when new requirements were initiated such as migrating from the proprietary eligibility file to the 834 EDI file.

West Virginia Northern Community College, Wheeling, WV — 1994 – 1998
Instructor

Taught Introduction to Computers, Business Information Systems and RPGII.

W.A. Wilson, Inc., Wheeling, WV — 1988 – 1997
Information Systems Director/Assistant Controller

Perform budgeting, accruals, physical inventories and year-end closings. Develop and maintain Sales/Inventory software. Create remote ordering (EWO) system for customer use.

POST+, Inc., Wheeling, WV — 1986 – 1988
Systems Coordinator

Coordinate all programming activities. Develop software enhancements, perform all hardware maintenance.

Leading Edge Data Services, Inc., Wheeling, WV 1983-1986
Programmer/Analyst

Design and develop custom software.

JEANETTE WILLIAMS

KEY STAFF TITLE: MHT MEMBER ADVOCATE

PROFILE

Jeanette Williams has the experience of assisting a variety of members, families and providers over the course of 9 years. Ms. Williams started with THP in 2016 in a customer service role and was quickly promoted to the Medicaid Coordinator. She continues to work with members, providers and BMS on a daily basis. With her experience working with members and providers, she has also taken on the responsibility of member appeals and grievances for THP.

In September 2019, Ms. Williams received an iCare award from the West Virginia Association of Health Plans (WVAHP). The iCare Awards are given to front-line employees of WVAHP member-MCOs who have demonstrated exemplary care and service to West Virginia Medicaid members by helping them achieve positive outcomes in their healthcare delivery. Ms. Williams was recognized for using her experience receiving Medicaid services to help others as a case manager.

EDUCATION AND TRAINING

- A.A., Paralegal; University of Everest Online Tampa, FL; 2014

SUMMARY OF RELEVANT EXPERIENCE

The Health Plan, Charleston, WV — December 2016 – Present
Internal THP Title: Medicaid Coordinator

Ms. Williams has a variety of responsibilities with her role as the Medicaid Coordinator. She assists the VP of Medicaid in ensuring all contractual requirements are met, is responsible for the submitting the required BMS monthly reports and communicates with the Bureau for various reasons, such as eligibility issues, capitation questions, fee schedule inquiries, case management issues, and State Fair Hearings. Ms. Williams assists our operations department regarding pricing for certain procedure codes. She assists the Customer Service team on any eligibility issues. In addition to working with BMS on a daily basis, Ms. Williams also is responsible for working with our members with their appeals and grievances with THP. She ensures that all turnaround times are achieved within the contract requirements. Ms. Williams is also the key person who handles all member walk-ins in the Charleston office.

HealthSmart Benefit Solutions — August 2012 – December 2016
Charleston, WV - *Senior Customer Service Rep*

In this role, Ms. Williams effectively managed a high-volume of inbound and outbound calls. She answered a constant flow of customer calls and assist with supervisor calls and problem-solving. During this time, she maintained a professional attitude towards daily work and environment situations. She addressed and resolved customer product complaints professionally and with empathy. She accurately documented, researched and resolved customer service issues, and demonstrated mastery of customer service

management systems and databases. She oversaw call center employees to ensure customer satisfaction goals were consistently met.

US Airways, Charleston — April 2010 – April 2014
Cross-trained Agent

Ms. Williams was a cross-trained agent that held several responsibilities. She assisted with day-to-day operations to ensure that passengers were checked in and on their flight to their destination. She held an additional role as a GSC (Ground Security Coordinator), and assisted if any immediate danger arose with the plane or passengers. As a cross-trained agent, there were times that she worked on the ramp, and that would consist of parking planes, loading/unloading luggage.

DIANE PALETTA, D.D.S.

KEY STAFF TITLE: DENTAL DIRECTOR

PROFILE

Dr. Diane Paletta's 35-plus years in the field of dentistry spurs her passion to help people achieve optimal oral health. Throughout the past three decades, she has not only worked in private practice as a dentist in West Virginia, she has served on numerous boards and as an advocate educating the public on the importance of dentistry and how it impacts overall health.

EDUCATION AND TRAINING

- B.S., Dental Hygiene, Magna cum Laude; West Virginia University, Morgantown, WV; 1978
- Doctor of Dental Surgery; West Virginia University, Morgantown, WV; 1983

SUMMARY OF RELEVANT EXPERIENCE

SKYGEN USA, Menomonee Falls, WI — October 2013 – Present
Consultant, WV Dental Director

Dr. Paletta has worked as SKYGEN USA's Dental Director for the state of West Virginia for over five years, providing local clinical representation. She has a deep understanding of Medicaid Dental Plans and strong Medicaid clinical program knowledge, allowing her to accurately review and provide authorizations through our Enterprise System. She identifies aberrant conditions and trends related to reviewing provider authorization of dental services, referring SKYGEN UM staff to appropriate research and resolution. She conducts clinical reviews, peer clinical reviews, and appeal considerations. Additionally, she uses resources available from SKYGEN UM staff to maintain current knowledge and understanding of dental coverage services requiring her review.

West Virginia Board of Dentistry — 2007 – 2014
Crab Orchard, WV
Clinical Advisor

West Virginia University Tech — 2006 – 2007
Division of Dental Hygiene, Charleston, WV
Professor of Pharmacology and Periodontology

Private Practice of Dentistry, Charleston WV — 1983 – 2005
Dentist

Dr. Joseph Bowles, Charleston, WV — 1978 – 1979
Dental Hygienist

Attachment 5: Mandatory Requirements

Instructions: The mandatory requirements must be met by the Vendor as a part of the submitted proposal. Failure on the part of the Vendor to meet any of the mandatory requirements will result in its disqualification of the proposal, at the sole discretion of the Department. The terms "must" and "shall" stipulate and identify a mandatory requirement. The Vendor is to demonstrate compliance with mandatory requirements in its proposal. If the Vendor's proposal meets the mandatory requirements, the Vendor's proposal will be included in the next part of the technical evaluation of this RFP. For mandatory requirements that necessitate a future action, the Vendor will respond in ***Attachment 7: Terms and Conditions*** with an attestation that it will meet all mandates. For mandatory requirements involving documentation to be submitted for this bid submission, Vendors must include that documentation with its technical proposal as part of this bid submission. The Vendor's narrative response for **Attachment 5** should not exceed 10 pages.

See the attached Microsoft Excel® file titled, ***"MHT_Attachment_5_ Mandatory_Requirements."***

THP currently meets or exceeds these mandatory requirements, as they are currently included in the Service Provider Agreement. Our proposal reflects our commitment to continue this compliance under the new MHT contract and to successfully comply with all new requirements. Please refer to Attachment 7: Terms and Conditions for our attestation that we will meet all mandates.

THP confirms that it will comply with all the mandatory requirements and that we have demonstrated compliance with said mandatory requirements within its proposal. In summary:

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.

THP will comply will all applicable requirements outlined in this procurement as well as the Service Provider Agreement.

MD002: The Vendor must comply with all Service Level Agreements (SLAs), as indicated in the Service Provider Agreement (SPA).

THP will comply with all SLAs outlined in the Service Provider Agreement.

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.

THP will accept the rate established by the State on a PMPM basis for physical and behavioral health services.

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.

THP has and will maintain a physical and behavioral health provider network that provides adequate access and serves all 55 counties in West Virginia. Additional information related to how we maintain our provider network can be found in Attachment 6, 7. Network Development, ND001.

MD005: The Vendor must submit its provider contract templates and addenda to the Department for approval

THP will submit our boiler plate provider contract templates to the Department for approval.

MD006: The Vendor must submit an initial Value-Based Payment (VBP) plan to the Department and annually thereafter.

THP will submit our VBP plan to the Department for readiness review and annually thereafter.

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.

THP currently holds an NCQA status of "Accredited." We have provided a copy of our current accreditation certificate in response to Attachment 3: Vendor Qualifications & Experience, Question 1.1 Vendor Overview.

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.

THP will provide all requested supporting documentation outlined in the RFP response and Section 3: General Terms and Conditions, as well as Appendix 4: List of Requested Documents.

MD009: The Vendor must provide twenty-four-hour access seven (7) calendar days a week to a provider or service in emergency situations.

THP currently provides an in-house 24/7 nurse line for providers and members in emergency situations.

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.

THP currently monitors PCP panels for compliance with BMS and will monitor PCP panels for the WVCHIP population. THP monitors PCP panels for compliance with BMS limit on members assigned per PCP. THP has measurable standards for the number of each practitioner type providing primary care. For internal review, the Network Department will conduct analysis against the defined standards for the number of each type of primary care practitioner to monitor PCP to member ratio. Any deficiencies identified as a result of this analysis will be documented and a plan for improvement will be created. Other account specific reviews may be conducted as necessary to meet the requirements of contracts (i.e. CMS, BMS). This data analysis will be performed annually or as needed according to contracts or per improvement plans aimed at maintaining a network that meets the needs of our members.

Details on how we will monitor can be found in Attachment 6, 7. Network Development, ND003-ND008.

MD011: The Vendor must submit network standards documentation and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement (SPA).

THP will submit our documentation to support our network and geographic mapping reports in accordance with the reporting instructions in the Service Provider Agreement.

Our detailed response can be found in Attachment 6, 7. Network Development, ND011.

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.

THP has an established screening process that ensures we do not subcontract with vendors that are prohibited, suspended or excluded from participating in Medicare, Medicaid or other federal healthcare programs. Each of our subcontractors are required to submit an annual disclosure ownership form to THP.

MD013: The Vendor must participate in public meetings and other events at the request of the Department.

THP will continue to participate in public meetings and other events at the request of the Department. Additional information on how THP currently participates in the community and with providers is located in Attachment 6, 4. Community/Stakeholder Engagement, CS001.

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

THP will comply with all current and future security policies and procedures of the WVOT. Information regarding our systems can be located in Attachment 6, 12. Information Management Systems, IM001.

MD015: The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.

THP will ensure compatibility with the most current WVOT supported versions and standards. Information regarding our systems can be located in Attachment 6, 12. Information Management Systems, IM001.

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.

THP currently accepts and will continue to accept the MAID member number generated by the Department for all members for data collection and billing purposes.

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.

Our system has the capability and is currently producing reports in accordance to MCFU's standardized reporting template.

MD018: The Vendor must adhere to all State-defined file formats and templates including, but not limited to, 834 enrollment and 837 encounter files.

THP will adhere to all State-defined file formats and templates, including but not limited to, 834 enrollment and 837 encounter files.

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.

THP will obtain approval from the Department for all key staff hired under the contract and all personnel assigned to the contract. In the event key staff must be replaced, we will replace with persons of equal or greater experience and qualifications.

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.

THP will obtain approval from the Department for all key staff who are hired for this project. If necessary, THP will replace with staff of equal or greater experience and qualifications. All key staff will be assigned to the Medicaid line of business on a full-time basis. All of the key staff identified within this proposal are existing THP staff. We will provide the Department a 10-day notice of any key staff changes for planned transitions and will replace key staff within 30 business days. If needed, THP will request an extension from the Department if we are not able to find a qualified replacement within the 30 days. THP will remove any staff who are involved in this project if the Department determines that staff has/have not performed in the best interest of the project.

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.

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

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.

THP provides a drug-free, healthful and safe workplace. Employees are required to report to work in appropriate mental and physical condition to perform their jobs in a satisfactory manner. While on company premises or company time, no employee may use, possess, distribute, sell or be under influence of alcohol or illegal drugs. Each applicant for employment is required as a condition of employment to undergo a pre-employment drug screening. If an applicant tests positive and is determined to be in violation of this policy, the applicant is ineligible for employment. THP has policies and procedures for a drug-free workplace that is also stated in our employee handbook.

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.

THP will be responsible for all expenses required to obtain and maintain access to the Department systems.

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.

THP will 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.

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.

THP will make available to the Department any third-party audits such as SOC 2.

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.

THP agrees and will provide authorization for the State to have access to our records if our performance impacts 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.

THP agrees to comply with the guidelines outlined above regarding the protest of an award.

MD028: The Vendor must have all requirements operational, as agreed upon with the Department, by July 1, 2020.

THP will have all requirements operational, as agreed upon with the Department, by July 1, 2020.

MD029: The Vendor must maintain a primary workplace in the State of West Virginia.

THP currently maintains and will maintain our Wheeling, Morgantown and Charleston, WV, offices during the life of this contract.

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	P. 1
MD002	The Vendor must comply with all Service Level Agreements (SLAs), as indicated in the Service Provider Agreement (SPA).	Attachment 5, Mandatory Requirements	P. 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	P. 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 6, Network Development, ND001 and Attachment 5, Mandatory Requirements	P. 1 P. 2
MD005	The Vendor must submit its provider contract templates and addenda to the Department for approval.	Attachment 6, Network Development, ND002 and Attachment 5, Mandatory Requirements	P. 1 P. 2
MD006	The Vendor must submit an initial Value-Based Payment (VBP) plan to the Department and annually thereafter.	Attachment 6, Provider Services, PS007 and Attachment 5, Mandatory Requirements	P. 26 P. 2
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 3, 1.1 Vendor Overview and Attachment 5, Mandatory Requirements	P. 5 P. 2
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	P. 2
MD009	The Vendor must provide twenty-four-hour access seven (7) calendar days a week to a provider or service in emergency situations.	Attachment 6, Provider Services, PS001 and Attachment 5, Mandatory Requirements	P. 2 P. 2
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 6, Network Development, ND003-ND008 and Attachment 5, Mandatory Requirements	P. 8 P. 3
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 6, Network Development, ND011 and Attachment 5, Mandatory Requirements	P. 17 P. 3
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 6, Network Development, ND017 and Attachment 5, Mandatory Requirements	P. 34 P. 4
MD013	The Vendor must participate in public meetings and other events at the request of the Department.	Attachment 6, Community/ Stakeholder Engagement, CS002 and Attachment 5, Mandatory Requirements	P. 8 P. 4
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 6, Information Management Systems, IM001, IM003 and Attachment 5, Mandatory Requirements	P. 1 P. 4

MD015	The Vendor must ensure compatibility with the most current West Virginia Office of Technology (WVOT) supported versions and standards.	Attachment 6, Information Management Systems, IM005 and Attachment 5, Mandatory Requirements	P. 12 P. 4
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 6, Information Management Systems, IM005 and Attachment 5, Mandatory Requirements	P. 15 P. 4
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 6, Program Integrity, PI005 and Attachment 5, Mandatory Requirements	P. 17 P. 5
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 6, Information Management Systems, IM005 and Attachment 5, Mandatory Requirements	P. 13 P. 5
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 4, 1. Initial Staffing Plan and Attachment 5, Mandatory Requirements	P. 21 P. 5
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 4, 2. Key Staff and Resumes and Attachment 5, Mandatory Requirements	P. 30 P. 5
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 6, Program Integrity, PI010 and Attachment 5, Mandatory Requirements	P. 23 P. 6
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	P. 6
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 6, Information Management Systems, IM005 and Attachment 5, Mandatory Requirements	P. 13 P. 6
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 6, Information Management Systems, IM005 and Attachment 5, Mandatory Requirements	P. 13 P. 6
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 6, Program Integrity, PI006-PI009 and Attachment 5, Mandatory Requirements	P. 23 P. 7
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	P. 7

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	P. 7
MD028	The Vendor must have all requirements operational, as agreed upon with the Department, by July 1, 2020.	Attachment 5, Mandatory Requirements	P. 7
MD029	The Vendor must maintain a primary workplace in the State of West Virginia.	Attachment 5, Mandatory Requirements	P. 7

TheHealthPlan

Attachment 6
General

Attachment 6: Detailed Specifications Approach

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

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

1. Responses should be focused on the business processes and specifications, and not just provide generic or marketing descriptions of Vendor qualifications.
2. A statement of compliance or intent to perform the specification may not be considered a narrative description or explanation, and may result in deduction of points from the Vendor's score if given when a narrative description or explanation was requested.
3. The Vendor is not required to address each specification independently and may combine responses to specifications, particularly if a more comprehensive response helps the Vendor convey its approach. However, the Vendor should cite where each specification is addressed within the narrative for traceability (using the appropriate IDs) and provide a level of detail that enables the Department to evaluate the response at the individual specification level. A generic example below provides the expected format for combining specifications into a singular response:

Vendor X, per Detailed Specifications GE001 and GE002, has provided their response in 12-point font, single-sided, double-spaced, and numbered pages, and also in adherence with defined templates as per the RFP requirements.

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

1. General

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP. The specifications for the General (GE) subject matter area do not require a narrative response, however, the Vendor should adhere to the formatting guidelines of this RFP.

GE001: 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.

GE002: 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.

Our proposal adheres to the page limits as defined in Section 5 of the RFP. It follows the formatting guidelines of the RFP, including 12-point font, double-spaced, single-sided copies and page numbers. Additionally, we did not alter the format of the tables throughout our response.

TheHealthPlan

Attachment 6
Benefit Administration

2. Benefit Administration

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Benefit Administration (BA) as part of their bid. The Vendor's narrative response should not exceed 100 pages.

We have been administering member benefits for the Mountain Health Trust (MHT) program since 1996. In that time, we have developed a comprehensive benefit administration program that includes:

- Established processes and systems to track member co-pays for medical and pharmacy services for all lines of business, which will allow us to track co-pays for WVCHIP members based upon their benefit plans. We currently track each Medicaid member's quarterly household maximum and will track each WVCHIP member's annual out-of-pocket maximum.
- Comprehensive training programs for utilization management (UM) and clinical staff, including cultural competency training and inter-rater reliability (IRR) testing to verify the consistent delivery of care management services and the authorization of services.
- The adoption of UM guidelines from nationally recognized sources, such as American Diabetes Association, and oversight mechanisms and processes to review, update and adopt our utilization management guidelines.
- A comprehensive UM program that features an integrated clinical, quality management and fraud, waste and abuse oversight structure and an interdisciplinary set of principles, policies and systematic processes and workflows that verify we are delivering positive outcomes in terms of member experience, outcomes and quality of life and the quality and cost of care.
- A Compliance/FWA Plan that demonstrates a commitment to the prevention, detection and correction of potential fraud, abuse or erroneous billings. The plan includes policies, procedures, an oversight structure and reporting that confirms compliance with laws and regulations.
- Processes, tools and policies that empower our clinical reviewers to evaluate the whole member and use their clinical experience and expertise when evaluating service requests for all our members, including members with special healthcare needs. This includes modifying our standard UM protocols when we determine that a service is in the member's best medical interest.
- Extensive experience and processes as well as tools to confirm the continuity of each member's care when they are newly enrolled with The Health Plan (THP), including the ability to identify members who have open service authorizations and honor those open service authorizations.
- Written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services.

- An extensive network of out-of-state providers to ensure that all members have access to needed care, including members who live in proximity to state borders.
- Processes that allow for approval of standing referrals, referrals made by specialist providers and referrals for out-of-network providers.
- Processes to allow members to continue an ongoing course of treatment with out-of-network providers during the transition period and when it is in the best medical interest of the member.
- Processes, tools and education to members and providers that confirm our ability to connect members to preventive services as determine by Healthcare Effectiveness Data and Information Set (HEDIS) and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedules.
- Providing access to and covering family planning services (those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy) in accordance with Article III, Section 5.3.3.1 Family Planning of the Service Provider Agreement.
- Processes to confirm continuity of care for members requiring urgent, emergent crisis stabilization or post-stabilization medical, behavioral and dental care by making arrangements for or facilitating access to care and providing coverage for services needed urgently or emergently as defined under prudent layperson language.
- Policies and procedures for assisting the State or fiscal agent with the pharmacy rebate resolution process including rejected or disputed physician-administered drug claims.
- Tools that allow our care managers and member advocates to schedule and track the completion of member appointments, regardless of the services the member will be receiving. Using our care management system, member advocate and care managers can view and change the status of a member's appointments, including pending, scheduled, confirmed, completed, rescheduled, canceled, missed or requested.

BA001. 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. Medical Services (includes Physical, Behavioral Health, Dental and Vision)

BA003. Pharmacy Services

We currently administer co-pays and cost-sharing requirements for all services, including medical and pharmacy services, through our claims adjudication system. This system provides a high-level of flexibility, allowing us to quickly deploy updates to meet changing business needs or State requirements.

Imposing Co-pays

We publish the required member co-pays in our Member Handbook, our provider manual and on our provider portal. Providers can also identify the member's co-pay level through the fiscal agent's web portal or by calling our customer service department. Providers have the ability to collect the member's co-pay at the time of service or once the claim has been paid. Once the provider submits a claim for the services, we adjudicate the claim based upon the business rules (e.g., if it is determined it is a non-emergency use of the ER, we apply the applicable $8 co-pay to the claim) and document the member's co-pay that should have been collected by the provider on their remittance advice. Our provider contracts prevent providers from waiving co-pays. We will apply the appropriate co-pay to the claim when processed. Responsibility rests with the provider to collect the appropriate co-pay.

Monitoring Co-pays

Our claims system monitors co-pays for Medicaid and will be adapted to monitor applicable co-pays for WVCHIP members based upon their benefit plans (Blue, Gold, Premium or Exempt) and eligibility levels. It monitors physical, dental, vision and behavioral health services as follows:

For Medicaid members: The state's enrollment file includes the income level for each member, which determines the co-pay amount owed by the member. When we process the enrollment file, our systems identify each member's income level to determine their co-pay, the member rate code and services that are exempt from co-pays, such as members who are pregnant or under 21, and services such as family planning.

For those services that are subcontracted such as children's dental and vision, our subcontractors apply the same logic to their system to ensure co-pays are either applied

or waived based upon the criteria. For our WVCHIP members who will be responsible for a co-pay, we will share accumulator files with our subcontractors.

For WVCHIP members, the state's enrollment file documents the member's benefit package as Blue, Gold, Premium or Exempt. The benefit package determines the amount of the co-pay owed by the member. THP applies the correct co-pays per these enrollment files. We program our claims system to apply the co-pay based upon the services rendered under the member's benefit structure. For example, if a WVCHIP member in the Gold benefit plan sees a specialist, we will apply a $5 co-pay.

For Medicaid and WVCHIP members, in addition to the co-pays owed based upon income level and benefit package, our claims system sets up co-pays by place of service, such as a hospital or office visit and by CPT code, such as a non-emergent visit to the ER (CPT code 99281). This allows our claims system to auto-adjudicate co-pays when the provider submits their claim for services.

Tracking Co-pays

Our claims system tracks co-pays applied to services incurred by members and guardians for medical, dental, pharmacy and behavioral health services. For services that are currently contracted to one of our subcontractors, we exchange a daily accumulator file to ensure the limits are applied appropriately. In the event that the pharmacy benefit is carved back into managed care, we would apply the same process with the daily accumulator file with our pharmacy subcontractor.

THP has the ability to share daily accumulator file with outside vendors such as the fiscal agent and the pharmacy benefit manager (PBM) for WVCHIP to ensure the co-pay or lifetime limits are applied correctly. The daily accumulator file provides THP, the

dental and vision subcontractors and the fiscal agent and PBM with up-to-date information about the co-pays that have been paid by Medicaid and WVCHIP members. This allows THP, the dental and vision subcontractors and the PBM to track each Medicaid member's quarterly household maximum and each WVCHIP member's annual out-of-pocket maximum so that we no longer apply co-pays when these limits have been reached. We provide this information on the provider's remittance advice. Providers can also call our customer service department to determine when a member has reached the maximum limit for co-pays.

BA004. The Vendor should describe its process for development and revision of Utilization Management (UM) guidelines, as indicated in the Service Provider Agreement (SPA).

Our Quality Management (QM) Program provides oversight of the development and review of our utilization management (UM) guidelines through our QM oversight structure. The QM committees and teams that provide input and oversight of our guidelines include:

- ***Executive Management Team (EMT)*** is accountable for the operations, results and effectiveness of our health plan operations. The EMT provides final approval of any guidelines recommended for adoption by the Medical Directors Oversight Committee.
- ***Medical Directors Oversight Committee (MDOC),*** chaired by a medical director, oversees UM activities and shares information and expertise to verify the consistent application of guidelines when determining medical necessity. The MDOC reviews UM guidelines and provides clinical recommendations and preliminary approval of new and revised UM guidelines, with input from our Physician Advisory Committee and Transplant & New Technology Assessment Committee.
- ***Our clinical team*** researches medical literature to identify the most current national recommendations. The review includes collecting information from existing guidelines and establishing thresholds and acceptable standards of care. The team reviews and adopts guidelines based upon published guidelines from sources, such as the American Diabetes Association (ADA) and relevant medical literature from valid and nationally recognized clinical evidence-based sources, such as Change Healthcare InterQual, a set of criteria used to determine the

appropriateness of a requested service when our UM RNs are determining the medical necessity of the requested service.

- ***Physician Advisory Committee (PAC),*** a subcommittee of the MDOC, provides input from the physician community to guide THP in its decision-making related to medical policy, including the adoption of UM guidelines for our members. The committee helps us improve healthcare and clinical quality and communications, relations and cooperation between physicians and addresses matters of a clinical or administrative nature that impact our interaction with all providers. Members of the PAC include THP providers from a variety of board-certified physicians and specialists.
- ***Transplant & New Technology Assessment Committee (T&T),*** which includes representatives from various THP departments and medical directors, provides multidisciplinary oversight and review of new and evolving technology for possible inclusion in the benefit structure. When new treatments are approved, the committee develops review guidelines and submits them to the MDOC for review and adoption. The T&T verifies the inclusion of federal and state Medicaid coverage decisions in medical and claim review guidelines.

Process to Update Our Guidelines

We review our UM guidelines at least annually for any changes that reflect the most up-to-date standards using the process presented in the figure.

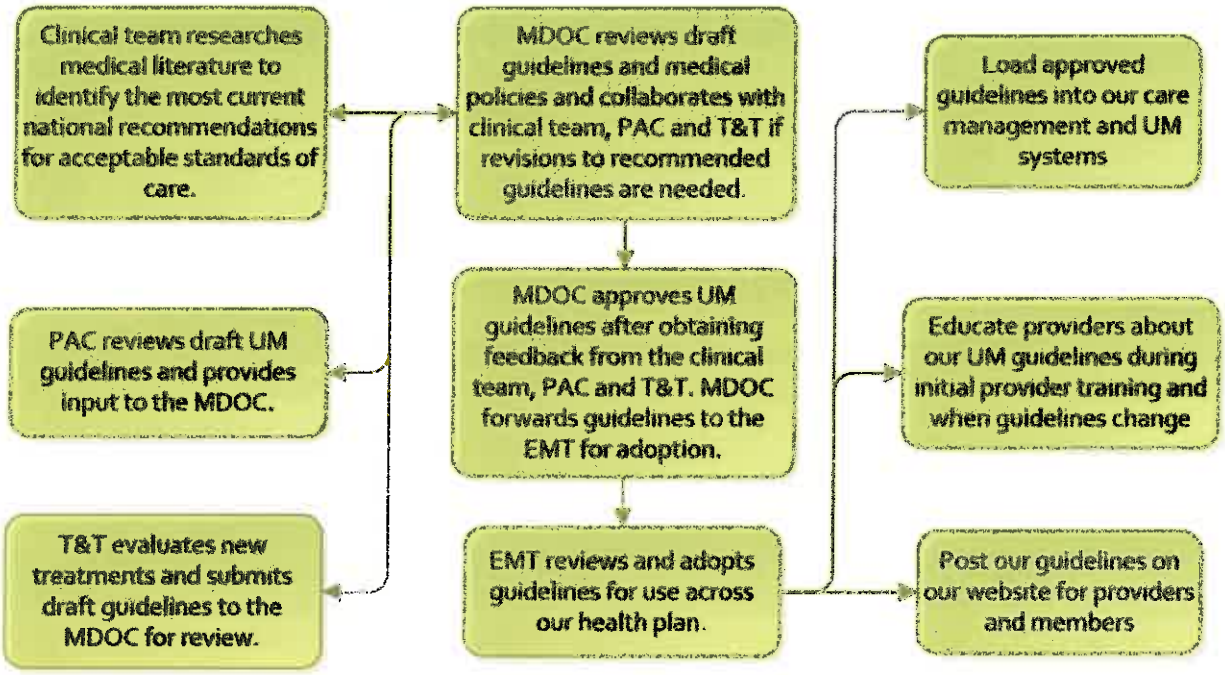


Figure 1: Process to update our guidelines. Our MDOC evaluates our guidelines at least annually with input from our clinical team, PAC and T&T. Our EMT approves guidelines recommended by the MDOC for use across our health plan. Once adopted we educate our providers about our guidelines and post them to our website for providers and members to access.

Our Evidence-based Guidelines

In accordance with Article III, Section 5.7, Practice Guidelines and New Technology in the Service Provider Agreement, we have adopted evidence-based guidelines that serve as the framework for clinical decisions and service provision that optimizes member care and outcomes. We select evidence-based guidelines from a variety of sources that address physical and behavioral health, such as:

- InterQual Criteria used to determine the medical necessity of a requested service.
- Disease management program guidelines from organizations, including the ADA, Disease Management Association of America (DMAA), the American College of Obstetricians and Gynecologists (ACOG), and the Agency for Healthcare Research and Quality (AHRQ).
- American Society of Addiction Medicine (ASAM) criteria for substance use disorder (SUD).
- Autism and ADHD guidelines from the American Academy of Pediatrics (AAP)
- "Guidelines for the Treatment of Patients with Substance Use Disorders," published by The American Psychiatric Association (APA).

- Guidelines for the treatment of depression, "Adult Depression in Primary Care," published by the Institute for Clinical Systems Improvement
- Trauma-informed care guidelines from the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Maternal child health guidelines based upon nationally accepted standards of care and key treatment elements as outlined by ACOG.
- Centers for Disease Control (CDC) recommendations for screening of pregnant women for HIV/AIDS.
- HEDIS and EPSDT guidelines that help determine preventive services our members should be receiving, such as dental services for children.
- National Comprehensive Cancer Network (NCCN) guidelines for cancer.
- Guidelines for the diagnosis and management of asthma from the National Heart, Lung and Blood Institute (NHLBI).
- Numerous primary and subspecialty guidelines from national policies and standards, valid and reliable clinical evidence, and expert consensus in specific fields. For example, we follow AAP Bright Futures recommendations for preventive services for children.
- Hayes ratings review system to evaluate the strength and direction of the evidence regarding a medical technology, such as procedure, test, device, biologic, drug, intervention, process or program.

Sharing the Guidelines and Condition-specific Protocols with Providers and Specialists

We share our guidelines with providers by placing them on our website located at www.healthplan.org under the For Providers tab and notifying providers of the availability of the updated guidelines via THP's Provider Focus quarterly provider newsletter, provider training seminars, including the Bureau for Medical Services' (BMS') bi-annual provider workshops, and on-site visits by THP's provider engagement representatives during provider on-site reviews. As new providers become participants with THP, our provider engagement representatives educate them about the availability of the guidelines on the website.

BA005. The Vendor should provide its training curriculum for Utilization Management (UM) and clinical staff.

Training is a critical component of our MHT program and includes initial and ongoing training for our UM and clinical staff and member advocates using classroom, web-

based and self-paced, role-playing and person-centered teaching approaches. Trainees are required to complete classroom exercises and manual worksheets on all training material to assure they understand how the system applications work. Testing is completed on all subjects trained. A review of each trainee is sent to their supervisor, manager and director each week to keep managers informed of progress and needs. Training completion is documented in THP's HEART electronic information system.

Initial Training: UM and clinical staff and member advocates are required to complete an orientation program that covers a variety of topics as presented in the table.

Initial Training
Initial Orientation Training
▪ Organization chart ▪ New employee – introductory orientation checklist ▪ Job description, licensure requirements ▪ Orientation program – mission, goals, purpose ▪ Current Julian calendar ▪ Human resource Employee Handbook
Telephone Directory Training
▪ Clinical service department phone list with alphabet list ▪ Language Line use ▪ Telephone directory – (800 #'s) provider calls for benefits, eligibility, etc. ▪ Nurse information line ▪ Voicemail Quick Start Guide ▪ Example of RN voice mailbox message
Overview of Clinical Services Department Training
▪ Clinical Services department staff and committee overview (Transplant and New Technology Assessment Committee, Medical Directors Oversight Committee, Physician Advisory Committee) ▪ Provider Manual THP website ▪ Provider Manual – Section 7 Medical Management Program ▪ Provider Manual – Section 3 Member Benefits ▪ Provider Manual – Section 10 Pharmacy ▪ Provider Manual – Section 4 Medicare ▪ Provider Manual – Section 5 Medicaid ▪ Provider Manual – Section 8 Quality Improvement/NCQA ▪ Provider Manual – Section 9 Behavioral Health
PolicyStat Overview Training
▪ Clinical services policy review
Crisis Management Training

Initial Training
Initial Orientation Training
▪ CL-217 Handling a Crisis Call and CL-200 Crisis Reporting
General Information Training
▪ Types of plans ▪ Glossary of health coverage and medical terms ▪ Basic terminology ▪ Definitions of health insurance terms ▪ How You and Your Insurer Share Costs – example ▪ Abbreviations ▪ Coordination of benefits ▪ Group numbers ▪ Network information ▪ Customer service application
Utilization Management Training
▪ Referral checklist ▪ Preauthorization list ▪ CPT tool ▪ Census (concurrent facility review checklist) ▪ eviCore/Palladian/SKYGEN (subcontractors) ▪ Clinical criteria algorithm ▪ Hospital matrix ▪ Facility heart screens ▪ West Virginia Health Information Network (WVHIN) ▪ Interqual Guidelines (Change Healthcare) ▪ Hayes technology ▪ Transplant and technology guidelines ▪ UM interrater tools ▪ ASAM modules ▪ Timeliness review/denial decision notification requirements ▪ Appeals and grievances
Care Management Programs Training
▪ Outreach ▪ HEDIS (gap in care closure, landing page review) ▪ Health risk assessments ▪ Complex case management criteria and workflow ▪ Care navigation criteria and workflow ▪ Disease management programs and workflow ▪ Tobacco cessation ▪ Clinical analytic tools (Impact Pro and CC Group Marketbasket) ▪ Coordinated Care Assessments (Change Healthcare) ▪ Care coordination interrater tool ▪ Cost savings tool ▪ Community resources (social worker referral; Aunt Bertha, our social services resource tool) ▪ Disability outreach (SSI, SSDI support for members) ▪ Children with Special Health Care Needs (CSHCN) role, referral and workflow

Initial Training
Initial Orientation Training
▪ DXC technology website
Required Testing of all Care Managers, UM RNs, Medical Directors and Member Advocates
▪ Motivational interviewing and trauma-informed care ▪ Cultural Competency, including social determinants of health (SDOH) and access for members with disabilities or limited English proficiency (annual) ▪ Medicaid Contract (annual) ▪ D-SNP Model of Care (annual) ▪ Interqual Modules (UM in orientation) ▪ ASAM Modules (UM in orientation) ▪ HIPAA Privacy and Security (Annual) ▪ Compliance and Fraud, Waste and Abuse (Annual) ▪ Anti-Harassment (Orientation)

Ongoing training. We perform ongoing training, such as annual cultural competency trainings and lunch and learns. We conducted the following Lunch and Learn sessions for our staff in 2019:

- Home Health Basics presented by Stonerise
- Transplantation presented by CignaLifeSource
- Program Update presented by WIC
- Organ Transplantation presented by Lifetrac
- Children with Special Health Care Needs (CSHCN) Enrollment and Overview of Disability Outreach presented by Kim Jordan
- Population Health and Epic Access presented by WVU Medicine
- Behavioral Health Case Management Basics presented by Sheila Kelly and Amy Bott
- Reinsurance/High Cost Review and Documentation presented by Kim Jordan
- Behavioral Health Services and Resources Overview presented by Sheila Kelly
- Case Management 101 presented by Kim Jordan
- Managed Care and Insurance Basics presented by Cindy Matthews

In June 2019, a representative from the Ohio County WIC office visited our office to provide training in the WIC program to our care managers, perinatal team and outreach staff. The training covered a variety of topics, including:

- Who is eligible for WIC and how to encourage members to participate
- How to refer members to the WIC program
- Nutrition education
- Additional programs for WIC-eligible members, such as Right from the Start or pregnancy assistance programs
- WIC-eligible foods
- WIC clinics across West Virginia

We also partner with community organizations to train our staff on topics important to our members. In June 2019, a representative from the Ohio County WIC office visited our office to provide training in the WIC program to our care managers, perinatal team and outreach staff.

Inter-rater Reliability (IRR) Testing

To verify the consistent delivery of care management services and the authorization of services, we conduct monthly IRR reviews for care managers, inpatient concurrent review nurses, medical directors and clinical member advocates and quarterly IRR reviews for pre-authorization RNs. IRR testing determines if our care managers and UM staff are following care management and UM policies and procedures. Care managers, UM nurses, medical directors and clinical member advocates must achieve a score of at least 90% on IRR testing to be considered competent.

Staff not meeting benchmark are educated and placed on a performance improvement plan (PIP) that has measurable performance goals, specific timeframes for objectives and an end date to achieve improvement objectives. Failure to achieve performance goals can result in extension of the PIP and disciplinary action, up to and including termination. PIPs are reviewed, signed and dated by the staff member and their direct supervisor and kept on file in the employee's folder in our human resources department.

We conduct IRR testing for care managers and member advocates to determine adherence to care management requirements. UM hospital review and UM pre-authorization IRR testing confirms our UM RN reviewers and medical directors apply our guidelines consistently and follow UM processes. Our member advocate IRR testing

confirms their compliance with new member welcome calls and HRAs and appropriate referral of members to care management.

Care Manager Review

IRR testing for care managers monitors their adherence to care management requirements, such as completion of the initial assessment within 60 calendar days, engagement of the member's providers, completion of the member's care plan and proper documentation of the member's health information in our care management system. We perform this testing monthly. The figure presents the first page and the first six questions of the care manager review IRR testing. ***Each of our care managers exceeded the minimum required score of 90% in 2019.***

Competency Monitoring Report 00001

Test Name: Case Management
Date Range: 01/01/2019 thru 01/02/2020
# of Reviews: Average Score:

Review Date:
Employee:
Reviewer:
Member ID
Group ID

Questions			
1 - WAS THE REVIEW DECISION TIMELY (WITHIN 7 WORKING DAYS) AND APPROPRIATE (CASE ACCEPTED, DECLINED, FORWARDED)?			
2 - WAS THE MEMBER FLAGGED APPROPRIATELY IN HEART AT THE TIME THE CASE WAS OPENED/BUILT AND SUBSEQUENT NEW FLAGS ENTERED AS APPROPRIATE IF LEVEL OF CARE CHANGED?			
3 - WAS APPROPRIATE TYPE OF CASE OPENED/BUILT (ALL DROP DOWNS COMPLETED FOR SPECIFIED PROGRAM, PRIMARY DIAGNOSIS ENTERED, CARE LEVEL UPDATED WITH FLAG CHANGES)?			
4 - WAS INITIAL ASSESSMENT COMPLETED WITHIN A 60DAY TIME FRAME AFTER ENGAGING WITH MEMBER/CAREGIVER AND ANY SUBSEQUENT ASSESSMENTS UPDATED IF APPLICABLE?			
5 - WAS THE CARE PLAN COMPLETED (MODIFIED, PERSONALIZED AND DATED WITH UPDATES AS APPLICABLE)?			
6 - WAS INTRODUCTION TO CASE MANAGEMENT NAVIGATION LETTER SENT?			

Figure 2: Care Manager Review. IRR testing for care managers monitors adherence to care management requirements, such as completion of the initial assessment within 60 calendar days. The monthly review tests care managers across 14 review questions. Each of our care managers exceeded the minimum required score of 90% in 2019.

UM Hospital Review

IRR testing for UM hospital review confirms our UM RN reviewers apply our guidelines consistently and follow UM processes, including pre-admission authorization and concurrent review of inpatient stays. The figure presents the first page and the first 10 questions of the UM hospital review IRR testing. ***Each of our nurse reviewers exceeded the minimum required score of 90% in 2019.***

Competency Monitoring Report 00001

Test Name: Hospital Review Nurses
Date Range: 01/01/2019 thru 01/02/2020
# of Reviews: Average Score:

Review Date:
Employee:
Reviewer:
Member ID
Group ID

Questions			
1 - DAYS CERTIFICATED CORRECTLY? (ADMIT & DISCHARGE DATES CORRECT/ ALL DAYS HAVE A PAY LEVEL. LCD IS ENTERED AND DISPALYED CORRECTLY ON THE FRONT CENSUS SCREEN)			
2 - SERVICE TYPE CORRECT?			
3 - ADMIT TYPE CORRECT?			
4 - ICD 10 DIAGNOSIS CODES CORRECT/ SPECIFIC TO THE CORRECT DIGIT?			
5 - ICD-10 PROCEDURE CODES CORRECT / SPECIFIC TO THE CORRECT DIGIT?			
6 - MEMBER NETWORK REVIEWED CORRECTLY?			
7 - PRINCIPLE DIAGNOSIS SUPPORTS INTERQUAL USED FOR REVIEW?			
8 - CORRECT USE OF INTERQUAL (COMPLETED AT THE APPROPRIATE TIMES?)			
9 - INTERQUAL USES CORRECTLY APPLIED?			
10 - MEDICAL DIRECTOR REVIEW IF APPLICABLE, (WHEN CRITERIA NOT MET/ OUT OF NETWORK/ WITHOUT **PRIOR AUTH)**			

Figure 3: UM Hospital Review. IRR testing confirms our UM RN reviewers apply our guidelines consistently and follow UM processes, including pre-admission authorization and concurrent review of inpatient stays. The monthly review tests UM nurse reviewers across 26 review questions. Each of our nurse reviewers exceeded the minimum required score of 90% in 2019.

UM Pre-authorization Review

IRR testing for UM pre-authorization review confirms the UM nurse reviewers consistent application of our guidelines and adherence to pre-authorization processes. The monthly review tests UM nurse reviewers across 25 review questions. The figure

presents the first page and the first four questions of the UM pre-authorization review IRR testing. ***Each of our nurse reviewers exceeded the minimum required score of 90%. Each of our medical directors exceeded the minimum required score of 90% in 2019.***

Competency Monitoring Report 00001

Test Name: Referral Review Nurses
Date Range: 01/01/2019 thru 01/02/2020
# of Reviews: Average Score:

Review Date:
Employee:
Reviewer:
Member ID
Group ID
Referral #

Questions			
1 - DATE, TIME OF ENTRY, ALL REVIEWERS IDENTIFIED? REVIEW ALL ENTRIES FOR DATE & TIME INCLUDING: THE REMARKS SCREEN/DIARY, INTERQUAL SCREENS AND DATE(S) OF DECISION(S).			
2 - MEMBER DRIVEN REQUEST IDENTIFIED CORRECTLY? (USE OF MEM9999 AND REFERRAL TYPE MC)?			
3 - GROUP BENEFIT INTERPRETATION/ LIMITATIONS APPLIED ACCURATELY REFERRAL WAS REVIEWED FOR WHAT WAS REQUESTED? WAS THE REFERRAL REVIEWED APPROPRIATELY? WERE THE GROUP BENEFITS APPLIED?			
4 - SOURCE OF INFORMATION, E.G. UR STAFF, PROVIDER, OFFICE STAFF, CLINICAL NOTES, TEST RESULTS WAS IDENTIFIED? REQUESTOR OF THE REFERRAL WAS IDENTIFIED? FAX(S) WERE FOR THE CORRECT MEMBER?			

Figure 4: UM Pre-authorization Review. IRR testing for UM pre-authorization review confirms the UM nurse reviewers consistent application of our clinical guidelines and adherence to pre-authorization processes. The monthly review tests UM nurse reviewers across 25 review questions. Each of our nurse reviewers exceeded the minimum required score of 90% in 2019.

Member Advocates Review

We perform member advocate reviews to confirm their compliance with HRAs and appropriate referral of members to care management. The monthly review tests member advocates across 11 review questions. ***Each of our member advocates exceeded the minimum required score of 90% in 2019.***

Competency Monitoring Report 00001

Test Name: Governmental Member Advocate
Date Range: 01/01/2019 thru 01/02/2020
# of Reviews: Average Score:

Review Date:
Employee:
Reviewer:
MEMBER ID
GROUP NUMBER

Questions			
1 - IF INITIAL MEMBER CALL IS UNSUCCESSFUL, WAS IT FOLLOWED BY 2 ADDITIONAL CALLS AND POSTCARDS AND/OR LETTER X3 WITHIN 28DAYS ?			
2 - WAS THE HRA OR GENERAL ASSESSMENT COMPLETED WITHIN 30 DAYS?			
3 - IS THERE DOCUMENTATION OF ATTEMPTS TO ENGAGE THE MEMBER'S PROVIDERS THROUGH FAXES/CALLS/EMAILS OR REVIEW OF REFERRAL OR HOSPITAL REVIEW NOTES?			
4 - ARE FAXES/MEMBER CORRESPONDENCE ATTACHED WITH APPROPRIATE DESCRIPTION IN CASETRACKER DOCS?			
5 - WAS CASE REVIEWED CORRECTLY AND FORWARDED TO RN,SW, DM, FLAGGED BY ADVOCATE, OR CLOSED?			
6 - WAS MEMBER FLAGGED APPROPRIATELY WITH PROPER NAVIGATION CASE BUILD? (PROPER INDICATION,PARTICIPATION LEVEL,LEVEL OF CARE, DIAGNOSIS)?			
7 - WAS INTRO TO CASE MANAGEMENT LETTER SENT, AND FILED IN DOCS IF RETURNED?			

Figure 5: Member Advocate Review. IRR testing for member advocates confirms their compliance with new member welcome calls and HRAs and appropriate referral of members to care management. The monthly review tests member advocates across 11 review questions. Each of our member advocates exceeded the minimum required score of 90% in 2019.

Cultural Competency Training

Every THP employee is required to complete annual cultural competency training, attested to with an 80 percent passing score. We last completed this training in January 2020. This training reinforces that cultural competency requires effort. As individuals, we must keep an open mind and ask questions. Our cultural competency training is web-based and covers several important topics, including:

- ***Cultural Competence:*** Defines BMS, CMS and NCQA expectations, culture and how culture influences care.
- ***Language Competence:*** Explains the value of communicating effectively with diverse audiences, including persons with limited English proficiency, persons

who are not literate or those with low literacy skills, individuals with disabilities and individuals who are deaf or hard of hearing.

- ***Social Determinants:*** Defines social determinants and explains why they are important and how they can impact a member's care.
- ***Ageism:*** Defines ageism as the specific use of negative or derogatory images to discriminate a certain population group, and why it is important to treat people as individuals.
- ***Learning Cultural Competence:*** Includes the national standards for Culturally and Linguistically Appropriate Services (CLAS) in healthcare, and provides information on how to conduct a cultural assessment.

BA006. 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. Ongoing monitoring of Emergency Room (ER) utilization.

BA008. Ongoing monitoring of potential abuse or inappropriate utilization of controlled prescription medications.

BA009. Reports and other tools that will be used to monitor and manage service utilization

BA010. The Vendor should describe its process for preventing and detecting fraud and abuse related to all administered services including Pharmacy, if applicable.

Continual monitoring of the effectiveness of our care management and member engagement programs is critical to identifying trends and opportunities for improvement to our care management systems, tools and processes. Our comprehensive utilization monitoring program features an integrated clinical, quality management and fraud, waste and abuse oversight structure. We use an interdisciplinary set of principles, policies and systematic processes and workflows that verify we are delivering positive outcomes in terms of member experience, quality of life and the and cost of care. Our utilization monitoring program accomplishes five key tasks, including:

1. Identifying members who have needs, such as care management, or who have gaps in care.
2. Confirming the appropriateness of care delivered to members.
3. Confirming the effectiveness of our care management programs.
4. Monitoring and addressing overutilization, underutilization and inappropriate utilization patterns.
5. Identifying potential FWA related to utilization and referring to the SIU for further investigation.

Oversight

As presented in the figure below, our UM and FWA monitoring program is a collaborative effort among our UM clinical staff, population health management team, Medicaid Oversight Workgroup, Continuous Quality Improvement (CQI) Workgroup and Special Investigations Unit (SIU). We train our UM clinical staff to look for concerns during real time preauthorization and concurrent review. They are often the first to identify patterns and trends that may indicate over- and under- utilization including FWA. Using tools, reporting and dashboards, discussed below, developed by our population health management team, our Medicaid Oversight Workgroup monitors utilization across our Medicaid program. When the Medicaid Oversight Workgroup identifies issues that need to be addressed system-wide, such as utilization concerns, it forwards the issue to our CQI Workgroup to develop a solution. Analyses that indicate potential fraud, waste and abuse (FWA) are forwarded to our SIU for investigation.

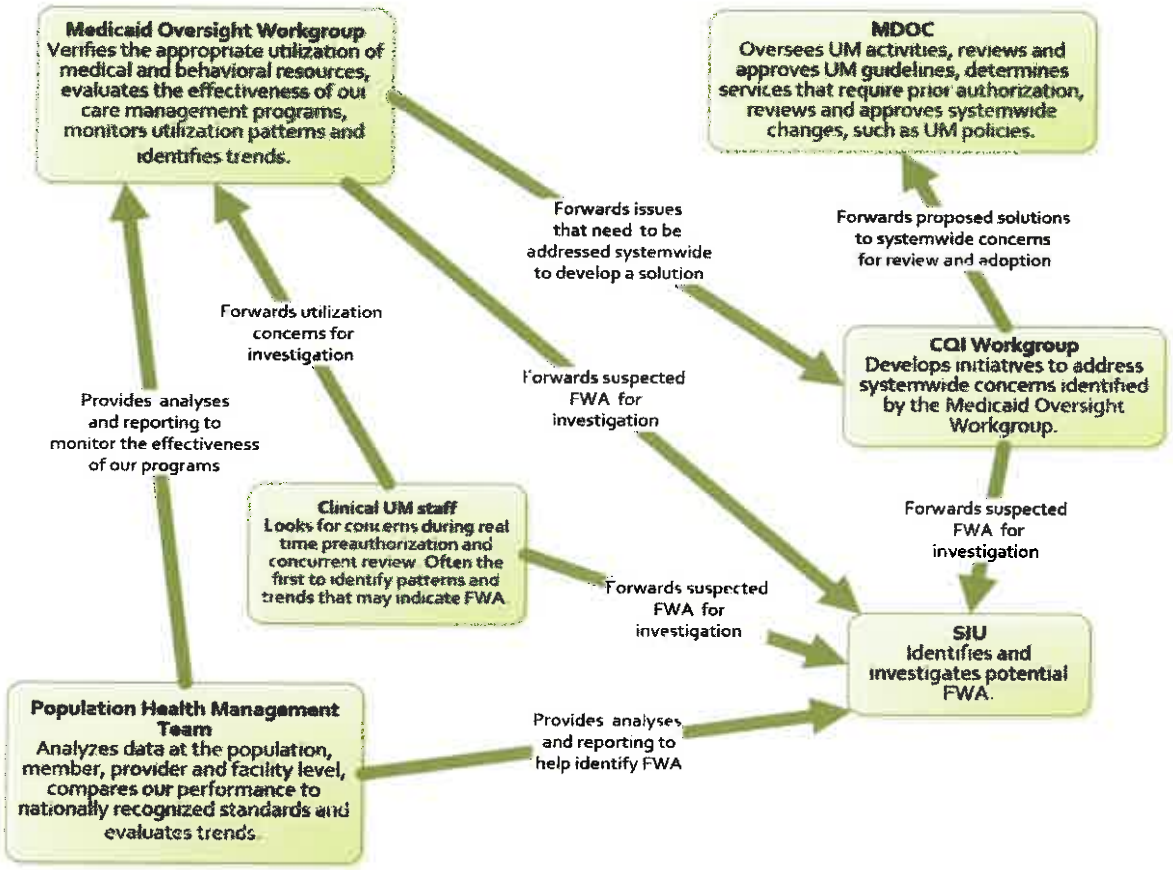


Figure 6: Utilization and FWA Monitoring Oversight. Our population health management team, Medicaid Oversight Workgroup, CQI Workgroup and SIU collaborate to verify we are delivering positive outcomes in terms of member experience, outcomes and quality of life and the quality and cost of care and identify and correct instances of FWA. Our MDOC reviews recommended system-wide changes developed by the CQI Workgroup.

Our population health management team continually analyzes data at the population, member, provider and facility level, compares our performance to nationally recognized standards (e.g., HEDIS, CMS) and evaluates trends, such as increasing use of the ER or inpatient utilization. The team monitors and trends rates of preventive care services, including cancer screenings, immunizations and well visits, to ensure individuals are receiving the appropriate evidence-based care. It also monitors evidence-based services related to disease specific care, such as statin therapy for cardiovascular disease and diabetes, medication management for people with asthma and adherence to effectiveness of care in people with severe and persistent mental illness.

Identification of outlier activity related to over- and under- utilization and non-adherence to evidence-based practice is reviewed at the Medicaid Oversight Workgroup where referral to SIU may be indicated, provider education may be suggested or further review at the Medical Directors Oversight Committee to understand the patterns of care may be recommended.

We use the analyses to identify each member's level of health risk and to analyze trends at the population level. We complete reviews on member-specific trends regarding ER usage, seeking care from multiple providers across geographic areas and any patterns of care that are concerning. These analyses help us identify members who may benefit from care management and helps to develop member interventions to address member needs across the state. Any outlier activity will be discussed with a medical director or shared with the quality department or reported to the SIU as suspicious.

Medicaid Oversight Workgroup. Population health analyses are reviewed by our Medicaid Oversight Workgroup to follow trends across the state and determine if further drill down, investigation or corrective action is needed based on patterns of care. The Workgroup verifies the appropriate utilization of medical and behavioral resources in the amount, duration and scope necessary to achieve desired enrollee health outcomes, evaluates the effectiveness of our care management programs, monitors utilization patterns and identifies trends and provides actionable information about our members to our care teams and providers. When utilization concerns are identified by the Medicaid Oversight Workgroup, it forwards the concern to our CQI Workgroup. Analyses that indicate potential FWA are forwarded to our SIU for investigation.

Oversight Workgroup, it forwards the concern to our CQI Workgroup. Analyses that indicate potential FWA are forwarded to our SIU for investigation.

CQI Workgroup. The CQI Workgroup, which is chaired by a representative from the quality management department, includes THP staff representing every department to promote collaborative initiatives that improve care delivery for members. Representation from each department provides a multidisciplinary approach from clinical, non-clinical and operational areas to promote problem identification and problem-solving and oversight of our health plan operations. Analyses that indicate potential FWA are forwarded to our SIU for investigation.

Utilization patterns are discussed at the program level and proposals to modify the UM program may be researched, developed and sent back MDOC via a policy amendment, workflow or guideline change for implementation in clinical service practices. Examples would be additions or deletions to our list of services that require preauthorization based upon UM analysis, focused review of providers with demonstration of care provision outside standard measures requiring new targeted guideline or changes in clinical review practices like the 2018 addition of medical review for all 30-day readmissions to determine if they were clinically related or preventable. Provider notification and education related to any UM change impacting providers is made 30 days in advance of change as required by contract.

SIU. THP maintains an SIU to uphold its commitment to prevent, detect and correct issues that could lead to FWA. The SIU works with BMS, the Medicaid Fraud Control Unit (MFCU), the Office of Inspector General (OIG) and CMS to administer effective FWA detection and prevention practices. The SIU participates in coordination activities

with the State to maximize resources for FWA issues, meets regularly and as requested with BMS and the MFCU and attends FWA training sessions scheduled by the State. THP's SIU stands ready to assist its state and federal partners in identifying, investigating or prosecuting healthcare FWA. The SIU routinely executes various data mining initiatives.

Tools and Reports to Monitor and Manage Service Utilization (BA009)

Our population health management team uses a variety of advanced data analytics tools to produce reports, dashboards and scorecards that help our Medicaid Oversight Workgroup, CQI Workgroup and SIU evaluate our performance, including monitoring utilization patterns for FWA. They include:

- ***Impact Pro*** integrates data from our initial HRA, SDOH and other assessments, medical behavioral claims, pharmacy data from the Department of Health and Human Resources (DHHR) or internal PBM if carved back in, lab results, consumer data and publicly available data. Impact Pro then analyzes variables at the member- and population-level to stratify members into care management levels in alignment with their health risk and identify population trends and member sub-populations within the larger member population so we can deliver interventions relevant to our members.
- ***STARSSolutions*** offers provider, pharmacy and member alerts, identifying outliers related to prescription and medical utilization. It is a powerful tool for identifying potential fraud, waste and abuse.
- ***Cotiviti*** allows us to collect HEDIS data through electronic means, such as claims data and lab values, and supplemental data, such as blood pressure readings and cervical cancer screenings, and analyze our performance against HEDIS measures. Underperforming HEDIS measures indicates underutilization of HEDIS preventive services.
- ***CCGroup Marketbasket*** analytical software provides reports related to prevalence of medical conditions and the utilization patterns of services used to treat these conditions, and builds practice pattern variation reports based on providers of the services. Identifies outlier activity in both utilization of services and quality of care reports.

Impact Pro

We evaluate our member population using Impact Pro, our data analytics tool, to integrate data from our initial HRA, SDOH and other assessments, medical behavioral

claims, pharmacy data from DHHR, lab results, consumer data and publicly available data from sources, such as the U.S. Census Bureau, County Health Rankings and Roadmaps, data from DHHR such as diabetes prevalence in West Virginia, the CDC and the Food Research & Action Center.

Impact Pro then analyzes variables at the member- and population-level, such as gender, age, future inpatient risk, prior year total cost of care spending, acute inpatient admissions, ER visits, pharmacy, behavioral conditions, total chronic conditions, acute social determinants and more than 300 clinical rules to identify utilization trends. Some examples of Impact Pro's analyses include identifying:

- Members who have atypical utilization patterns, such as a member with bipolar disorder with no regular behavioral health visits as indicated by claims.
- ER use without associated primary care follow-up.
- Members who have a history of ER use, repeat hospital admissions, high utilization of medical outpatient services, potential quality-of-care issues or an indication of multiple providers of services that appear to lack coordination.
- Members who have gaps in evidence-based care.
- Each member's "future risk score" that represents the degree to which care management has the opportunity to have an impact on the member's health status and clinical outcomes.
- Indications of multiple providers of services or the delivery of services that appear to lack coordination, such as high utilization of outpatient services, lack of medication adherence, potential medication interactions and potential quality-of-care issues or aberrant practice patterns.
- Compliance with a standard set of nationally recognized metrics, such as 7-day readmission rate, the risk-adjusted 30-day readmission rate, follow up after behavioral health hospitalization, the case-adjusted average length of stay and spending per member.

Some additional reporting reviewed for utilization trends include: Adults who have congestive heart failure (CHF), which monitors utilization for members age 40-60 who have CHF

- Children with asthma, which monitors utilization for members age 0-20 who have asthma
- All-cause readmissions
- Low back imaging
- Prenatal and post-partum care
- Suspicious services/claims when considered in light of the member's history, diagnosis or demographics, which could indicate potential fraud
- Providers with suspiciously high utilization of certain codes, such as every member that walks through the door gets a certain test or a certain diagnosis, which could indicate potential fraud, waste or abuse
- Excessive tests or other procedures, which could indicate potential abuse or waste

These are examples of targeted population health reporting that we review for adherence to evidence-based practices to support identification of overutilization and underutilization, used to drive member outreach and provider education. For example, if we see a child with asthma has not obtained a refill for his/her medication, we can perform outreach to understand what barriers were encountered to keep them from getting the refill. By drilling into readmission data, we trend patterns of care related to appropriate discharge planning and ensure that the post-discharge care and any socially necessary services were received. If not, additional follow-up

Peer Recovery Support Specialist Services (H0038) is a new Substance Use Disorder Waiver service put into place by DHHR in 2018 and turned over to the MCOs for management in July 2019. In August, THP reviewed the initial data on the use of this service. It became evident that three providers were filing claims for far more units of service than other providers.

We conducted an onsite chart review for one provider, and determined that the provider did not understand the correct boundaries for the service. The provider was given feedback after a discussion with the program manager for the service at BMS.

THP collaborated with BMS to form a workgroup to clarify the instructions and guidance given to providers using and billing for peer recovery support services to provide consistency in interpretation of the manual guidelines among all three MCOs. The MCOs and BMS' utilization management vendor, KEPRO, were present at the first meeting at BMS in October and the workgroup continues to meet to clarify the boundaries of the service and to develop a uniform documentation format so that provider education can be expanded by spring 2020.

with outreach to the member, community resources, and provider help us understand what barriers were encountered to prevent the services from being completed. Any suspected instances of fraud, waste or abuse are referred to the SIU.

Practice patterns variation reports. THP uses advanced data analytics to identify variation in practice patterns and provides detailed specialty specific peer-to-peer trends related to cost, utilization and quality of care, giving us insight into over and under utilization of services. Overall trends are reviewed by the Medicaid Oversight Workgroup, Network and Provider Services, and the MDOC, as this report provides us with data based on adherence to best practices, tracks practice-level improvements and gives us an opportunity to partner with providers to implement initiatives that improve the quality of care and service provided to members. Care that fails to meet professionally recognized standards or services that are medically unnecessary are elements of abuse, so suspect cases are referred to the SIU.

Identifying Overutilization of the Crisis Stabilization Unit

We monitor the utilization of crisis stabilization services, including H0036, Crisis Stabilization Unit. This service provides urgent care for members with psychiatric concerns, and is typically billed in 15 minute units up to a maximum of 48 units per day, and does not include room and board. While reviewing the utilization of this code, clinical staff discovered that one provider was using it at a much higher rate than others. THP presented the de-identified data to BMS and to the West Virginia Behavioral Healthcare Providers Association for review and comment. Ultimately, utilization management amendments were made to enable closer monitoring of use of units per day by providers by authorizing in units of 15 minutes (which is how the provider is typically paid) rather than days. Other utilization management procedures were also adopted, all with proper provider notification and webinar trainings. This has been in place since Nov. 1, 2019. These refined procedures ensure more appropriate utilization, thereby reducing the likelihood of fraud, waste or abuse.

STARSSolutions

We use STARSSolutions, a data analytics software program that offers provider alerts, to identify top scoring providers across numerous schemes and pharmacy and member alerts, identifying outliers related to prescription utilization. STARSSolutions is a powerful tool for identifying potential fraud, waste and abuse, identifying claims

containing potentially falsified procedure codes, services not rendered, upcoding, overutilization and other common fraud tactics. Using STARSSolutions, over 100 data mining reports are created each month. We discuss the STARSSolutions reporting we use to detect FWA in our response to **BA008** and **BA010**.

Cotiviti

We use Cotiviti, an NCQA-certified HEDIS analytics tool, to gather, trend and report our HEDIS data. Cotiviti allows us to collect HEDIS-related data through electronic means, such as claims data and lab values, and supplemental data, such as blood pressure readings and cervical cancer screenings, which we obtain through medical record reviews performed by THP registered nurses and load into the Cotiviti software. We also gather supplemental data from West Virginia and Ohio state immunization registries, and lab data submitted electronically from our lab providers. The information we enter into Cotiviti is validated by an NCQA-certified HEDIS auditor to confirm the validity of the data gathered and the processes we use to collect the data.

We will track the measures in the 2020 PMV Report and incorporate the 2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) into our QM activities. While these reports are key to our ongoing accreditation process, we also share "gap in care" reports with providers to ensure our members are receiving the appropriate evidence-based services. By incorporating the 2020 PMV measures established by the EQRO in this process, we confirm our MHT members are receiving care identified by all relevant key performance indicators.

Ongoing Monitoring of ER Utilization (BA007)

Using the tools and reporting discussed in the previous section, we monitor inappropriate utilization of ER services. This analysis includes identifying:

- Members with atypical utilization patterns, such as ER use without associated primary care follow-up or high utilization of ER services.
- Members with high year-to-year healthcare spend and unnecessary or inappropriate use of the ER.
- Hospitals with the propensity to admit members from their ER to observation or inpatient level of care compared to peer hospitals in West Virginia, the region and nationally. We share this data with hospital partners to discuss opportunities to reduce unnecessary, costly care. If intentional non-compliance with proper care and/or billing practices is suspected, a referral is made to the SIU.

We have implemented a specific ER policy and review queue that is worked by an experienced claims team, RN supervisors and THP medical directors. The team reviews all level 4 and 5 ER visits for medical necessity/intensity of service billed. Codes 99284 and 99285 that are unsupported are paid at a lower, more appropriate level and facilities are educated about appropriate billing for ER services. Only a medical director can deny high level for intensity of service.

We also integrate admission, discharge and transfer (ADT) alerts from the WVHIN and provider systems, such as WVU Medicine's EHR, Epic system. This integration will automatically notify our care team about members experiencing an inpatient admission or discharge and members using the ER through an alert in our care management system. Once alerted, our care management system provides our care team tools to manage care setting transitions, such as workflows that prompt for member follow-up to address the causes of the member's inappropriate ER use, such as providing education about the appropriate use of the ER or arranging transportation to follow up PCP appointments.

We will provide all members with alternatives to the ER through Teladoc, a telehealth solution that provides free 24/7 member access to medical and behavioral health care via phone, video or app. Teladoc physicians are board-certified and state-licensed with an average of 25 years of practice.

For a member in care management, multiple or inappropriate use of the ER will prompt the care manager to engage the member to coordinate behavioral health and medical follow-up care, reassess the member's needs and update his/her treatment plan, if needed. For a member who is not enrolled in care management, multiple or inappropriate use of the ER will prompt a member advocate on our member outreach team to engage the member and resolve any concerns that led to their ER use, educate them about the appropriate use of the ER to help reduce waste, and how to access ER alternatives. Our clinical services team will also evaluate the member's health risk and needs to determine if they may benefit from care management.

Process for Preventing and Detecting Fraud and Abuse, including Pharmacy and Controlled Prescription Medications (BA008-BA010)

We have been a partner to the state on payment integrity and detecting potential fraud and abuse. Trina Crowder, Program Integrity Lead, has advised BMS on strengthening managed care program integrity efforts. She has implemented a variety of initiatives that focus on and improve our efforts to promote the integrity of the Medicaid program. They include:

> Each month, member advocates on our member outreach team call 90 members who have claims for services in the previous month. The member advocates contact these members to verify the services were rendered. If the service was not rendered, the outreach team makes a referral to our SIU.

- ***Developing a provider self-audit process*** that increases the impact of our SIU. If we have a provider who has received an overpayment, but the overpayment was not intentional and the case does not require a FWA referral to BMS, we may allow the provider to perform a proactive self-audit as part of their own efforts to confirm payment integrity. Self-audits are often preferred by providers because they are reviewing their own records versus having SIU staff or government regulators on-site conducting an in-depth review. Additionally, a self-audit process is generally educational for the provider and their billing staff, resulting in a greater likelihood of future compliance. A self-audit notification

includes the purpose of the review and a reminder that any overpayments made under federal health insurance programs must be recovered. The audit results are reviewed by the SIU, and follow up may include claims and documentation review, interviews with the provider or staff and other relevant investigative activities. The provider is further notified that acceptance of the audit or repayment does not necessarily constitute agreement with the audit results or overpayment amount, if it is later discovered that the self-audit results contained material misrepresentations or that supporting documentation or other relevant information was altered.

- ***Establishing a multi-MCO workgroup*** that provides a forum for each MCO's SIU to discuss trends, common bad actors, best practices and solutions to protect the integrity of the Medicaid program. Ms. Crowder facilitated the first workgroup meeting, attended by SIU/program integrity (PI) staff from THP and the other two MHT MCOs on Dec. 5, 2019.

Trina Crowder, in her role as the Fraud and Program Integrity subject matter expert at Lewin Group, advised BMS on strengthening managed care program integrity efforts. She was instrumental in developing the Finders Keepers program, which incentivizes MCOs to be more aggressive in their program integrity efforts since they keep any provider overpayments they identify, if certain contractual conditions are met.

- ***Training and certifying our SIU staff***. All our tenured SIU staff members are Certified Medical Coders to help them identify fraud, waste and abuse. New hires must obtain this certification within six months of hire date. This credential elevates our credibility and provides additional expertise to perform chart reviews to determine if the chart notes support a provider's level of billing.
- ***Training and certifying our provider engagement representatives.*** Eleven of our 13 provider engagement representatives are Certified Medical Coders. The CMC training and designation enhances our staff's ability to deliver appropriate training to providers. The SIU often partners with provider engagement staff to prevent and detect FWA. Provider education deters wasteful or abusive billing practices.
- ***Conducting provider awareness and outreach related to the SIU.*** We educated providers about the SIU in our Q4 2019 provider newsletter, Provider Focus through an article that describes how Medicaid and Medicare guidelines require us to perform payment integrity efforts. The article also described what our SIU does to detect, prevent and correct possible FWA. Additionally, network providers are educated about FWA and how to report it via information posted on the provider portal and through the Provider Manual.
- ***SIU-initiated provider onsite visits.*** Our SIU conducts provider site visits in instances where the allegation or evidence indicates a visit would be beneficial to the investigation.
- ***Revamping record requests*** to more clearly specify that our provider contracts require providers to respond to such requests. This has resulted in faster turn-around times and fewer delays in obtaining the records. If the records are not received timely, the investigator visits the provider. To reduce provider abrasion

related to records requests, we have educated providers that record requests help us confirm providers are being adequately and fairly compensated and appropriate services are being delivered to our members.

Detecting and Preventing Fraud and Abuse

THP maintains a Compliance/FWA Plan that demonstrates a commitment to the prevention, detection and correction of potential fraud, abuse or erroneous billings. The plan includes policies and procedures that confirm compliance with laws and regulations. Employees regularly participate in related training to ensure they understand how to recognize and report suspicious activity.

Identifying Claims Fraud

A provider submitted claims that were denied because the provider was not properly enrolled with the State. The claim was later resubmitted along with documentation indicating a different provider had rendered the services. Due to the questionable circumstances, the claims analyst referred the case to the SIU. The SIU investigation revealed a number of submitted claims attributed to a non-enrolled provider that were denied and subsequently resubmitted indicating a different rendering provider. The investigation also revealed altered medical records to support the false claims. As required, the case was referred to BMS.

Detecting Fraud and Abuse

Our claims department uses editing software to identify improperly billed or coded claims. Edits are in place to identify duplicate claims and high dollar claims are manually reviewed and released by a department manager. Edits also limit circumstances under which claims will be paid to prevent payment for inappropriate claims. For example, we use system edits for podiatry claims. Nail debridement will only be paid if the claim includes certain, specific diagnosis codes. If a provider consistently bills for nail debridement without the proper diagnosis codes, the claims analyst will make a referral to the SIU.

As another example, for new patient evaluation and management (E/M) claims, our software scans member history to determine if that patient has received any professional services, E/M services, or other face-to-face services from the same

physician or physician group practice with the previous three years. If they have, the new patient E/M code is denied because the visit should be billed as an established patient, which pays less.

Detecting and Addressing a Variance in E/M Coding

Our SIU team reviews system-generated reports that identify providers who are outliers for E/M coding. One provider was identified as an outlier for high-level E/M codes, with 95% of his established patient visits billed at the highest code (99215) and 100% of his new patients billed at the highest code (99205). At the SIU's request, provider engagement staff delivered education to the provider regarding the proper billing of E/M codes. Further investigation revealed the provider continued to bill in a similar manner, despite the previous education. This provider is currently under investigation by MFCU.

In addition to claims editing software, we use STARSSolutions, a powerful tool for identifying potential fraud, waste and abuse, identifying claims containing potentially falsified procedure codes, services not rendered, upcoding, overutilization and other common fraud tactics. Using STARSSolutions, we create more than 100 monthly data mining reports to identify inappropriate utilization and potential FWA. Our SIU runs multiple reports monthly to identify outliers in specific high-risk areas.

For example, to detect inappropriate utilization of potential FWA controlled prescription medications, the SIU analyzes STARSSolutions reports, such as:

- Controlled Substance Report identifying utilization of 22 controlled substances with high abuse potential
- Prescriber Report by Percentage identifying top providers ranked by the percentage of their total prescriptions that are controlled
- Prescriber Report by Volume identifying top providers ranked by the total volume of controlled prescriptions

Preventing Fraud and Abuse

The SIU examines reported incidents of suspicious activity from all sources and provides a telephone tip line, a dedicated email address (SIU@healthplan.org), and a website portal to facilitate receipt of referrals. Investigations may be initiated based on complaints or referrals from internal or external sources, alerts from government

agencies or law enforcement, or due to the SIU's proactive efforts such as data mining or routine claims monitoring. Referral sources include:

- Our Medicaid Oversight Workgroup, CQI Workgroup, THP staff, including UM clinical staff, provider engagement, claims reviewers, customer service, quality management and grievance and appeals.
- Members/beneficiaries, who may report of their own volition or in response to our member service verification efforts, notices included with EOMBs, or reminders posted in our member newsletter and on our website.
- BMS, CMS, NBI MEDIC, HHS-OIG, law enforcement and the media.

Collaboration with BMS to Address FWA

Our entire SIU team is located in West Virginia and enthusiastically participates in all program integrity related endeavors undertaken by the State. The SIU meets regularly with members of BMS to discuss fraud schemes, exchange ideas, discuss best practices and identify training topics. This trusted relationship allows for the free exchange of ideas, challenges and solutions. BMS is frequently complimentary of THP's SIU work and presentations, and has used THP's efforts as an example of best practices to share with the other MCOs. The SIU works cooperatively with BMS and MFCU.

The SIU's fraud analytics specialist conducts in-depth data analysis to vet the allegation and inform decision making as to case status. As the case progresses, the SIU uses their considerable experience and expertise to gather evidence and move the investigation forward. The fraud analytics specialist reviews each of these data mining reports and results, and conducts further data analysis and preliminary investigative activities as warranted. If those efforts support the likelihood of suspicious activity, a full investigation commences. Specific data mining reports include:

- ***Change in Diagnosis Code after Denial:*** identifies claims resubmitted with a different diagnosis after initial denial.
- ***Top Prescribing Rx for All Specialties:*** identifies the top at risk prescribing providers across all schemes for the selected time period.
- ***Top Paid Providers/Facilities:*** identifies the top paid providers and facilities.
- ***Top Controlled Substance Providers:*** identifies top controlled substance prescribers for the selected time period.
- ***Top Facility Risk Score:*** identifies the top suspected facilities that scored across all schemes for the selected time period.
- ***Top Provider Risk Score:*** identifies the top suspected providers who scored across all schemes for the selected time period.

- ***Controlled Substance Report:*** identifies spikes in utilization for one of the 22 drugs reviewed. Data are further analyzed to see if the spike relates to a specific prescriber.

In addition to data analysis, investigative activities may include review of prior cases, legal research, background research, interviews, site visits, review of contracts, medical records, provider or member correspondence or other documentary evidence, consultation with other subject matter experts, regulators or licensing boards, and other actions as necessary to complete a thorough investigation. Cases are reviewed regularly by the Program Integrity Lead.

Referring Suspected Fraud Cases

It is the policy of the SIU to refer all suspected fraud cases to the appropriate regulatory or law enforcement authority. For Medicaid specifically, when the SIU identifies that FWA may have occurred, the case is immediately referred to BMS following the completion of ordinary due diligence. Ms. Crowder, Program Integrity Lead, has an excellent working relationship with BMS and MFCU and is in frequent communication with BMS regarding any ongoing investigations related to Medicaid. When warranted, the Medicaid Fraud Referral Form is completed and delivered to BMS, along with a detailed report of investigation, claims data, documentary evidence, and all other relevant information obtained by the SIU. In conjunction with the referral, the SIU may also meet with BMS and or the MFCU to further discuss the case.

Criteria for referring suspected FWA cases to BMS include:

- Determination that the provider suspect is enrolled/credentialed for the Medicaid line of business or has some other means by which to impact Medicaid expenditures
- Determination that the member/beneficiary suspect is a Medicaid member or has some other means by which to impact Medicaid expenditures
- Identification of other parties involved that may impact Medicaid expenditures

- The SIU has completed its due diligence that may encompass a full investigation including interviews, record reviews, data analysis, legal and regulatory research, contact with licensing or other authorities, provider site visit, consultation with clinicians or other subject matter experts, and other necessary investigative activity
- The investigation reveals indicators that fraud, waste or abuse may have occurred
- The investigation has been reviewed and approved by the Program Integrity Lead

Pursuant to the contract, if BMS accepts the case for State investigation, the SIU may not engage in investigation efforts other than coordination efforts with the State without first deconflicting with BMS and MFCU. BMS will supply notice of the case acceptance status no later than the 10th business day after referral. The SIU may proceed with the investigation or payment recovery efforts if BMS so authorizes. Notification that MFCU does not accept the referral is deemed authorization for the SIU to proceed with the case. If the SIU has not received a response from BMS after three requests or within 45 calendar days of submission of referral, the SIU may proceed with its investigation up to and including recoveries.

The SIU follows the deconfliction protocol created by the State. The SIU may request to pursue other investigative or recovery action related to a provider who is the target of a MFCU investigation by submitting the required information and deconfliction request to BMS and MFCU. In May 2019, subsequent to a multimillion dollar civil settlement obtained by the MFCU and the USAO, the SIU identified additional overpayments based on the same scheme that occurred outside the time frame covered in the settlement. In adherence to the deconfliction protocol, the SIU obtained permission from the State to pursue over $31,000 in additional recoveries.

Other Investigative Outcomes

In addition to referral to BMS, other investigative outcomes may include:

- Claims monitoring
- Provider education
- Pre-payment review
- Referral to other THP departments such as quality management or credentialing
- Recovery of overpayments, upon appropriate deconfliction
- Payment suspension in accordance with the Code of Federal Regulations and the Service Provider Agreement
- Provider termination or non-renewal
- Referral to licensing boards
- Referral to other regulatory authorities
- Referral for civil litigation
- Referral to law enforcement for criminal prosecution

All investigative outcomes related to Medicaid cases are reported to BMS on the FWA Monthly Report and are deconflicted with the State as necessary.

In addition to case-specific investigative outcomes, certain cases may also result in the development and implementation of new data mining queries to detect similar schemes across other providers. If a provider appears on a spike report, the SIU will monitor the claims for a period of time to determine if the provider continues to be an outlier. Once a pattern is established, the case moves to the preliminary investigation stage, and then on to full investigation if warranted.

If provider education is used, the education is documented in the SIU's case file and the SIU follows up within a set period of time to review the billing patterns again to determine if the education had the intended effect. If suspicious billing is identified, the investigation resumes.

RFI Requests
In the past two years the SIU has responded to over 400 requests for information (RFIs) from the State consistently meeting tight deadlines, including urgent requests that required even shorter than usual turn-around times. Our average turnaround time in 2019 was less than 4 days, well under the contractually required 14 day response time.

Recovery of Medicaid overpayments is pursued if a case does not require referral to BMS and if the requirements of the BMS contract are met. Pursuant to that contract, THP is permitted to recover Medicaid overpayments from providers if:

- The MCO was not required to abstain from collections due to a MFCU or other law enforcement investigation
- BMS has not duplicated the recovery
- The MCO followed proper procedures regarding fraud and/or abuse referrals to BMS
- The MCO properly and timely disclosed the required information on its monthly FWA report
- The encounter data are properly adjusted to reflect the recovery
- Such recovery is not prohibited by state or federal law

Reporting to BMS

THP submits FWA-related reports to BMS as follows:

- ***FWA Report and Recovery of all Overpayments Report (Monthly, by the 15th):*** This report documents all program integrity activities related to the Medicaid line of business, including any suspected fraud, waste or abuse identified during the prior month. The report includes all program integrity activities initiated or completed, the target and value of these activities and the related outcomes; all referrals made to BMS, MFCU, and/or licensing boards; all overpayments identified, including those unrelated to program integrity (i.e., administrative overpayments); and all overpayments recovered, including those unrelated to program integrity.
- ***Suspension and Adverse Enrollment Action (Monthly, by the 15th):*** This monthly report conveys information to BMS related to any healthcare professional, institutional provider, or supplier that has been the subject of program integrity actions related to enrollment/credentialing such as denied credentialing, suspension, termination, corrective action plans (CAPs), fines or sanctions due to concerns about provider fraud, integrity or quality deficiencies. Providers not renewed due to program integrity concerns are also reported here.
- ***Activities Summary, Analyses and Results of Provider/Beneficiary Utilization to Detect FWA (Annually, by June 15):*** This annual report analyzes and summarizes THP's efforts in monitoring provider fraud for underutilization of services and beneficiary and provider fraud for overutilization of services. This includes, but is not limited to, upcoding, unbundling, services not rendered, unqualified providers and medically unnecessary services. Additionally, beneficiary claims are monitored for overutilization of services such as inappropriate emergency care and card-sharing.

- ***Compliance/FWA Plan (Annually, by Oct. 1):*** The Compliance/FWA Plan includes THP's policies and procedures to prevent, detect, investigate and report potential FWA. Additionally, the Plan addresses the requirements and obligations set forth by CMS and other applicable laws and regulations.

Identifying Pharmacy Fraud, Abuse or Inappropriate Utilization

THP employs in-house pharmacy personnel including but not limited to pharmacy data analyst, pharmacy technicians and pharmacists to monitor pharmacies submitting suspicious claims as well as members exhibiting suspicious narcotic prescription patterns. Members exhibiting suspicious behavior such as visiting multiple prescribers, multiple pharmacies or filling troublesome medication combinations may be locked in to only one pharmacy for their controlled substance prescriptions. A strict screening is run to ensure only members appropriate for pharmacy lock-in are enrolled into the program. The lock-in program is overseen by a pharmacist.

To review suspicious high cost claims and inappropriate compound prescribing, THP reviews daily high cost claim reports published by THP's IT department from PBM daily claims files. Upon review and investigation and when warranted, pharmacies billing suspicious claims or compounds may be barred from billing THP or a referral may be made to the appropriate regulatory bodies or law enforcement entities. The daily monitoring of this report helps THP stay ahead of inappropriate prescribing patterns such as patients living in different states as their prescriber and pharmacy. In addition, THP also uses counter strategy drug lists to identify drugs with no evidence of FDA approval or therapeutic advantage over other products already recommended for coverage. An example of counter strategy drugs include Livixil Pak, a significantly high-cost drug with minimal clinical utility. Monitoring of inappropriate drug utilization is a

multifaceted approach that leverages pharmacy platform benefit design, drug lists, reporting and management.

In the event DHHR carves pharmacy services into a future contract, our PBM claims engine and network provider, Express Scripts Inc. (ESI) also has established policies and procedures to detect pharmacy fraud, abuse or inappropriate utilization. Our PBM's SIU team investigates fraud related to network pharmacies. Our PBM proactively identifies suspicious activity, monitors CMS alerts, Medic Risk Assessments, media tips and fraud tips. In addition to data mining activities using a proprietary predictive modeling tool, our PBM conducts:

- Member verifications to confirm the member received the medication
- Prescriber verifications to confirm the prescriber ordered the medication
- Purchase verifications to confirm the pharmacy had sufficient inventory to justify the claim volume

Our PBM conducts a number of audit programs to confirm accurate submission and payment. They implement a collaborative approach that emphasizes the education of network pharmacies in proper claims submission procedures. Their automated predictive model review process aids in the detection of high-risk claims, followed by additional review by network auditors. Our PBM's desk audit program completes an automated review, using a large number of outlier indicators, of all claims submitted by network pharmacies the previous day. The historical audit program is an ongoing retrospective review of claims, in addition to the daily claims selected during the desk audit.

Our PBM's on-site audits include in-person reviews of prescription claims and operating practices to evaluate a pharmacy's compliance with federal regulations, pharmacy

practice and our PBM's provider manual. Our PBM selects pharmacies for on-site audits based on various criteria that may include findings from desk or historical audits, reliable tips or selection via our PBM's proprietary audit selection tool. Claim components verified through the audit process include:

- Compliance with all applicable laws
- Adherence to our PBM's Pharmacy Provider Agreement, and the Pharmacy Provider Manual
- Compliance with specific benefit parameters
- Claims submissions in accordance with prescriber guidelines and documentation, dispensed as written code usage
- Refill authorizations, proper quantities dispensed and pricing used, compounds and specialty claims

Investigating potential pharmacy abuse. Our PBM's SIU also conducts both desk and on-site investigations that include reviews of prescriptions, delivery records, quality assurance and other relevant documentation, and employee interviews. Our PBM maintains an exclusive contractual relationship with a pharmacy under investigation, and uses its many investigative tools allowed via the contract in tandem with all applicable federal or state laws, rules and regulations. Substantiated improper conduct is referred to the appropriate authorities and to the Pharmacy Disciplinary Action Committee for potential discipline up to and including termination.

BA011. 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:

BA014. 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.

BA015. The Vendor should describe its process for how condition-specific protocols and conditions will be updated and shared with primary and specialty care providers.

Our UM RNs and medical directors use our standard UM guidelines and processes to determine the medical necessity of a service request. However, we recognize

individuals with special healthcare needs may require treatments that are not available as a covered benefit. We empower our clinical reviewers to evaluate the whole member and use their clinical experience and expertise when evaluating service requests for all our members, including members with special healthcare needs. Our UM RNs refer these cases to a THP medical director for medical necessity review and determination when there are medical service limitations or prescription limits are imposed to make a medical necessity decision on a case-by-case basis, looking at all available information to make an informed decision.

One of the ways we do this is through our "grand rounds" process. During grand rounds, our interdisciplinary team of medical directors, pharmacists, nurses and operations staff reviews the member's case. Each of these team members brings a unique viewpoint to the member's needs, such as a deep understanding of pharmacy issues and available behavioral services or approaches. The interdisciplinary care team (ICT) discusses chronic conditions, developmental challenges, emotional and behavioral issues, pharmacy utilization and any special considerations unique to the member. The ICT also discusses care opportunities, goals and interventions for inclusion on the member's treatment plan.

We include the PCP in the process through peer-to-peer discussions with our medical directors and pharmacist to discuss treatment options presented during grand rounds. Through the grand rounds and peer-to-peer processes, we may decide to exceed the state's benefit when the services requested are supported by a PCP order, coordinated by a PCP through a specialist and are specifically requested to correct or ameliorate a condition or disability that may allow, or support age appropriate or developmental

capabilities may be allowable over and above specified benefit limits or allowable when not a covered benefit.

Modifying Standard Protocols

We modify standard UM protocols for children with special healthcare needs (CSHCN), when EPSDT requests are identified or when we determine that a service is in the member's best medical interest. For example we approved:

- An automatic external defibrillator (AED) from an out-of-network provider for a child who has complex needs. The AED is not a covered benefit, but we determined it was in the member's best medical interest because an implantable cardiac defibrillator was contraindicated due to his age and the potential for post-op complications and the spastic movement of his lower extremities would likely cause inappropriate shocks.
- A power wheelchair for a pediatric Medicaid member under EPSDT that lowers to the floor to provide independent transferring and raising to standing level (allowing for eye-to-eye contact for peer interaction) and has special traction wheels that allow for playground transition. This is a device that is not covered by West Virginia Medicaid. THP approved the chair due to supportive information that demonstrated the functional independence and age-appropriate peer interaction the chair would provide despite not meeting standard THP CMS durable medical equipment (DME) criteria.
- A non-covered continuous glucose monitor (CGM) for a member with uncontrolled type 2 diabetes. Our member had been treated with oral medications and insulin; however the member's A1C remained uncontrolled. His endocrinologist then started our member on an insulin pump. However, our member struggled with the pump and his A1C never went under 10. His endocrinologist switched our member to Omnipod, but he continued to experience hypoglycemia and uncontrolled blood sugars. His endocrinologist then switched him to Dexcom CGM, which is not covered according to BMS' policy, and the CGM was denied. On appeal, we conducted a literature review and cost studies and formalized coverage of this device and related DME. Coverage is based upon medical necessity due to the member's poor awareness of vast fluctuations in blood sugars and inability to safely achieve control of his blood sugars by standard self-testing. Our research demonstrated that plan cost and member outcomes were better when these high-risk members were able to

> Upon reviewing this case, our DME Committee recommended to our MDOC that we revise our DME policy to allow coverage for CGMs for all Medicaid beneficiaries meeting medical necessity. The MDOC approved the change and our EMT finalized the new DME criteria. We notified our provider network of the DME policy changes.

use continuous glucose monitoring. We modified our CGM policy to allow coverage for all Medicaid members meeting medical necessity for the device thereby reducing ER visits and admissions for hypoglycemia and diabetic ketoacidosis (DKA).

BA012. Standing referrals

Standing referrals can be approved by a UM RN when conducting preauthorization for a service request made by a provider. Additionally, we enroll all members with special healthcare needs (individuals with complex or serious medical conditions) in care management and assign a care manager who will manage their care, including managing their standing referrals. During the development of the member's treatment plan, the member's care manager identifies members who may need a course of treatment or regular care monitoring. The care manager identifies the member's services and supports and coordinates the delivery of those services and supports with the providers delivering them. This includes identifying, documenting and authorizing, if required, standing referrals for members who may need a course of treatment or regular care monitoring as directed by their PCP or SCP through a tertiary or non-participating provider.

For instance, we coordinate care for members with cancer through development of a treatment plan that specifies chemotherapy at set intervals and a plan for specialist visits, labs draws and PET scans. The treatment plan includes standing referrals with oncologists, tertiary facilities and PCPs to confirm care is easily accessed and smoothly delivered so members and their families focus strictly on care and recovery and providers can focus on delivering care rather than service authorizations and referrals.

BA013. Expedited utilization review processes

Our expedited prior authorization process complies with the requirements in Article III, Section 5.4, Service Authorization (Prior Authorization) in the Service Provider Agreement, including resolving the request within two business days of receipt. Once the provider makes a request for expedited prior authorization, we implement our expedited prior authorization process presented in the figure.

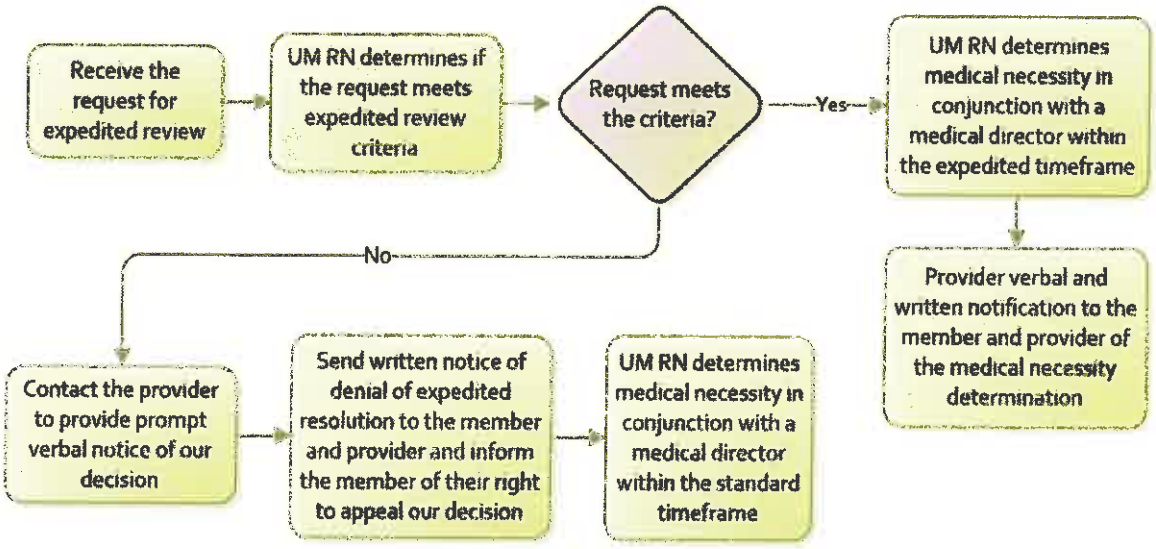


Figure 7: Expedited prior authorization process. A UM clinician determines if the request meets the criteria for expedited review. If it does not, the UM RN promptly informs the provider and processes the request within standard timeframes. If it does, the UM RN processes the request within the expedited time frame.

Following the determination, we notify the provider and member as expeditiously as possible based upon the member's health condition, but no later than two business days following receipt of the expedited authorization request.

In 2018, we completed 151 expedited service reviews. We completed 148 or 98% of the expedited reviews within required timeframes, exceeding the contract requirement.

We may provide an extension of up to 48 hours for expedited preservice authorizations and up to 72 hours for expedited concurrent reviews if the member or provider requests it or we justify the need to BMS and the delay is in the member's best interest.

BA016. 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. Medical Services (includes Physical, Behavioral Health, Dental and Vision)

BA018. Pharmacy

With the addition of WVCHIP members to the MHT program, selected MCOs will have to implement a new program and onboard these members with no disruption in their services. We have substantial experience making significant program changes and onboarding new members, including:

- Onboarded 10,000 SSI members in 2017.
- Onboarded 35,000 Medicaid expansion members in 2015. We extended the transition period six months, exceeding the 90-day requirement.
- Onboarded 16,000 West Virginia Family Health members in from May through July 2019.
- Added the SUD waiver benefit in summer 2019. From July 1, 2019, through Dec. 31, 2019, we have paid $2.5 million in claims for SUD services.
- Carved-in behavioral health benefits to managed care in 2015 for our entire population, including expansion members. We are the only MCO that has contracted with all the required comprehensive health centers.
- Carved-in dental benefits in 2014.
- Carved-out pharmacy benefits in July 2017.

For the SUD waiver implementation our staff was trained and licensed in required ASAM Criteria well in advance of go live, our information systems were quickly/efficiently updated to process new service requirements, our credentialing was completed efficiently for all mandated providers and our provider engagement team and clinical services psychologist provided excellent support and service for SUD waiver providers with onsite visits and direct access to telephonic support for quick resolution of any identified provider question, need or concern.

We also request authorizations that extend past the member's transition date and authorizations for members over the past year. This information helps us better understand each member's health risk and needs and helps us process service authorizations, such as an authorization for services from an out-of-network provider.

We know significant changes can be difficult and concerning for members and we strive to make their transition to THP as easy and seamless as possible. Our continuity of care approach seamlessly facilitates the

uninterrupted delivery of medically necessary physical, behavioral and specialty services, regardless of the provider's network status. Key features of our approach include processes and systems to:

- Identify, document and honor existing prior authorizations from the previous MCO, FFS or private insurance. We will work closely with the state's prior authorization vendor, KEPRO, and the fiscal agent and with BMS to obtain any available data that will identify existing authorizations. We will identify open authorizations for WVCHIP members by analyzing information from the fiscal agent. We also request authorizations that extend past the transition date and authorizations over the past year.
- Identify members receiving services from out-of-network (OON) providers and continue to deliver services through those providers using a single case agreement (SCA) if appropriate.
- Identify members in the midst of a treatment plan, such as pregnant members, and continue treatment with the member's provider.
- Identify members who may benefit from care management, enroll them in care management, reassess their needs and update their treatment plan.

Identifying open service authorizations. When a new member is enrolled with THP, we:

- Analyze any service authorization data sent by the State to identify members with open prior authorizations
- Review the fiscal agent's web portal to identify open service authorizations for those members coming from FFS
- Identify open service authorizations during the new member welcome call and initial health risk assessment
- Analyze authorizations available from KEPRO
- Obtain service authorization information from other MCOs when we identify a member transitioning from another MCO

Honoring open service authorizations. We automatically load authorized services and open prior authorizations into our UM system to prevent interruption of service. Open prior authorizations are those services that have

When we onboarded SSI members in 2017, some of them were receiving private duty nursing (PDN) services from another MCO. We worked with the MCO team to transition these members and confirm the uninterrupted delivery of their PDN services.

been requested but not delivered or have a date of service range crossing enrollment with our plan. Our UM team processes open prior authorizations and waives prior authorization requirements for authorized services during the transition period. Our systems flag members transitioning to us from another program or another MCO.

When reviewing the member's care management record, all THP staff can see that the member is transitioning to us so we can engage them in care coordination activities. THP honors services authorization approvals from previous coverage during the transition period. We continue to provide authorized services for the same amount, duration and scope until the end of the open authorization period or we have determined if the member will benefit from care management, assessed their needs, developed a treatment plan and issued a denial or new service authorization for the services in their treatment plan.

BA019. The Vendor should describe how providers and/or members will be notified regarding the expiration of medical authorizations, and pharmacy authorizations, if applicable.

We document all service authorizations in our UM system, including a reference number, a start date and an expiration date. Our UM system also documents referrals and generates an expiration date based upon the number of units that are requested and the anticipated timeframe to deliver the services to the member. Authorizations documented in our UM system are available to providers and members via the provider and member portals. We notify members and providers regarding the expiration of service authorization as follows:

- When we authorize a service, we notify the provider and the member of the authorization, including specifically indicating the expiration date.
- During the new member outreach, member advocates on our outreach team communicate with the member regarding any referral authorizations that are in place and anticipated expiration dates of those authorizations.

- We send a letter to the member and provider when authorizations are set to expire.
- Providers can check the status of service authorizations by calling our customer service center or by logging onto the provider portal.
- Members can check the status of service authorizations by calling our customer service center or by logging onto the member portal.

We notify members and providers regarding the expiration of service authorization by giving them the ability to check the status of their service authorizations, including authorizations that are about to expire, on our member and provider portals. Providers can check authorization status on the provider portal, presented in the figure.

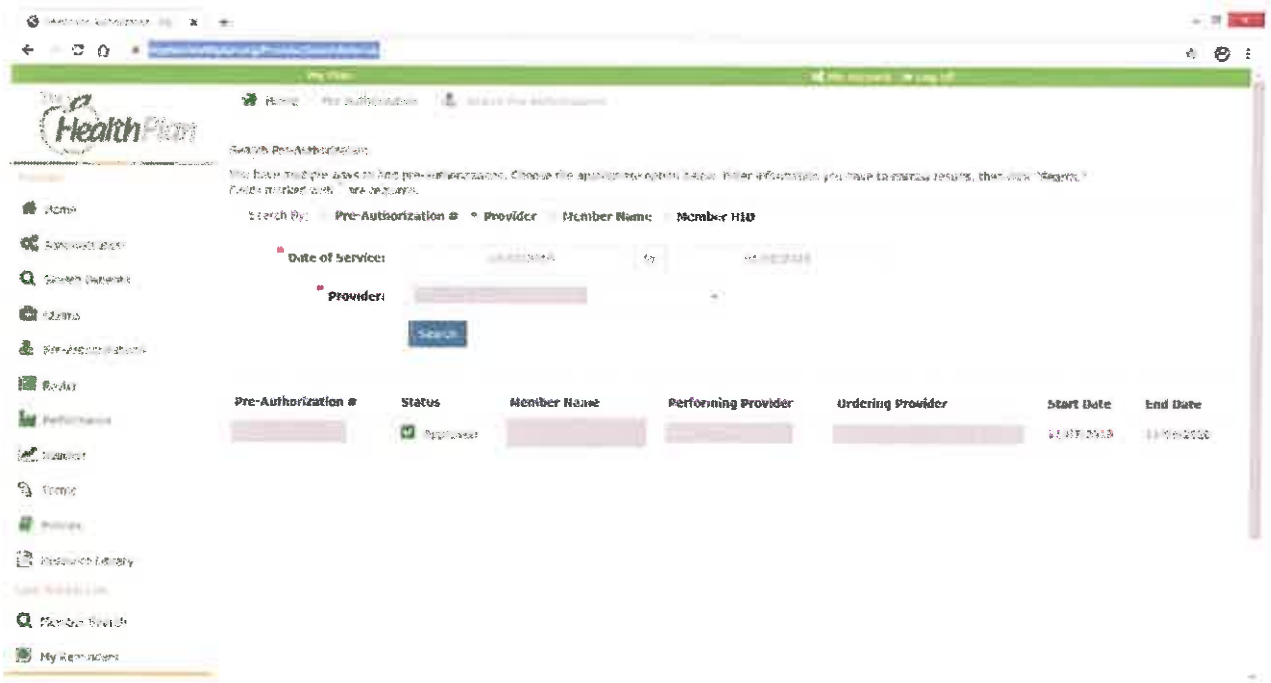


Figure 8: Authorizations on the provider portal. We notify members and providers regarding the expiration of service authorization by giving them the ability to check the status of their service authorizations, including authorizations that are about to expire, on our provider portal.

Members can check the status of authorizations on our THP member portal, presented in the figure.

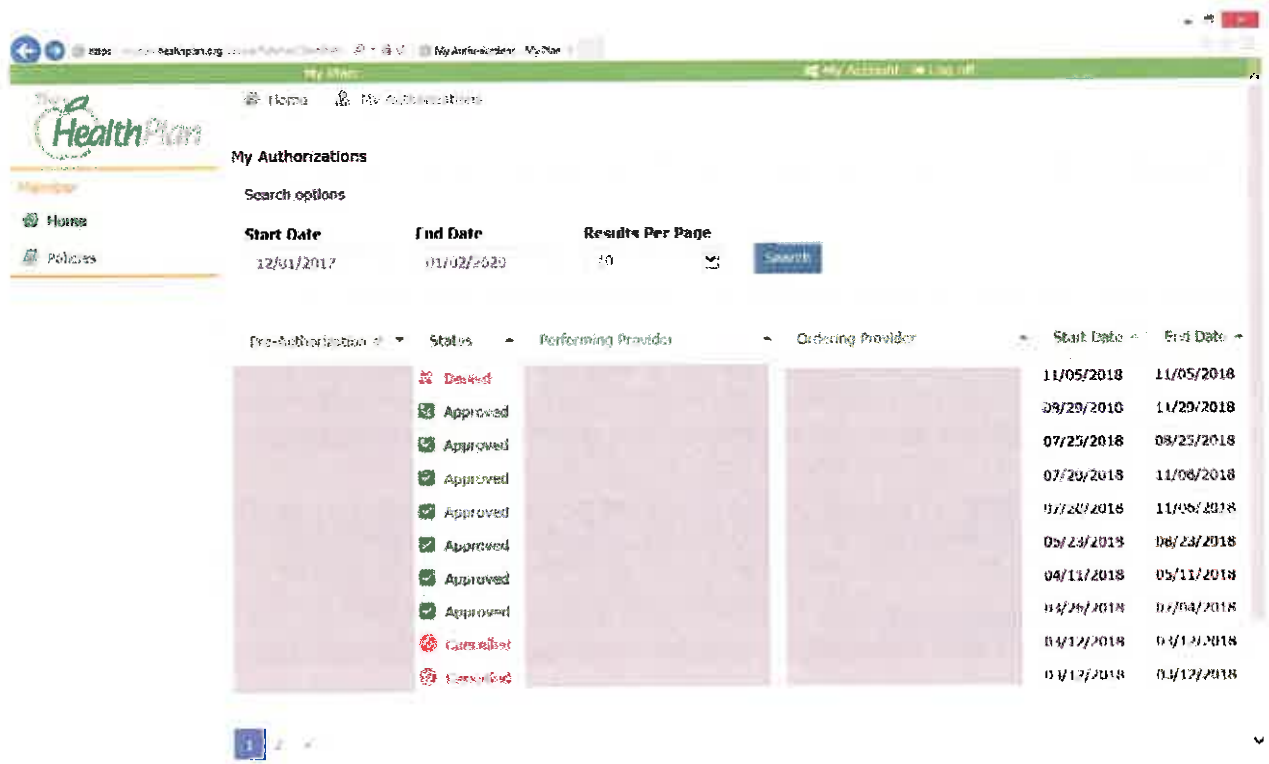


Figure 9. Authorizations on the member portal. We notify members regarding the expiration of service authorization by giving them the ability to check the status of their service authorizations, including authorizations that are about to expire, on our member portal.

BA020. The Vendor should describe its process for authorizing out-of-network access including, but not limited to, the following:

We allow the member to continue to receive services from an OON provider and cover out-of-network services in accordance with Article III, Section 5.2 Out-of-Network Services in the Service Provider Agreement. Our provider network team attempts to recruit and contract with the OON provider to continue to deliver these services as an in-network provider when appropriate. If the team is unable to bring the provider into our network, our provider network team works with the OON provider to execute a single case agreement (SCA) that includes balance billing protection language and to continue providing services to the member. Before execution of a SCA, our provider network

If an OON provider submits a claim to us, we load the provider into our claims and UM systems. OON providers can then register with our provider portal and request and monitor the status of service requests through our provider portal.

team validates the provider's licensure status since the provider will be reimbursed at the State Medicaid reimbursement rate.

Levels of Care

Our levels of care policy helps us deliver the appropriate services to our members. We created four levels of care, including primary care, secondary care, tertiary care and out-of-network care as described in the following sections.

Primary care. This level includes the basic level of care between members and our THP network. This includes pediatricians, general practitioners, internal medicine practitioners, the family physician, nurse practitioners or physician assistants. We also allow specialist providers to serve as PCPs, such as OB/GYNs, geriatricians, endocrinologists, nephrologists and oncologists. PCPs treat common diseases or injuries, provide basic curative care services, maternal and child health services, prevention of disease services, immunizations and health education. Members must have a PCP who acts as the coordinator of their care.

Secondary care. This level of care includes specialist providers (e.g., endocrinologist, oncologist or nephrologist) who focus on a specific system of the body or a specific disease or condition. When the member's care cannot be delivered in the primary care setting, we connect the member to an in-plan participating specialist to treat their condition. Reauthorizations are not required to see in-plan specialty care providers. Members have the ability to list a specialty care provider with the plan who may also have the ability to direct care. An example of this is a member with stage 4 chronic kidney disease who chooses to list their in-plan nephrologist for assistance with

directing care. All members identifying a condition requiring routine management by a specialty care provider are referred to care management.

Tertiary care. This level of care includes care that is highly technical and specialized in nature, typically provided in a medical center affiliated with a university, for members with unusually severe, complex or uncommon health problems. Examples of tertiary care include transplants, perinatology, neonatology, trauma surgery and complex cancer cases. An in-network PCP or specialty care provider evaluation may be required before care being deemed appropriate at a higher, tertiary, level of care.

Tertiary care requires preauthorization. Preauthorization requests for tertiary care should be submitted from a participating in-network primary or specialty care provider following a medical evaluation. Consideration of the member's needs and determination if their needs can be met with an-network provider or facility is reviewed by a medical director. Tertiary care is approved when services or providers required to meet a member's medical needs are not available within our primary or specialty network, or if they cannot be safely provided in-network care due to the complexity of their care needs.

Out-of-network care. This level of care is defined as care delivered outside of THP's contracted network of in plan (primary, specialty or tertiary) providers and facilities. Out-of-network care requires preauthorization except for emergency services. Preauthorization requests for out-of-network care should be submitted from a participating in-network primary, specialty or tertiary care provider following medical evaluation. Consideration of the member's medical needs and determination if their needs can be met with an in-network provider or facility is reviewed by a medical

director. Out-of-network care is approved only when services or providers required to meet a member's medical needs are not available within THP's network or cannot be safely provided in network due to complexity of care.

BA021. Emergency Services, including transportation

In accordance with Article III, Section 5.4.1, Service Authorization Continuity of Care in the Service Provider Agreement, we do not require prior authorization for emergency services, regardless of whether the services are delivered in- or out-of-network. This includes transportation. Our on-call nurse, available 24 hours per day/seven days per week, provides assistance to members who are in need of urgent treatment to help them locate a provider to perform such services, understand how to access emergency services and how to arrange transportation, including arranging transportation for the member, as needed. We inform members regarding their rights of access to and coverage of emergency services, both inside and outside of our network in our Member Handbook and during out new member welcome call.

BA022. Medically Necessary Travel, for the West Virginia Children's Health Insurance Program (WVCHIP)

We do not require prior authorization for emergency transportation. While non-emergency medical transportation (NEMT) is not a covered WVCHIP benefit, through our medical necessity determination process, we evaluate each member's situation to determine if transportation is medically necessary and will cover transportation services for the hemophilia and transplant programs in addition to others who meet medical necessity services on a case-by-case basis.

BA023. Medical Necessity

We determine medical necessity in accordance with Article III, Section 5.4, Service Authorization (Prior Authorization) of the Service Provider Agreement, using the same

process regardless of whether the request is received from an in-network or out-of-network provider. THP has written policies and procedures, reflecting current standards of medical practice, for processing requests for initial authorization of services or requests for continuation of services. Within those policies we provide for:

- Consultation with the requesting provider by a THP medical director or specialist reviewer when appropriate
- Evaluation to ensure consistent application of review determinations and notifications through IRR testing as discussed in **BA005**
- Ability to specify information sources and the process used to review and make medical necessity determinations regarding the provision of medical services including clear documentation of criteria for decisions on coverage and medical necessity
- Our documented and published policies and procedures (P&Ps) reinforced in training, require that decisions to deny service authorization or to authorize a service in amount, duration or scope that is less than requested must be made by a healthcare professional who has appropriate clinical expertise in treating the member's condition or disease and who has knowledge of local patterns of care
- Notification of any changes to authorization requirements at least 30 days before implementation

THP makes standard authorization decisions and provides written notice to the requesting provider, PCP and member as expeditiously as required by the member's health condition, and no later than seven calendar days of receiving the request for service. The seven calendar day period may be extended up to 14 additional calendar days upon request of the member or provider, or if we justify to BMS in advance and in writing a need for additional information and that the member will benefit from such extension.

THP provides an expedited authorization for services when the provider indicates and we determine that the standard timeframe could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function. THP will make the expedited authorization decision and provide notice to the member and provider(s) as

expeditiously as the members' health condition requires and in accordance with Article III, Section 5.4, Service Authorization (Prior Authorization) in the Service Provider Agreement.

BA024. Out-of-State Providers (for example, members who are students, live in proximity to State borders, etc.)

We recognize many of our members access care through out-of-state providers. We have a substantial network of in-network, out-of-state providers to meet their needs. This includes:

- ***PCPs:*** 550 in Ohio, 75 in Pennsylvania, 116 in Virginia, 96 in Maryland and 99 in Kentucky.
- ***Secondary providers:*** 1,168 in Ohio, 74 in Pennsylvania, 71 in Virginia, 43 in Maryland and 52 in Kentucky.
- ***Specialists:*** 9,162 in Ohio, 432 in Pennsylvania, 687 in Virginia, 243 in Maryland and 350 in Kentucky.
- ***All-fee providers:*** 1,190 in Ohio, 185 in Pennsylvania, 62 in Virginia, 61 in Maryland and 50 in Kentucky.

We also have a substantial network of in-network, out-of-state facilities, including:

- ***Primary hospitals:*** 65 in Ohio, five in Pennsylvania, four in Virginia, three in Maryland and three in Kentucky.
- ***Tertiary hospitals:*** Nine in Ohio, 10 in Pennsylvania and two in Kentucky.
- ***Long-term acute care hospitals:*** 15 in Ohio and two in Pennsylvania.
- ***Rehabilitation hospitals:*** Seven in Ohio and three in Pennsylvania.

Our process to determine the medical necessity of requested services, as described in **BA023**, is the same whether the provider is in or out-of-network or in- or out-of-state. We described our process for authorizing out-of-network access in **BA020**. This process does not differ for out-of-state providers. For members seeking care from an out-of-network provider, we work with them to connect them to a provider who is in our network (regardless of whether the provider is in- our out-of-state) if that is in their best medical interest.

Connecting a Member to Specialized Care

We identified and engaged the family of a preschooler with an extensive cardiac surgical history related to several congenital heart defects. This child had been well managed by pediatric cardiologists and surgeons in our local THP network, but despite her meticulous care, she presented in need of yet another extensive and complex cardiac surgery that was beyond the comfort level and expertise of even our tertiary network. The child's in-plan West Virginia cardiac team in conjunction with the ICT at THP discussed the case, the member's specific and unique need, and researched facilities providing the necessary procedure and their varied outcomes. The team confirmed that there were only two surgeons and facilities in the nation performing the particular procedure that she needed to survive.

Of the two, an expert pediatric cardiothoracic surgeon in California was ultimately determined to be the child's best option for her successful outcome, so arrangements were made for this specific surgery to be performed at this highly specialized facility in California. Services were approved as medically necessary with single case agreements placed for acute and post-acute care and pharmacy care out of plan. Care was coordinated with various agencies to arrange transportation and Ronald McDonald House stay for the family and plans were enacted. The member was safely transported, received her procedure on the West coast, recuperated near the facility with the love and support of her family and not only survived but thrived.

This member continues to thrive today. Her family remains actively engaged with Complex Case Navigation at THP. They are extremely grateful, to not only their nurse, but also to THP and West Virginia Medicaid for the personalized care, collaboration and assistance demonstrated across many providers and agencies working together to give a child a chance at life.

BA025. The Vendor should describe its process for circumstances under which a member might be granted a standing referral to a specialist provider.

We do not require prior authorization for referrals, including standing referrals, made to an in-network specialist by the member's PCP. We require prior authorization for OON referrals. The circumstances under which a member might be granted a standing referral to a specialist provider is when we identify a member who may need a course of treatment or regular care monitoring from a tertiary provider as described in **BA020**.

For instance, we coordinate care for members with cancer through development of a treatment plan that specifies chemotherapy at set intervals and a plan for specialist visits, labs draws and PET scans at routine intervals. The treatment plan includes standing referrals with oncologists, tertiary facilities and PCPs and for PET scans to confirm care is easily accessed and smoothly delivered so members and their families focus strictly on care and recovery and providers can focus on delivering care rather than service authorizations and referrals. During development of the member's

treatment plan, the care manager identifies and documents all standing referrals in our care management system.

BA026. The Vendor should describe the extent to which a specialist provider may refer services.

Certain specialists can make referrals, including OB/GYNs, endocrinologists, oncologists and nephrologists. Other specialist providers can make referrals if they are serving as the member's PCP of record. In this instance the PCP specialist may make the referral without prior authorization since we do not require prior authorization for referrals made by the member's PCP. In all other instances, if a specialist provider makes a referral, the referral requires prior authorization.

BA027. The Vendor should describe its process for out-of-network referrals, including, but not limited to, the following:

Out-of-network referrals require prior authorization except for emergency services. Prior authorization requests for out-of-network care must be submitted from a participating in-network primary, specialty or tertiary care provider following medical evaluation of the member. A THP medical director considers the member's medical needs and determines if their needs can be met by an in-network provider or facility. The medical director will approve out-of-network care only when services or providers required to meet a member's medical needs are not available within THP's network or cannot be safely provided in-network due to complexity of care. Examples where this may occur include tertiary care or complex procedures that are not available within the local service area, such as a child with a rare cardiac procedure who can only access treatment through an out-of-network facility.

BA028. Members and/or providers requesting out-of-network referrals

If a member requests an out-of-network service, we direct them to discuss their care needs with their PCP and explain that if in agreement, their PCP needs to request the

out-of-network referral or otherwise direct their care. If the PCP requests an out of network service, a UM nurse and medical director will review the medical necessity of the service and its potential availability through an in-network provider. If the request is medically appropriate and can be delivered safely, timely and appropriately through an in-network provider, the out-of-service request will be denied and we notify the member and provider per UM policy.

If we redirect the member to an in-network provider, their care manager (if they are enrolled in care management) or a member advocate on our clinical team will facilitate the transition of the member's care to the in-network provider. If the service is reviewed and deemed medically appropriate and not available in-plan it is approved. We contract with the out-of-network provider or develop an SCA to deliver the services as we discuss in **BA029** through **BA031**.

BA029. 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. 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

BA031. The Vendor should its procedures for ensuring that member information from non-network providers is shared with the member's Primary Care Provider (PCP).

At a minimum, we allow a member to continue an existing relationship with an OON provider until the 90-day transition period expires or until we reassess the member needs and develop a treatment plan. We may allow for continuation of existing relationships with OON providers past the 90 day transition period (including a provider that leaves our network) when considered to be in the best medical interest of the member as determined by a THP medical director. Instances in which this may occur include a member is receiving an active course of treatment or is in the second or third

trimester of pregnancy. An active course of treatment is one in which discontinuity could cause a recurrence or worsening of the condition under treatment and interfere with anticipated outcomes.

When member needs cannot be met by in-network providers, we take immediate steps to address gaps so a member's care is not compromised and continuity of care is assured. If a contracted provider is not available to meet member access and availability needs, we first attempt to contract with the OON provider to continue to provide these services. If the OON provider is unwilling to contract with us, we enter into an SCA with the provider to deliver the needed care. Before we enter into the SCA, we validate the licensure status, good standing as the provider will be reimbursed at the State Medicaid reimbursement rate. For OON providers that have not recently left our network, we forward the provider's name and address to our provider network team to recruit the provider to our network.

Sharing information with the PCP. Our care team works closely with the member and the OON provider to gather the clinical information necessary for the PCP to coordinate the delivery of the member's care. The care team documents this information in our care management system. Our care management system maintains all information about the member's care and services in their care management record, providing a comprehensive view of their needs and goals and the services and supports being delivered to meet their needs and help them achieve their goals. This includes:

- ***Member information***, such as demographics, primary and secondary insurance, the names and contact information of interdisciplinary care team (ICT) members and programs for which the member is enrolled.
- ***Member health***, such as service dates, diagnosis summary; ADT alerts, conditions, pharmacy data, medication adherence and health indicators.

- ***Member gaps in care*** using member demographic data to identify members who are due for preventive services/required screenings, enabling the care manager to conduct targeted outreach.
- ***Member treatment plan*** that integrates social, medical and behavioral issues and data and includes information, such as referrals, progress notes and case conference notes.
- ***Member activity record***, such as scheduled activities, case notes, prior authorizations, physician orders, documents (e.g., x-rays) and signed consent forms and disenrollment agreements.

The care manager shares this information with the new provider, such as during discussions with the PCP, or the provider can access the member's information through the secure provider portal, which gives authorized providers, including the member's PCP, a variety of capabilities to access member data and collaborate to coordinate member care, including:

- ***Data sharing***. Securely shares the information in the member's care management record.
- ***Assessment.*** Allows providers to review, acknowledge, sign and contribute to member assessments.
- ***Care planning.*** Allows providers to review, acknowledge, sign and contribute to a member's treatment plan.
- ***Communication.*** Provides a mechanism for providers to securely communicate with care team.
- ***Monitoring member care.*** Integrates data analyses and provides this information to help providers:
  - Monitor the member's progress toward achieving their goals
  - Monitor the member's adherence to their treatment plan
  - Respond to data analyses indicating members who are at risk, such as an individual under the age of 25 who is experiencing their first psychiatric episode and who has a history of SUD
  - Respond to ADT alerts from the WVHIN
- ***Managing care setting transitions***, such as prompting for follow-up PCP appointments, performing patient reminders and tracking the completion of a post-hospital assessment.
- ***Identifying members with gaps in care using*** a customizable Quality Measure Dashboard that allows providers to view their members with care gaps using HEDIS quality measure data, refreshed twice monthly.
- ***Identifying each member's risk level***, allowing providers to engage their members with the highest risk.

BA032. 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.

If the member has not chosen a PCP, we auto-assign a PCP to them. During the new member welcome call, the member advocate verifies the member's provider relationships, including confirming they have a relationship with the PCP identified on their member ID card. The member advocate educates the member on the importance of establishing and maintaining a relationship with the PCP.

At least annually, we automatically re-attribute each member's PCP to where they are actually receiving primary care as indicated by claims. This re-attribution confirms we are engaging the member's PCP when coordinating the member's care. We developed the policy with the input of our VBP partners.

If the member has not established with the assigned PCP or wants to change their PCP, the member advocate helps them select one. Building a relationship between the member and their PCP helps the member manage their health conditions, leads to improved health outcomes and helps avoid unnecessary utilization. Recognizing the importance of engaging the PCP to enhance, coordinate and monitor the member's care, we leverage every member interaction to confirm the member has a PCP, connect the member to their PCP and confirm the member is actively engaged with their PCP, including:

- Including the PCP in the comprehensive assessment and care planning process
- Engaging the PCP when a member experiences a change in condition
- Engaging the PCP during reassessments and treatment plan updates
- Sharing member data with the PCP and promoting collaboration through our care management system
- Confirming the member is visiting the PCP during discussions with the member
- Monitoring claims to confirm the member is visiting their PCP
- Helping schedule PCP appointments and arranging transportation
- Confirming the member visits their PCP within seven days of an inpatient discharge
- Verifying the member has a PCP and is seeing their PCP when the member calls our customer service

BA033. The Vendor should describe its process for transferring necessary clinical information to a member's new provider.

We document the clinical information necessary to coordinate the delivery of the member's care in our care management system. This system maintains all information about the member's care and services in their care management record, providing a comprehensive view of their needs and goals and the services and supports being delivered to meet their needs and help them achieve their goals. The provider can access the member's information through our secure provider portal, which gives the provider access to the information in the member's care management record.

In addition to providing this information to providers through our provider portal, we facilitate the sharing of this data between providers in the following circumstances:

- If we have enrolled the member in care management, their care manager will facilitate the transfer of this information between the providers.
- If the member or provider calls our customer service, the CSR refers the request to our care team, who assigns a member advocate or care manager to facilitate the transfer of this information.
- During our annual reattribution process, we will notify PCPs who have had members added to their rosters and encourage them to engage these members.

BA034. The Vendor should describe its process for member access and coverage of Family Planning services.

We provide access to and cover family planning services (those services provided to individuals of childbearing age to temporarily or permanently prevent or delay pregnancy) in accordance with Article III, Section 5.3.3.1 Family Planning in the Service Provider Agreement. Upon enrollment with THP, we educate the member about the availability of our Member Handbook on the member portal and that the member can request a printed copy of the handbook. The Member Handbook describes how members can access in- and out-of-network family planning services.

We also educate members about family planning services in our member newsletter. During the new member welcome call, the member advocate on our outreach team discusses family planning services and self-referral services and how to access family planning services through in-network and out-of-network providers. For members who are pregnant, we educate them about family planning services during their third trimester and discuss family planning options after the mother gives birth.

Family planning services may be obtained by a member without a referral or prior authorization through any family planning provider, regardless if they are in our network or not. When a family planning provider submits a claim for family planning services, we reimburse them at the Medicaid rate.

BA035 The Vendor should describe its process for accessing crisis stabilization services

THP has a process in place to confirm continuity of care for members requiring urgent, emergent crisis stabilization or post-stabilization medical, behavioral and dental care. The process ensures continuity by making arrangements for or facilitating access to care and providing coverage for services needed urgently or emergently as defined under prudent layperson language. The process allows for coverage of services when a medical, behavioral or dental condition manifests with symptoms severe enough (including pain) that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate care could result in serious jeopardy to their health or that of their unborn child, serious impairment to bodily functions or serious dysfunction of any organ or body part.

THP has qualified medical personnel accessible 24 hours each day, seven days per week to provide direction to patients in need of urgent or emergent care or post stabilization support.. Medical personnel include both physicians and nurses. They can be accessed via our 24/7 nurse line to assist members and providers with information regarding wellness, prevention, obtaining care and services, the utilization management process and authorization of care.

Depth of Community Ties and Connections

In December of 2019, a THP nurse became aware via media reports of a fatality at a local mining facility in Marshall County, West Virginia. The nurse felt that the miner's family and colleagues may have experienced considerable trauma associated with the incident, and that THP could facilitate professional assistance/support in addressing that trauma.

THP staff collaborated with mining company management to identify the needs of employees and their families to obtain requested mental health services. Through THP's strong connection with the mining company and their executive staff, as well as our close working relationship with Northwood Health Systems, THP enabled on-site emergency mental health services for employees and their families for several days after the incident. Northwood continues to provide services to several company employees and family members under a special contract for services with THP

THP is responsible for and capable of covering crisis stabilization (urgent/emergent care):

- Regardless of whether services are obtained inside or outside THP's network or service area
- Regardless of whether there is pre-authorization for services
- When a contracted plan provider instructs a member to seek such services
- For ambulance services dispatched through 911 or its equivalent or when another means of transportation would endanger the member's health
- When a THP representative, such as the afterhours on call nurse (on our 24/7 nurse line), instructs the member to seek such services

THP does not:

- Limit what constitutes an urgent/emergent condition on the basis of diagnosis or symptoms

- Refuse to cover services based on the provider, hospital, or fiscal agent not notifying the PCP, THP or applicable State entity of the member's screening and treatment within 10 calendar days of presentation for services

Post-stabilization care refers to out-of-plan services subsequent or related to an urgent/emergent condition that a treating physician views as medically necessary after a member's condition has been stabilized that are required to maintain the stable condition or to improve or resolve the member's condition. The attending physician treating the member is responsible for determining when the member is sufficiently stable for transfer or discharge. That determination is binding on THP.

Upon notification of an out of plan urgent/emergent admission, THP's UM and care managers work to gather pertinent clinical information and work with the attending physician treating the member, the member's PCP or another in-plan provider and the member/family to develop a plan of care. When appropriate, the member may be transported back to the area for continued inpatient care and services with the assistance of a complex case manager or care navigator or supported by care coordination for follow up care and services post-discharge.

THP integrates WVHIN alerts (e.g., immediate notifications that THP receives through network provider electronic health record (EHR) information regarding patient access to services such as ER, outpatient surgery or admissions into our care management system to confirm our UM and care management team is alerted to any member experiencing these encounters to coordinate appropriate follow-up care for the member.

BA036. 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.

BA047. 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

We educate members and providers about the importance of EPSDT services in a variety of ways, including:

- In our welcome packets that are mailed to all new members, we include a preventive health guideline chart
- In our Member Handbook, which is available on our member portal at healthplan.org or by request by calling our customer service
- During welcome calls, member advocates on our outreach team discuss EPSDT with the member and the importance of having yearly exams
- We send a postcard to members before their birthday each year reminding them about these services
- We post EPSDT requirements and guidelines in our provider manual
- Our provider engagement team provides on-site education of providers related to HealthCheck/EPSDT requirements.

We have developed a gap report that tracks members who have not received EPSDT services. Member advocates on our member outreach team use this report to identify members with gaps in care and outreach to them to educate them about the importance of receiving EPSDT services and overcoming any barriers to accessing them.

We require PCPs and pediatricians to complete a HealthCheck exam that promotes adherence to the EPSDT periodicity schedule. We track when the HealthCheck exam is due and its completion in our care management system, which reminds our member outreach team and care managers when a member is due to have the exam completed. We track well child exams until the member's 21st birthday. Upon completion of the exam, our care management system automatically updates the next screening due date based upon the periodicity schedule.

We offer members a variety of incentives to connect them to care, such as a $25 gift card for completing yearly well visit for members ages 3-6 and 12-21.

Our care management system monitors compliance with preventive and chronic care standards, such as HEDIS or EPSDT screenings. It uses member demographic data to identify members who have not received required screenings, allowing the care manager or member advocate to conduct targeted outreach to members with gaps in care. As presented in the figure, our care management system presents the care manager or member advocate with the members who have care gaps and allows them to take action.

For members who are not enrolled in care management, a member advocate from our

Figure 10: Quality measures scorecard. Care managers and member advocates can view members with gaps in care in our care management system and use this information to take action to close the care gaps, such as scheduling an appointment for the member with their PCP. Note: This screen shot does not include actual member data.

member outreach team engages the member to remind them of their required screening and help them schedule an appointment. For a member in care management, the care manager works with the member to create an opportunity, goal and intervention (OGI) in their treatment plan for each required preventive service. For example:

- ***Opportunity:*** Member well-child and EPSDT checkups are not up-to-date
  - ***Goal:*** Well-child checkup and EPSDT services are up-to-date
    - ***Intervention 1:*** Educate member/caregiver about importance of well-child checkup and/or help member set up appointment (Duration: 60 days)
    - ***Intervention 2:*** Confirm member has completed office visits for well-child checkup and EPSDT (Duration: 60 days)

Our care management system reminds the care manager and the member when the required screening is due. Our secure provider portal helps providers identify members with gaps in care using a customizable Quality Measure Dashboard, presented in the figure that allows providers to view their members with care gaps using HEDIS quality measure data, refreshed twice monthly.

Figure 11: Quality Measures Dashboard. The dashboard provides summary scorecard of performance against HEDIS or EPSDT measures with quick-access links to identify those members in the provider's panel who have gaps in care. Note: This screen shot does not include actual member data.

BA037. 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.

Providers are required and advised to submit a rebate-eligible national drug code (NDC) with all applicable J-Codes (codes for non-orally administered medication and chemotherapy drugs) upon claims submission. Information related to the requirements of rebate eligible NDC codes are housed within our provider manual. Monthly, we receive an NDC code file from the fiscal agent. This file is loaded into our HEART system for claims processing within a week of receiving. Non-rebate eligible NDC codes are denied within our claims processing system. If a discrepancy is found with the file,

our team works closely with BMS to rectify. Our customer service and pharmacy teams point our providers to the list of NDCs on the CMS website so they know what is rebate-eligible. Once the encounter files are submitted to the fiscal agent, Christy Donohue, VP Medicaid, and Larry Welling, Encounter Data Integrity Manager, work with the fiscal agent and BMS on any rejected or disputed physician-administered drug claims. If required, revised encounter files are submitted to ensure the appropriate rebate can be obtained.

BA038. The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when medical service limitations are imposed.

BA039. The Vendor should describe its policies and procedures that outline how cases of medical necessity will be handled when prescription limits are imposed.

We recognize members can exhaust their benefits, such as running out of inpatient rehabilitation days or private duty nursing. We have adopted evidence-based guidelines that serve as the framework for clinical decisions and service provision that optimizes member care and outcomes, such as InterQual Criteria. Through our medical necessity determination process, our UM RNs and medical directors use our standard UM guidelines and processes to determine the medical necessity of a service request, with respect to the type of request or the specifics of the member's situation or needs. Our UM RNs or pharmacy technicians refer these cases to a THP medical director or pharmacist for medical necessity review and determination when there are medical service limitations or prescription limits are imposed to make a medical necessity decision on a case-by-case basis, looking at all available information to make an informed decision.

One of the ways we do this is through our "grand rounds" process. During grand rounds, our interdisciplinary team of medical directors, pharmacists, nurses and operations staff

reviews the member's case. Each of these team members brings a unique viewpoint to the member's needs, such as a deep understanding of pharmacy issues and available behavioral services or approaches. The ICT discusses chronic conditions, developmental challenges, emotional and behavioral issues, pharmacy utilization and any special considerations unique to the member. The ICT also discusses care opportunities, goals and interventions for inclusion on the member's treatment plan.

We include the PCP in the process through peer-to-peer discussions with our medical directors and pharmacist to discuss treatment options presented during grand rounds. Through the grand rounds and peer-to-peer processes, we may decide to exceed the state's benefit when the services requested are supported by a PCP order, coordinated by a PCP through a specialist and are specifically requested to correct or ameliorate a condition or disability that may allow, or support age appropriate or developmental capabilities may be allowable over and above specified benefit limits or allowable when not a covered benefit.

Prescription limits. THP has a well-developed system that manages prescription limits for members when their medical and pharmacy plans are managed by THP. THP is able to code the state's PDL and utilization management requirements into the PBM's claims processing platform. By coding the PDL into the claim's adjudication platform, THP verifies that members are using the state's preferred drugs.

The claims processing platform also allows for the coding of quantity management and safety management. Quantity management is used to ensure the most efficient dosage is used to fill a prescription. Concurrent DUR is used to provide a means for safety checks of both drug and disease interactions before a pharmacy filling a prescription.

A specific example of prescription limits is the approval of the drug H.P. Acthar that cost the state over $300,000 during 2017. THP has very strict authorization criteria for the use of H.P. Acthar due to the abundance of more affordable and clinically comparable steroids available. THP works closely with our Pharmacy and Therapeutics (P&T) Committee to develop coverage criteria to augment the coverage rules the State outlines in their PDL.

THP convenes a quarterly meeting of our P&T Committee, which oversees policy and procedure development, formulary management and utilization management. The P&T Committee evaluates non-PDL drugs for addition to formulary and creation of UM criteria policies. The non-PDL formulary is coded and electronically maintained for claims processing via THP's contracted PBM. THP's contracted PBM also maintains an electronic portal allowing for customized non-PDL drugs to be coded for portal submission.

BA040. 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:

We inform PCPs regarding members experiencing a change in behavioral health status by notifying PCPs of all admissions and ER visits through the provider portal. Additionally, we send every PCP a letter when a member experiences an inpatient admission along with an identification of the reason for their admission or ER use. PCPs can view all authorizations/pre-authorization for behavioral health services for the members in their panel through our provider portal. We also communicate changes to PCPs based upon certain circumstances. For instance, during the new member welcome call and HRA we perform a PHQ-2 depression screen. If the member screens positive on the PHQ-2, we refer them to care management and perform a PHQ-9. If the

member scores positive on the PHQ-9, we identify them for engagement in care management and send a letter to their PCP. We perform a depression screening for pregnant members at each trimester and postpartum. If the member scores positively for depression or indication of self-harm or harm to others, we engage them in the High Risk Perinatal disease management program to address their depression and inform the member's OB of the results of the screening.

BA041. What constitutes a change in behavioral health status

We identify a member experiencing a change in behavioral status in a variety of ways, including a member who has a behavioral health condition and:

- An ER visit
- An inpatient admission
- A change in medications
- An increased, inappropriate or unnecessary utilization
- A positive depression screening
- A self-reported change in condition

Additionally, we use our advanced data analytics to identify members experiencing a change in condition. For example, each quarter, we analyze our membership to produce a Red Alert report that identifies members who have a care need index (CNI) – an indicator of their level of health risk – of 3 or greater and have experienced a 20% increase in their CNI in the past three months. We combine this score with the identification of the member's condition, such as a member with a behavioral health diagnosis, to identify a member experiencing a change in behavioral health status.

BA042. How the member will be assisted to access additional services as a result of a change in behavioral health status

For a member not previously enrolled in care management, a change in behavioral health status triggers an assessment of the member's needs and an evaluation of

whether the member will benefit from care management. If the member cannot be reached or declines to participate in care management, we keep them in our care management program at a "following" level and attempt to engage them at any transitional care opportunities (e.g., hospitalization) and coordinated through a provider with whom the member is participating.

Engaging members in the community through a community-based health navigator. In March 2020, we will implement a pilot with the Prestera Center that will include a community-based health navigator—paid for 100% by a THP care coordination fee. The navigator will be employed by Prestera Center. The navigator will supplement the Prestera Center chronic care management team in Cabell, Kanawha and Putnam counties. They will locate and engage members who are difficult to reach and support THP members who need extra support in managing their healthcare challenges, such as coordinating a PCP or specialist appointment, completing laboratory testing, dietary needs/food insecurity or non-emergent transportation.

We also will use the community health worker embedded as part of an interdisciplinary care team at Community Care to help us locate and engage these members.

For a member enrolled in care management, a change in behavioral status will trigger a reassessment of the member's needs. The member's care manager will engage the member to assess or reassess the member's needs and update their treatment plan. The care manager works with the member and their providers to have an initial assessment of the member completed by a behavioral health professional within 7 to 10 days of becoming aware of the change in the member's behavioral health status.

Depending on the results of the assessments, and in conjunction with the member's interdisciplinary care team (ICT) and placement entity (e.g., emergency shelter, hospital), if relevant, ongoing behavioral health interventions will be identified and scheduled by the care manager. Preference will be given to any behavioral health provider entity with whom the member is already engaged. The care manager will share any information about the member with the behavioral health provider so as to be sensitive to any issues of trauma, in particular.

During the care planning meetings with the member and their ICT the care manager facilitates the development of goals and interventions to address the member's change in condition. This process and the outcomes are documented. The care manager confirms the member's treatment plans are up-to-date and shared with the team. Additionally, the care manager will make the member's PCP aware of the existence of any behavioral health providers engaged with the member and will help obtain necessary releases to facilitate sharing of information between the PCP and the behavioral health provider.

BA043. 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).

We enroll every CSHCN in our complex case management program and assign a care manager to coordinate their care. For members who have not been identified as CSHCN or who are not enrolled in a care management program, a member advocate on our member outreach team coordinates these activities.

Improving Access to Dental Services Among Children

In Q1 2018, we implemented a PIP to improve access to dental services among children as measured by the Annual Dental Visits for 2-3 Year Olds (HEDIS) measure and the Percentage of Eligible Who Received Preventive Dental Services (Child Core Set Measure). Our annual HEDIS rates for Annual Dental Visits ***increased from 27.40% in 2018 (MY2017) to 36.29% in 2019 (MY2018)***. Additionally, the Percentage of Eligible Who Received Preventive Dental Services ***increased from 34.98% in 2018 (MY2017) to 43.35% in 2019***

We track when the HealthCheck (formerly EPSDT) exam is due and its completion in our care management system, which reminds our member outreach team and care managers when a member is due to have the exam completed. We track well child exams until the member's 21st birthday. Upon completion of the exam, our care management system automatically updates the next screening due date based upon the periodicity schedule.

We require PCPs and pediatricians to complete a HealthCheck exam to identify each member's dental needs. We track the completion via claims submission for the exam. The child's care manager or our member outreach team monitors the completion of the HealthCheck exam and collaborates with the PCP and the member to confirm the exam is completed.

If the HealthCheck exam indicates dental concerns, a member advocate or the child's care manager will coordinate the referral to a dentist with the child and their PCP. THP subcontracts with SKYGEN USA to provide dental services to our members. SKYGEN takes a case-by-case approach to confirming members receive the specialized care they need. For CSHCN, depending on the member's needs and their disability, our member advocate or the child's care manager will coordinate with SKYGEN to identify any specialized dental care needed by the member and connect them to providers who can deliver these specialized services.

BA044. The Vendor should describe its mechanisms to remind members of upcoming appointments, including, but not limited to, the following:

BA045. Medical Appointments and Screenings

BA046. Dental Appointments and Screenings, including monitoring utilization and interventions if a member has not had a screening in over one year

Our care management system allows our care managers and member advocates to schedule and track the completion of member appointments, regardless of the services the member will be receiving. The figure presents the appointment history tab in our care management system.

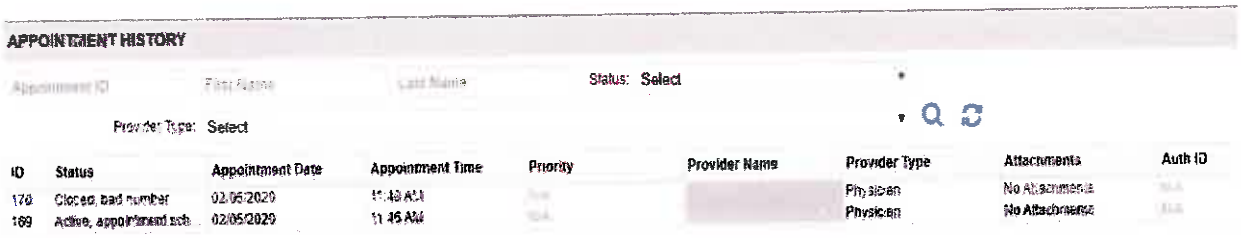


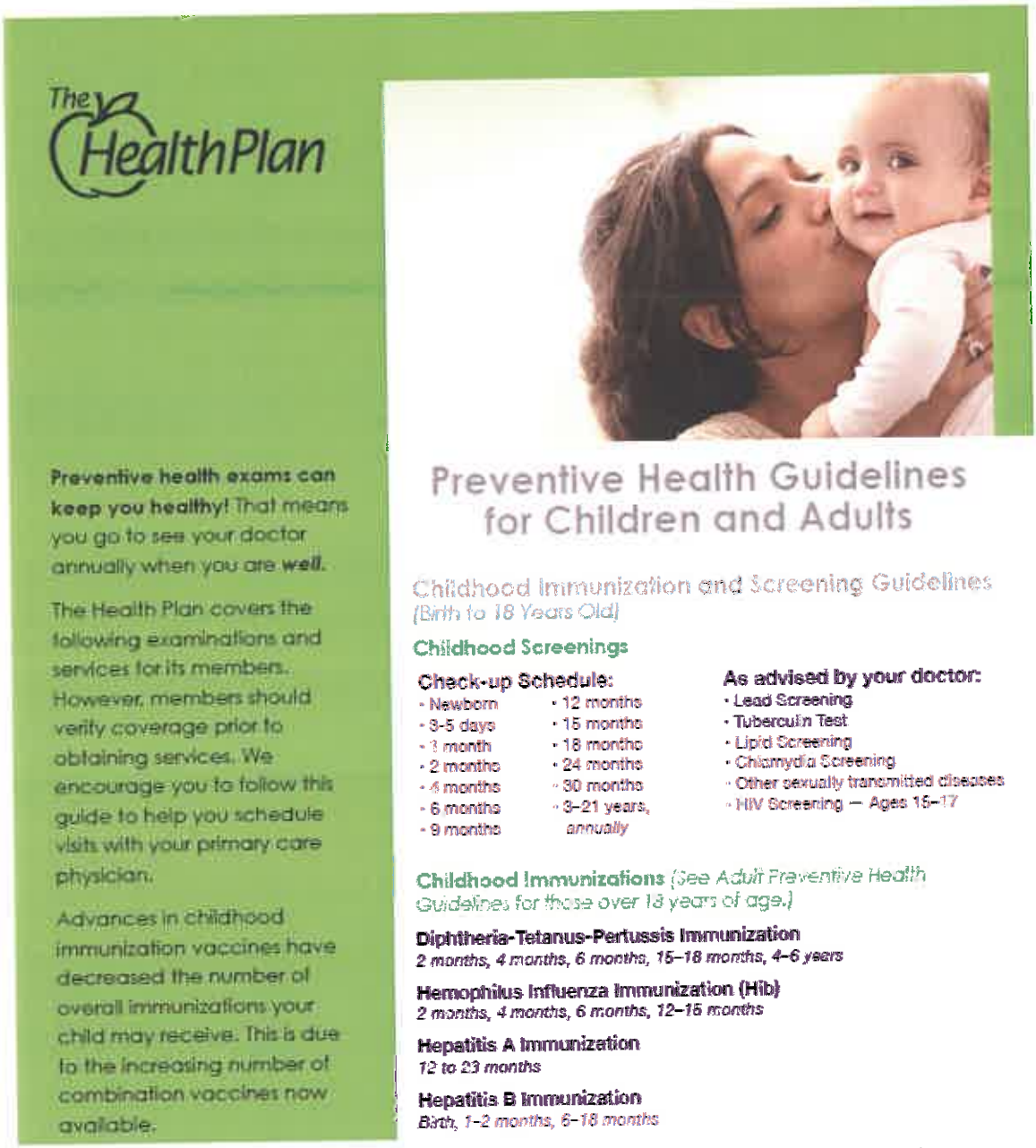
Figure 12: Tracking appointments. The appointment history tab in our care management system allows member advocates and care managers to view and change the status of a member's appointments, including pending, scheduled, confirmed, completed, rescheduled, canceled, missed or requested. Through this tab, the provider advocate or care manager can identify the member's missed appointment and can reschedule the appointment with the provider.

Through this tab, the member advocate and care manager can view and change the status of a member's appointments, including pending, scheduled, confirmed, completed, rescheduled, canceled, missed or requested. Providers can view any member appointments scheduled with them through our secure provider portal. Members can view their appointments through our care management system member portal.

Care managers and member advocates play a significant role in confirming members receive timely care and maintain appointments for routine medical and dental care. For a member enrolled in care management, the care manager tracks the completion of member appointments and reminds the member of upcoming appointments using our care management system. When a member has missed an appointment (as indicated

by a lack of a claim for the service or through engagement with the member or their provider), the care management system alerts the care manager to engage the member.

The care manager will educate the member about the importance of attending these appointments to access needed care and how missing an appointment affects the overall health of the member. The care manager then works with the member to schedule the appointment and follows up to verify the member has kept the appointment, which may mean that transportation is provided to the member for the scheduled appointment. Our population health management team tracks members with gaps in care as indicated by HEDIS and EPSDT measures. When those members are due for a screening, member advocates on our outreach team call these members to remind them of their screening, help them arrange an appointment and remove barriers to care, such as transportation. We send members information that explains preventive services, including why they are important and how to access them. The figure presents the Preventive Health Guidelines flyer we include in the new member welcome packet.



The HealthPlan

Preventive health exams can keep you healthy! That means you go to see your doctor annually when you are **well.**

The Health Plan covers the following examinations and services for its members. However, members should verify coverage prior to obtaining services. We encourage you to follow this guide to help you schedule visits with your primary care physician.

Advances in childhood immunization vaccines have decreased the number of overall immunizations your child may receive. This is due to the increasing number of combination vaccines now available.

Preventive Health Guidelines for Children and Adults

Childhood Immunization and Screening Guidelines
(Birth to 18 Years Old)

Childhood Screenings

Check-up Schedule:
- Newborn
- 3-5 days
- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 24 months
- 30 months
- 3–21 years, *annually*

As advised by your doctor:
- Lead Screening
- Tuberculin Test
- Lipid Screening
- Chlamydia Screening
- Other sexually transmitted diseases
- HIV Screening — Ages 15–17

Childhood Immunizations *(See Adult Preventive Health Guidelines for those over 18 years of age.)*

Diphtheria-Tetanus-Pertussis Immunization
2 months, 4 months, 6 months, 15–18 months, 4–6 years

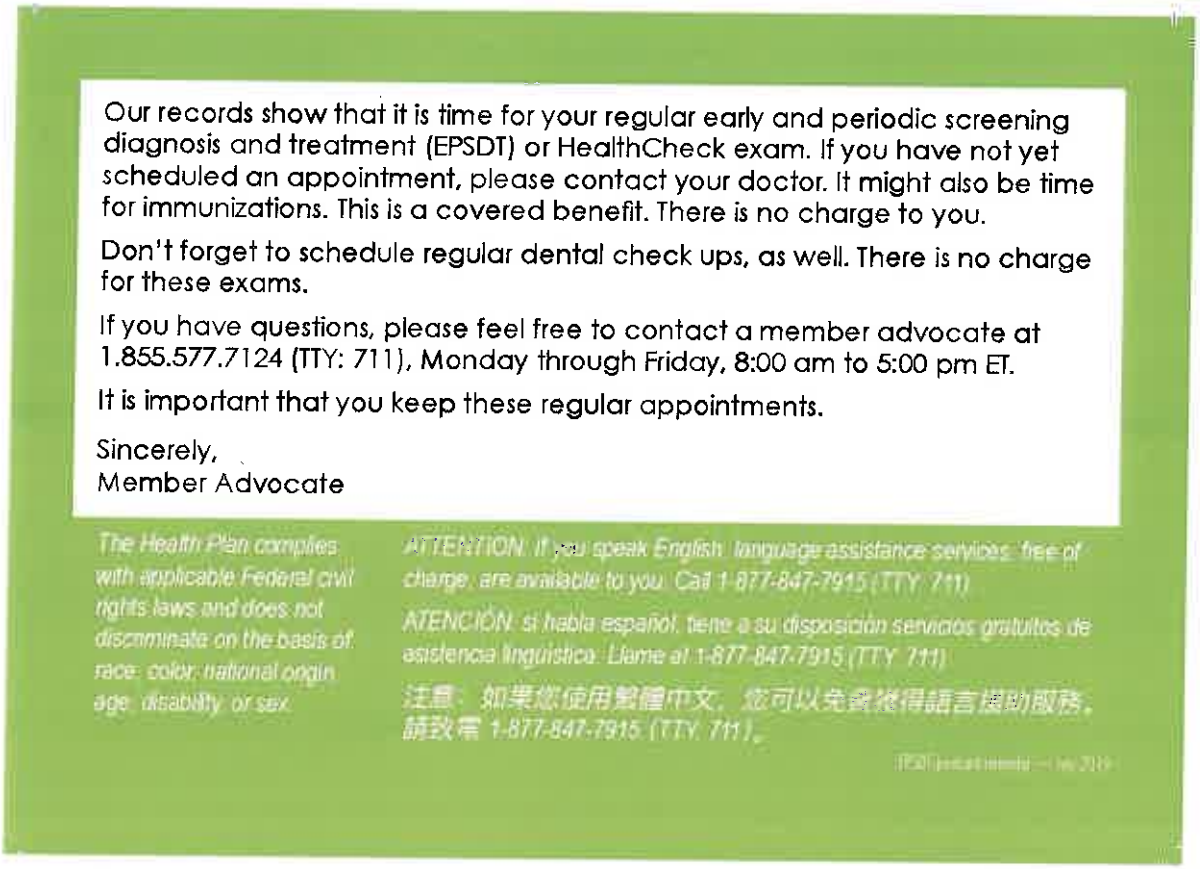
Hemophilus Influenza Immunization (Hib)
2 months, 4 months, 6 months, 12–15 months

Hepatitis A Immunization
12 to 23 months

Hepatitis B Immunization
Birth, 1–2 months, 6–18 months

Figure 13: Preventive Health Guidelines. We include this flyer in our new member welcome packet. It educates members about preventive screenings, why they are important and how to access them.

As presented in the figure, we send a postcard to members who are due for preventive screenings. It reminds of the screening needed and how to access it.



Our records show that it is time for your regular early and periodic screening diagnosis and treatment (EPSDT) or HealthCheck exam. If you have not yet scheduled an appointment, please contact your doctor. It might also be time for immunizations. This is a covered benefit. There is no charge to you.

Don't forget to schedule regular dental check ups, as well. There is no charge for these exams.

If you have questions, please feel free to contact a member advocate at 1.855.577.7124 (TTY: 711), Monday through Friday, 8:00 am to 5:00 pm ET.

It is important that you keep these regular appointments.

Sincerely,
Member Advocate

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7915 (TTY: 711)

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7915 (TTY: 711)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-847-7915 (TTY: 711)。

Figure 14. EPSDT Reminder Postcard. We send a postcard to members who are due for preventive screenings. It reminds of the screening needed and how to access it.

Improving the Rates of Access to Dental Services Among Children

In Q1 2018, we implemented a Performance Improvement Project (PIP) to improve rates related to accessing dental services among children aged 2-3. As presented in the figure, we developed and a mailed a dental postcard to parents/guardians, "Taking Care of Your Teeth is as Easy as...," to provide dental awareness and member education on the importance of early screenings and cleanings. The postcard was a coloring page postcard designed to get the child's attention instead of just throwing the postcard away.

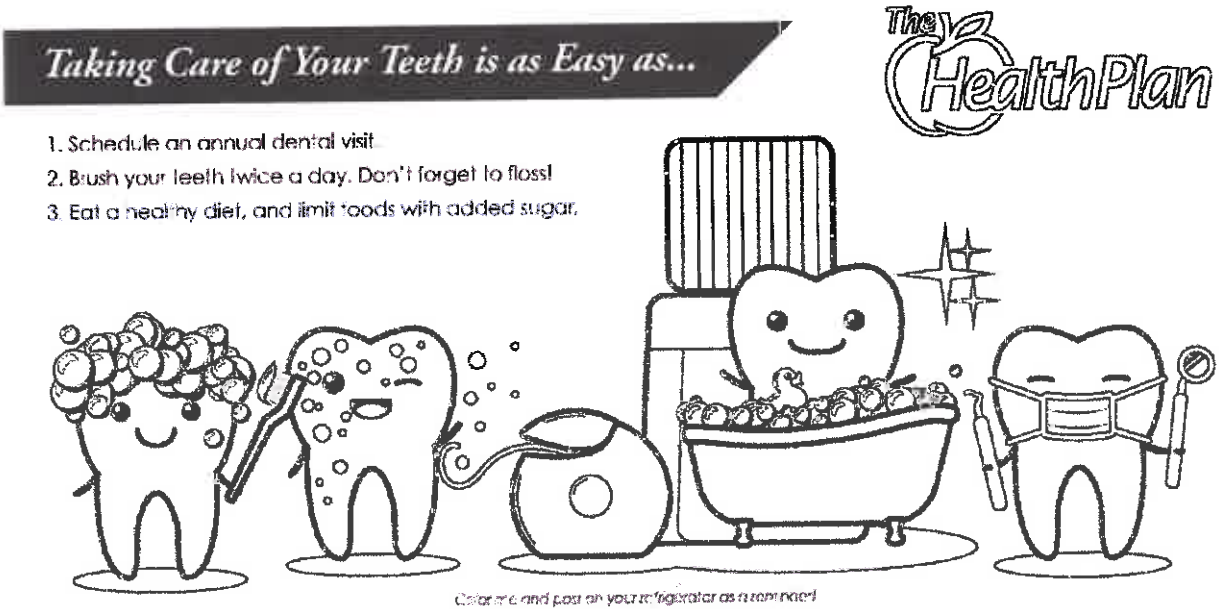


Figure 15. Our Dental Postcard. We developed a mailed a dental postcard to parents/guardians, "Taking Care of Your Teeth is as Easy as...," to provide dental awareness and member education on the importance of early screenings and cleanings. The postcard also provides information on what to do if the member has questions about their dental benefit and if they need help finding a provider.

As a demonstration as to the effectiveness of this reminder, our annual HEDIS rates for Annual Dental Visits increased from 27.40% in 2018 (MY2017) to 36.29% in 2019 (MY2018). Additionally, the Percentage of Eligible Who Received Preventive Dental Services increased from 34.98% in 2018 (MY2017) to 43.35% in 2019.

TheHealthPlan

Attachment 6
Care Management

3. Care Management

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Care Management (CM) as part of their bid. The Vendor's narrative response should not exceed 125 pages.

Foundational to The Health Plan's (THP's) clinical model is our systematic process to understand every member's circumstances and needs, their level of health risk and the focus (medical, behavioral or social) of their needs. Based upon this understanding, we engage our members in a continuum of care management, health and wellness and disease management programs that align with their needs and health risk. The figure presents an overview of the elements of our care management program.

Figure 1. Care Management Approach. Our approach seeks to understand every member's social, behavioral and medical circumstances and engage them in programs that support members across the continuum of care, including care management, wellness and preventive programs and disease management programs. We have implemented care management processes and tools, such as our advance data analytics, to understand our member's needs at the individual and population level so we can implement programs relevant to their needs and determine if our programs are improving member outcomes.

The table summarizes the elements of our care management approach for each of the elements in the previous figure.

Elements of our Care Management Approach
1. Wellness, Prevention and Health Promotion
▪ Outreach/Welcome calls ▪ Health risk assessment ▪ Screening reminders/gap in care closure/under and over utilization calls ▪ Trimester screening calls for pregnant women ▪ Risk reduction information: nutrition, exercise, stress management, safe opiate use ▪ Resource referrals: WIC, Birth to Three, Workforce ▪ Tobacco cessation
2. Chronic Disease Management
Education and service access support for high prevalence chronic conditions, including cardiac conditions, respiratory conditions and diabetes/pre-diabetes.
3. High Risk Pregnancy Program
Education, risk reduction service access and support, including: ▪ Maternal/Fetal medical conditions ▪ Maternal behavioral health and substance use disorders ▪ Couplet care for substance exposed infants ▪ Couplet care for neonatal abstinence syndrome
4. Utilization Management

▪ Dedicated medical preauthorization and behavioral health preauthorization units
▪ Dedicated medical concurrent, inpatient review and behavioral health inpatient review units that:
  ▪ Perform discharge planning with facility utilization management (UM)
  ▪ Conduct a 72-hour discharge outreach assessment
  ▪ Manage appointment set up and reminders post-discharge
  ▪ Refer members to navigation programs when need identified

5. Holistic Medical/Behavioral Care Navigation
Short-term episodic care coordination for members with identified needs related to: ▪ Caregiver support ▪ Personal resources ▪ Poor linkage to care (primary care provider [PCP], specialty care provider) ▪ Poor symptom or disease management ▪ Benefit issues ▪ Participation in a clinical trial ▪ Functional deficits ▪ Medication adherence ▪ End-of-life care
6. Holistic Medical/Behavioral Complex Case Navigation
Long-term care coordination for members at high risk based upon life altering diagnosis, disease or injury. Examples of trigger diagnosis groups include: ▪ Organ failure/transplantation ▪ Progressive degenerative neuromuscular conditions

Elements of our Care Management Approach
▪ Spinal cord injury/brain injury/trauma ▪ Serious and persistent mental illnesses ▪ Complex cancer cases ▪ Children enrolled in Children with Special Health Care Needs (CSHCN) Program
7. Pharmacy
▪ Utilization management ▪ Specialty pharmacy ▪ Site of care management ▪ Medication reviews and reconciliation ▪ Comprehensive opioid management program ▪ First fill limitations ▪ Claims and West Virginia Board of Pharmacy Controlled Substance Monitoring Program monitoring ▪ Confirmation of enrollment in pain management programs

Delivering Improved Outcomes

In 2019, we enrolled 8,548 members in a care management program. We were able to address the needs of 6,355 of those members and they no longer required care management services. As presented in the figure, we have seen substantial improvements in several measures for members we engaged in care management.

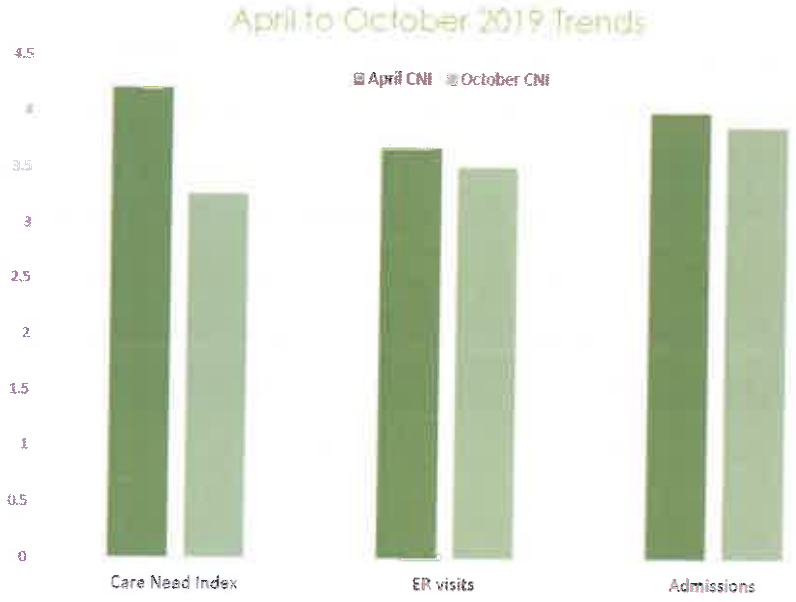


Figure 2: We have seen significant improvements for members we engaged in a care management program in 2019.

These are members who, based upon 12 months of data, had risk factors, such as a care need index (CNI) greater than 3.75, that indicated a need for engagement in care management. We discuss our care management criteria in **CM003** and **CM005**. We referred these members to care management. After six months, comparing the period Apr. 1, 2019 to Oct. 31, 2019, we saw significant improvements in the average:

- CNI dropped 22.57% from 4.21 to 3.26
- Number of ER visits dropped 4.82% from 3.68 to 3.50
- Number of admissions dropped 3.13% from 4 to 3.88

Community health worker pilot. In September 2018, we partnered with Marshall University, Community Care of West Virginia, Inc. and the Claude Worthington Benedum Foundation to implement a community health worker program that incorporates a community health worker as part of an interdisciplinary care team (ICT) at Community Care. On Nov. 1, 2018, we enrolled in the program 40 high-risk THP Medicaid members who have chronic conditions and poor patterns of utilization of healthcare services. Comparing the period Nov. 1, 2018, to Oct. 31, 2019, we saw significant improvements in the average:

Average per member health care spending dropped from $26,639 to $14,135 in the first year, a substantial reduction of 46.9%.

- Patient risk score, an indicator of a member's health risk, dropped 8.8% from 3.07 to 2.80
- Number of ER visits dropped 23.1% from 3.55 to 2.73
- Number of admissions dropped 85.9% from 0.64 to 0.09
- Number of prescriptions increased from a total of 59 to a total of 80, indicating more members receiving appropriate care

Improving access to dental services among children. In Q1 2018, we implemented a PIP to improve access to dental services among children as measured by the Annual Dental Visits for 2-3 Year Olds (HEDIS) measure and the Percentage of Eligible Who Received Preventive Dental Services (Child Core Set Measure). Our annual HEDIS rates for Annual Dental Visits increased from 27.40% in 2018 (MY2017) to 36.29% in 2019 (MY2018). Additionally, the Percentage of Eligible Who Received Preventive Dental Services increased from 34.98% in 2018 (MY2017) to 43.35% in 2019 (MY2018). This was the first re-measurement year and interventions will be ongoing. These increases exceeded our goal to improve these measures by 5%.

CM001. The Vendor should describe its Care Management program, including, but not limited to, the following:

CM002. Processes to organize its care management department by disease or problem type

Our comprehensive care management program includes appropriate oversight, operational processes, care management, health and wellness and disease engagement programs that comply with the requirements in Article III, Section 5, Health Care Management in the Service Provider Agreement. Our care management process and program achieves the Departmental goals, objectives and vision as described in RFP Section 1.4, Mountain Health Trust Managed Care Procurement Goals and Objectives. Core components of our care management program, discussed in the following sections, include:

- Assigning a navigator to help members navigate the healthcare system
- Employing advanced data analytics to understand our members' needs
- Quickly connecting members to care management services
- Improving care coordination by enhancing our care management system
- Delivering interventions to meet member needs across the care continuum
- Improving member outcomes through value-based payment (VBP) contracts
- Providing additional support to members in the community

Assigning a navigator to help members navigate the healthcare system. For members with low risk, but who have gaps in care, we assign a member advocate from our member outreach team to close gaps in care for members with HEDIS or EPSDT care gaps and support pregnant women with low risk throughout their pregnancy. For members who may benefit from care management, we assign a registered nurse (RN) care manager to help manage their care. We assign specialized care managers and resources to meet each member's needs for members in our care navigation and complex case navigation programs as we discuss in **CM004**.

Employing advanced data analytics to understand our members' needs. We evaluate our member population using Impact Pro and CC Group Marketbasket, our data analytics tools, to integrate data from a variety of sources to stratify members into care management levels in alignment with their health risk and identify population trends and member sub-populations within the larger member population so we can deliver interventions relevant to our members.

Quickly connecting members to care management services. Upon completion of the new member welcome call and health risk assessment (HRA), we immediately engage newly enrolled members in programs that can address their needs across the continuum of care, such as health and wellness programs, care management, disease management or pregnancy support programs. For members who may benefit from care management, before we assign a care manager to manage the member's care, we first assign a member advocate from our clinical team to engage the member. The member advocate works with the member to quickly resolve concerns that may be leading to their increased health risk and, potentially, avoid the need for care management.

Improving care coordination through the implementation of an enhanced care management system. We share data and promote collaboration among our care managers and the member's ICT and others involved in the member's care using our care management system. Our care management system facilitates the delivery of timely, integrated and coordinated services and supports across varied populations and delivery systems. It maintains all information about the member's care and services in their care management record, providing a comprehensive view of their needs and goals and the services and supports being delivered to them. It provides tools to collaboratively develop a treatment plan that meets each member's needs and goals, monitors the member's progress toward achieving their goals and identifies acute events so we can coordinate relevant and timely member interventions.

Delivering a range of programs and interventions to meet member needs across the entire care continuum. Based upon our understanding of each member, we deliver a range of interventions to meet their needs across the entire care continuum as we discuss in **CM003** and **CM005**. For instance, we connect members with low risk with a PCP and deliver prevention and wellness programs that empower them as they take responsibility for managing their health. For members who are at higher risk, we enroll them in an intensity of care management appropriate to their needs and assign a care manager to work with the member to coordinate their care. For members with specialized needs, such as members who are

WVU Medicine EHR, Epic, gives THP's care managers the ability to collaborate with WVUM providers and care coordinators by allowing them to access information about our members who are enrolled with WVUM. This includes information, such as discharge plans, member appointments, case notes, assessments and treatment plans. THP care managers can also update each member's EHR when providing the member with care management services.

pregnant with high-risk factors, such as previous pre-term birth, substance use disorder (SUD) or advanced maternal age, we engage them in our Perinatal Care Management Program and assign a perinatal care nurse experienced in labor, delivery, recovery and post-partum to coordinate their care.

Collaborating with providers to improve member outcomes through VBP contracts. We currently have three contracted VBP relationships in West Virginia and are in discussions with providers and major academic centers in the state to implement additional VBP contracts. We have VBP contracted relationships with the Prestera Center, WVUM and Community Care of West Virginia, Inc. We discuss our VBP contracts in **CM054**, **CM055** and **CM059**.

Care Management Department Organization

We have organized our care management department to provide care management services and supports to members across the continuum of care, and to confirm that each member receives the right care, at the right place, at the right time and the right cost. Through our care management process, we verify we are delivering positive outcomes in terms of quality of care, member experience, member outcomes, member quality of life and the cost of care. As presented in the figure, we have organized our care management department by member risk level (e.g., members who have low risk and/or no gaps in care versus members with high risk and several gaps in care), duration of care management need (short- or long-term) and disease or problem type, such as pregnant members with high risk or members who have SUD.

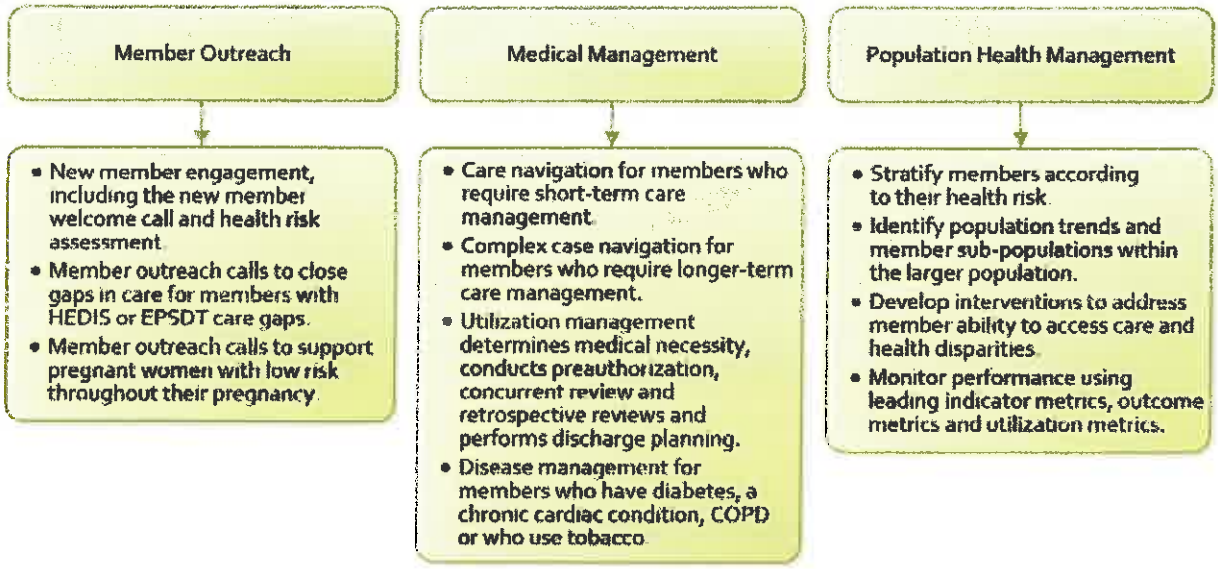


Figure 3. Care management department organization. We have organized our care management department by member risk level (e.g., members who have low risk and gaps in care or individuals with special health care needs), duration of care management need (short- or long-term) and disease or problem type, such as pregnant members with high risk.

CM003. 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)

CM005. Processes for identifying candidates for care management, or those receiving high-cost care, who would benefit from care management

We recognize the importance of understanding and addressing the social, behavioral and medical needs of our members in the Mountain Health Trust (MHT) program and delivering care management interventions that align with their health risk and their specific needs or circumstances. We identify members for participation in care management in accordance with Article III, Section 5.3.4 Coordination of Care for Persons with Special Health Care Needs and SSI Eligibles in the Service Provider Agreements.

We use a variety of methods to understand ***every*** member's circumstances and needs, their level of health risk and the focus (e.g., social, medical, behavioral) of their needs:

- ***For new members,*** we analyze data, such as paper enrollment forms from the enrollment broker. Member advocates on our outreach team perform an initial HRA to identify new member health risk and specific concerns, such as pregnancy or social determinants of health (SDOH) needs.

- ***For established members,*** our population health management (PHM) team conducts a monthly and quarterly predictive modeling analysis of all members to identify changes to their health status or risk. The team reviews referrals from members, families, providers, state agencies and other THP departments, such as our customer service center.

The figure presents our process for identifying new members for care management.

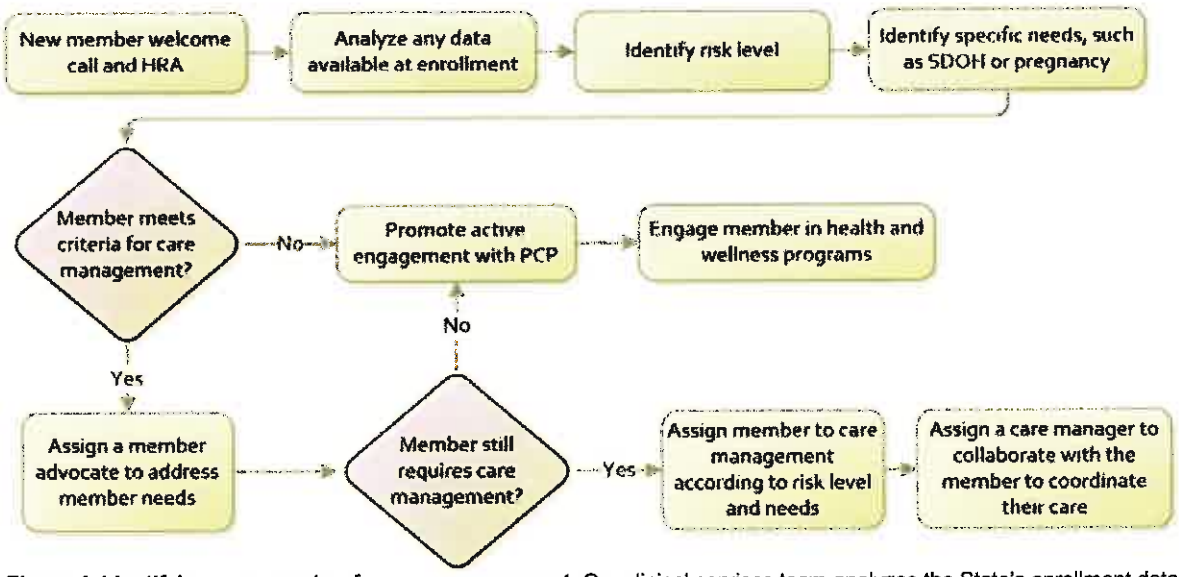


Figure 4. Identifying new member for care management. Our clinical services team analyzes the State's enrollment data, including a predictive modeling analysis of available data. Our outreach team performs an initial HRA to identify their health risk and specific concerns, such as pregnancy, chronic conditions or SDOH needs.

The figure presents our process for identifying established members for enrollment in care management.

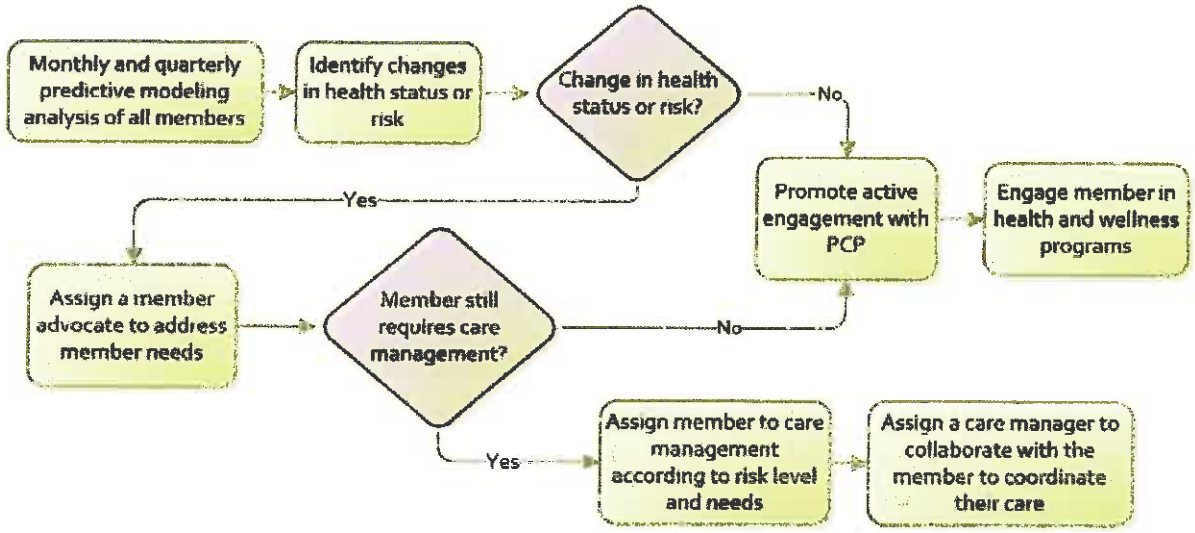


Figure 5. Identifying established members for care management. Our clinical services team conducts a monthly and quarterly predictive modeling analysis of all members to identify changes to their health status or risk. The team also reviews referrals from members, families, providers, state agencies and other THP departments, such as our member services center.

Identifying New Members – Welcome Call and Initial Screening

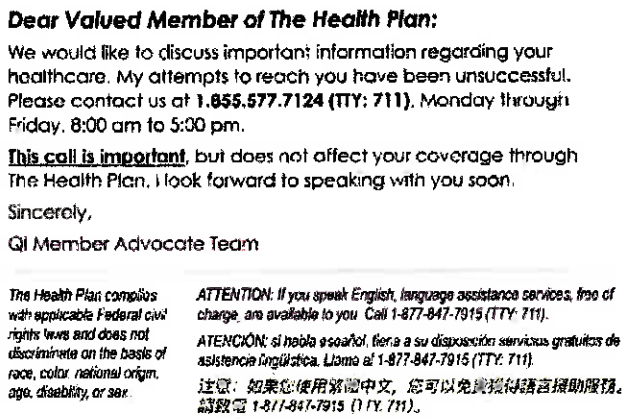
Completing the new member welcome call and HRA are critical to identifying members who may benefit from care management or other specialized programs (e.g., disease management) and connecting them to resources as soon as possible. The welcome call is often our first live contact with a member, and the HRA is our opportunity to understand our members in a personal way. We recognize that we are asking members to share deeply personal information through the HRA, so we train our member advocates to implement evidence-based engagement strategies, such as motivational interviewing, to help us build trust with every member.

Attempting to Reach the Member to Complete the Screening

We complete the initial HRA within 90 days of enrollment in accordance with Service Provider Agreement, Article III, Section 5.3.1 Initial Health Assessment. We attempt all initial assessments via our welcome calls within the first 30 days of member enrollment, far exceeding the Bureau for Medical Services (BMS) and NCQA 90-calendar day completion requirement and, most importantly, getting members the care they need

quickly. When a new member is assigned to us, we begin outreach to the member as follows:

- Send the member a welcome packet that introduces the member to THP and includes an HRA the member can complete and return to us. We document HRAs members send to us in our care management system and use it to determine if the member may benefit from care management.
- Send the member's ID card to them with a request for the member call us.
- A member advocate from our outreach team attempts to reach each member at telephonically in the first 30 days of their enrollment. Every unsuccessful attempt is followed by a mailed postcard requesting a return call.



Dear Valued Member of The Health Plan:

We would like to discuss important information regarding your healthcare. My attempts to reach you have been unsuccessful. Please contact us at **1.855.577.7124 (TTY: 711)**, Monday through Friday, 8:00 am to 5:00 pm.

This call is important, but does not affect your coverage through The Health Plan. I look forward to speaking with you soon.

Sincerely,

QI Member Advocate Team

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7915 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7915 (TTY: 711).

注意：如果您使用繁體中文，您可以免費得到語言援助服務。請致電 1-877-847-7915 (TTY: 711)。

Figure 6: Postcards to members we are unable to reach. We send this postcard to members with outstanding initial HRAs to encourage HRA completion.

The member advocate from our outreach team attempts to complete the new member welcome call and HRA, calling at different times of the day and on different days of the week to maximize success. We leave messages, when possible, for the member to return our call. Member advocates document each attempt to complete the HRA in our care management system. We send a postcard that explains we are trying to reach them and asks them to call us to complete the HRA. Additionally, our care management team takes advantage of every member interaction to complete the HRA. For instance:

- Members can complete their HRA through our member portal.
- When a member calls our customer service, our care management system identifies that the member needs an HRA. Our customer service representative (CSR) connects the member to our outreach team to complete the HRA.
- We analyze claims data to identify the member's recent providers so we can engage the member's providers to help us locate and engage the member.
- Our care management system identifies members when they engage with the healthcare system, such as a member in the hospital, so we can engage the member when they use healthcare services.

- We analyze pharmacy data to identify refill dates and service locations so we can engage the member's pharmacy to help us locate and engage the member.

Initial Screening Using Our Health Risk Assessment

Once a member advocate reaches the member, they complete the HRA, confirm the member has received their welcome packet, confirm the member has their ID card, confirm the member has a PCP or help them select a PCP and educate the member about what their plan covers and how to reach us. The member advocates use evidence-based pediatric and adult HRAs to evaluate the member's overall health and wellness and identify critical information, such as:

- SDOH needs, such as caregiver support, housing, food security, awareness of available community resources or health literacy
- Current PCP and provider relationships, active treatment plans and services
- Barriers to accessing care, such as transportation
- Chronic physical or behavioral health conditions or members who are pregnant
- Members with specialized needs, CSHCN

Identifying behavioral health concerns or specialized needs. When the HRA identifies a member's behavioral health condition, it triggers additional assessments to understand their needs. For example, our adult HRA includes validated tools, such as the Alcohol Use Disorders Identification Test (AUDIT)-C to screen for risky drinking and the Patient Health Questionnaire (PHQ)-2 depression screener. Our pediatric HRA assesses trauma using the Child Stress Disorders Checklist-Screening Form (CSDC-SF), and the need for special services and well-child (EPSDT) exams.

Identifying members who have chronic conditions. Our HRAs identify those members who have a significant disease process or chronic condition. When a condition is identified, this prompts a referral to the care management team, who will conduct a condition-specific assessment. We combine the identification of members

with specific conditions or needs with an assignment to a risk level and engage them in care management activities aligned with the intensity and focus of their needs. For example, members with asthma who are managing their condition may be assigned to a low risk level and engaged in disease management education. Members with the same condition, but who are not managing their condition well may be identified as high-risk and engaged in our high-risk disease management care navigation program.

Identifying members who have gaps in care. We identify members who have gaps in care using a variety of methods, including an analysis of HEDIS and EPSDT measures and using our advanced data analytics, described in the following section. Our analytics identify members who have gaps in care such as a member with a chronic condition who has not seen a PCP in the prior six months or a member with atypical utilization patterns, such as a member with bipolar disorder with no regular behavioral health visits as indicated by claims analysis, or ER use without associated primary care follow-up.

Identifying members who are pregnant. We identify and engage members who are pregnant as we discuss in **CM009** and **CM010**.

Identifying New and Established Members – Advanced Data Analytics

We evaluate our member population using our data analytics tools, to integrate data from a variety of sources, including our HRA, SDOH assessment and other assessments, medical and behavioral claims, pharmacy data from Department of Health and Human Resources (DHHR) or internal PBM if carved back in. Other sources include lab results, consumer

Initially for new members (using available historical data) and monthly for established members, we use our data analytics tools to create a health risk score for every member that incorporates expected future trending on each member based upon current patterns of care and key performance indicators, such as gaps in care, severity of illness of medical conditions, high cost, fragmented care, and utilization of ER and frequency of admissions or readmissions.

data, electronic health records, data from our UM and care management programs, all-payer claims databases or regional health information exchanges, and publicly available data from sources, such as the U.S. Census Bureau; County Health Rankings and Roadmaps; data from DHHR, such as diabetes prevalence in West Virginia; the CDC; the Food Research & Action Center; and West Virginia Food Link.

Our clinical analytics tools analyze variables at the member- and population-level and uses more than 300 clinical rules to stratify members into care management levels in alignment with their health risk and identify population trends and member sub-populations within the larger member population so we can deliver interventions that are relevant to our members.

Identifying Members Experiencing an Inpatient Admission

We identify members admitted to any clinical setting, including medical detoxification, substance use treatment centers, acute behavioral health inpatient units and crisis centers. We identify members experiencing an inpatient admission in a variety of ways, such as member notifications and UM reporting. Our care management system integrates ADT alerts from the WVHIN. As we discuss in **CM008**, once identified, we implement transitional care management programs as follows:

- ***Discharge planning*** for all members admitted to an inpatient setting
- ***Behavioral Health transitional care*** for members who have severe and persistent mental illness (SPMI)
- ***Transitional care navigation*** for members identified as at-risk for readmission or who have needs that are identified at the 72-hour post-hospital assessment

During their inpatient stay and during member touchpoints after the member has been discharged, our care management team evaluates the member's health risk and their continued need for care management. If the member continues to have unmet needs,

we identify them for engagement in care management. We automatically identify members with an inpatient stay over 20 days for engagement in care management.

Enrolling Members in Care Management – Timeliness of Enrollment

Our identification process leads to immediate engagement of resources to meet the member's needs. For instance, for members who have low risk, but who have gaps in care or members who are pregnant, but who have low pregnancy risk, our outreach team engages these members within 30 days of identification. The member advocate works with members to identify and resolve their barriers to accessing care, close their gaps in care or engage them in perinatal care. We discuss our process to identify and engage pregnant members in **CM009** and **CM010**.

For members who may benefit from care management, our care management team assigns a clinical member advocate within seven days of identification, (unless the member has requested care management, in which case the assignment takes place in 24 hours) to outreach to the member to:

- Determine if they have immediate needs that need to be resolved
- Identify and resolve barriers to accessing care, such as not having a PCP relationship or a lack of transportation
- Engage the member's providers to obtain information, such as a provider treatment plan, which will inform the care manager's comprehensive assessment and care planning processes.

If the member advocate is unable to resolve concerns or we determine the member continues to require care management, the member advocate discusses the value and

We assign a clinical member advocate to engage members who may meet the criteria for care management to:

- Identify and resolve concerns that may be leading to increased health risk, such as a lack of transportation.
- Obtain additional information for the care manager who will coordinate the member's care, such as provider assessment findings or treatment plans.

benefit of care management and whether it is right for them. If the member decides to participate in care management, the clinical member advocate refers the member to our care management team. The team enrolls the member in a care management program appropriate to their health risk and needs and assigns a care manager to collaborate with the member to coordinate their care.

Locating and Engaging Difficult to Reach Members

The clinical member advocate makes three attempts over a three-week period to engage the member, making one call per week for three weeks at different times of the day and days of the week. After the first call, we send a letter to the member that explains that we are attempting to reach them and the benefit of care management to them. After the second and third calls, we send the member a postcard explaining we are trying to reach them. We flag members we are unable to reach in our care management system at a "following level," indicating we were unable to contact them or they declined care management. We monitor their access to healthcare services through claims and interactions with relevant providers. We reach out again at transitional care opportunities (e.g., ER visits, post discharge) and make attempts to engage them in care management based on changing needs.

Partnership with Episource. Episource will help us locate and engage members who are high risk and may benefit from care management. We currently partner with Episource in our Medicare line of business and are expanding this partnership to Medicaid in 2020. Episource leverages technology to build comprehensive member profiles and engage members via multiple channels. Episource clinicians perform a face-to-face visit to understand member needs and connect them to care, including

reviewing their social environment and other risks that can be difficult to capture during office visits or telephonically.

Engaging members in the community through a community-based health navigator. In March 2020, we will implement a pilot with the Prestera Center that will include a community-based health navigator—paid for 100% by a THP care coordination fee and employed by Prestera Center. The navigator will supplement Prestera's care management team in Cabell, Kanawha and Putnam counties. They will locate and engage members who are difficult to reach and support THP members who need extra support in managing their healthcare challenges.

As we discussed in our introduction to the Care Management section, we will also use the community health worker we have embedded as part of an interdisciplinary care team at Community Care to help us locate and engage these members.

Care Management Risk Levels/Tiers

Based upon our understanding of each member's circumstances, needs and level of health risk, we deliver a customized array of services, supports and programs across the continuum that confirm every member receives the right care or support, at the right time, in the most appropriate setting, in the most efficient way. We have designed care management programs based upon five core factors: 1) member risk as indicated by a CNI over 3.75 or risk factors, such as high cost (e.g., more than $20,000 in behavioral health expenses in one year); 2) inappropriate or unnecessary utilization, such as four or more admissions in prior 12 months; 3) gaps in care, such as a member who has diabetes and an A1c over eight; 4) specific conditions (e.g., SUD); and 5) the intensity of intervention required (short or longer term). Our care management risk tiers include:

- ***Health and wellness programs*** promote member self-management by helping members close care gaps, continue to manage their health and chronic conditions and provide services and supports to members who are pregnant.
- ***Care navigation*** provides short-term, episodic care management, such as a member experiencing a high-risk pregnancy.
- ***Complex case navigation*** provides long-term care management to address high-cost care needs, catastrophic diagnosis or complex care delivery issues.

The table presents our risk levels and tiers and member engagement criteria for our health and wellness and care management programs across the continuum of care.

Programs to Address Member Needs Across the Continuum of Care	
Health and Wellness Programs for All Members	
Encouraging Annual Well-Visits	Members age 13-21 who have not had a well-visit in the previous 12 months, The goal is to increase the rate of members receiving well visit appointments by 10% through social media, outreach calls to members who have no claims for a well-visit within the past 12 months, notifying PCPs of their patients who have not had a well visit within the past 12 months and delivering targeted coordinated care through value-based agreements.
Improving Glycemic Control	Members age 18 and over who have diabetes. The goal is to lower or maintain the population with an HbA1c control by <8.0% by 5% through outreach and care navigation calls to members with an HbA1c >8.0% or a missing HbA1c, providing a list to the provider of patients who have an elevated or missing HbA1c, engaging members in diabetes disease management programs and delivering targeted coordinated care through value-based agreements.
Improving Diabetic Eye Exams	Members age 18 and over who have diabetes. The goal is to increase the target population who receive diabetic eye exams within the past 12 months by 10% through outreach calls to members who have no claims for a diabetic eye exam within the past 12 months, notifying PCPs of patients who have a missing diabetic eye exam, engaging members in diabetes disease management programs and delivering targeted coordinated care through value-based arrangements.
Women's Health Initiative 2020	This initiative is designed to support and improve evidence-based breast cancer, cervical cancer and chlamydia screening rates in women enrolled in the MHT program.
Performance Improvement Projects (PIPs)	We have implemented two PIPs to address to improve performance for the following measures: Adolescent Well-Care Visits and Annual Dental Visits for 2-3 Year Olds.

Incentive Programs	We offer members a variety of incentives to connect them to care, such as:
	- $50 gift card for a diabetes screening
	- $25 gift card for a pediatric dental visit
	- Maternity outreach programs:
	  - $50 gift card for 2 visits in 1st trimester
	  - $50 gift card for 4 visits in 3rd trimester
	  - $50 gift card for post-partum visit between 7-84 days after delivery
	- $25 gift card for yearly well visit for ages 3-6 and 12-21
	- $25 gift card for women ages 21-64 for pap smear every 3 years

Gap in Care	Member advocates on our member outreach team engage members who have

Programs to Address Member Needs Across the Continuum of Care	
Closure	gaps in care identified by HEDIS and EPSDT measures. During outreach calls, member advocates work with members to identify barriers to accessing these services, including SDOH, and connect members to resources that can resolve these barriers.
Other Wellness Programs	▪ Tobacco cessation packets, managed internally by our certified smoking cessation coordinators, for all members ages 12 and older, with workbook, relaxation exercises CD, and quit smoking survival kit ▪ Access to our CoreWellness online tool that helps members learn ways to get and stay healthy ▪ Connect members to *SafeLink* wireless that provides members with a free cell phone with free minutes for text and voice, unlimited calls to THP customer service and free wellness and appointment reminder text messages.
Disease Management	Members who have low risk and diabetes, a chronic cardiac condition, COPD or who use tobacco, including members who are pregnant.
Perinatal Care	We engage pregnant women who have low-risk pregnancies in a variety of activities to connect them to care throughout their pregnancy as we discuss in **CM010**.
Care Navigation – Short-term Engagement for at-risk Members	

SUD/BH Program	▪ Members who have SUD
	▪ Opiate overdose
	▪ Admission to crisis stabilization unit
	▪ Admission to SUD residential program
	▪ Acute inpatient psychiatric treatment
	▪ More than $20,000 in behavioral health expenses in one year (excluding ACT Program)
	▪ Members with a behavioral health condition, such as:
	  ▪ Schizophrenia
	  ▪ Attempted suicide or homicide
	  ▪ 30-day inpatient LOS members
	  ▪ Major depressive disorder
	  ▪ Psychosis
	  ▪ Bipolar disorder
	  ▪ Eating disorder

Perinatal Care	Pregnant women who have high risk or high-risk factors, such as previous pre-term birth, SUD or maternal age
Neonatal Abstinence Syndrome (NAS)	Family or couplet care for babies experiencing symptoms or effects of intrauterine substance exposure
Disease Management Programs for members with high risk	Members with high risk and one of the following conditions: ▪ Diabetes ▪ Chronic cardiac condition ▪ Chronic respiratory condition, such as COPD
Coordinated Care Navigation for Multiple Chronic Illnesses	Members who have three of the following six conditions, including high blood pressure, ischemic heart disease, CHF, COPD, diabetes or major depression
Individuals with Special Health	Members who require short-term assistance due to specific conditions or identified needs

Programs to Address Member Needs Across the Continuum of Care	
Care Needs (Care Navigation)	▪ Enrollment in a clinical trial ▪ Members receiving care from an out-of-network provider ▪ Member experiencing care transition between providers or MCOs or into or out of fee-for-service programs, such as transplant ▪ High-cost care identified through monthly claims-based analysis ▪ Members with diagnoses likely to represent chronic pain and the need for pain management services. ▪ Children with high risk or high-risk factors enrolled in WVCHIP ▪ Needs related to end-of-life care, functional deficits, lack of personal resources, benefit issues, poor linkage to care, poor symptom management, lack of caregiver support and medication adherence
Complex Case Navigation – Longer Term Engagement for at-risk Members	
CSHCN	▪ Children enrolled in the CSHCN program ▪ Children with autism or ADHD with high risk or high-risk factors ▪ Babies diagnosed with neonatal abstinence syndrome (NAS)
Complex Case Navigation for Individuals with Special Health Care Needs	Members who require long-term assistance due to high-cost care needs, catastrophic diagnosis, illness or injury or complex care delivery issues, including: ▪ Transplant ▪ Catastrophic neuromuscular diseases ▪ Brain injury in active treatment ▪ Cystic fibrosis ▪ New spinal cord injury ▪ Critical or major burns ▪ Immunodeficiency ▪ Ventilator cases in home setting ▪ Major congenital anomalies ▪ Complex cancer cases in active treatment with ongoing high cost care ▪ Hemophilia ▪ Genetic abnormality with ongoing care, treatment or monitoring ▪ Trauma - complex care needs in active treatment ▪ Serious and persistent mental illness (as evidenced by recurrent, non-substance abuse related psychosis or mania with multiple emergent admissions-more than three admissions for CSU and/or inpatient psychiatric acute admissions per year) ▪ Extreme premature birth – 28 weeks or less ▪ Children with high risk or high-risk factors enrolled in WVCHIP
Value-based Payment Models for At-risk Members	
We have three contracted VBP relationships in West Virginia and are in discussions with providers and major academic centers in the state to implement additional VBP contracts. Our contracted VBP relationships include the Prestera Center, WVU Medicine and Community Care of West Virginia, Inc.	

Identifying each Member's SDOH

Our identification process identifies barriers that stand in the way of our members accessing care. We incorporate SDOH into our care management approach as follows:

- ***New member welcome call and initial screening.*** During the new member welcome call, our member advocates on our outreach team document SDOH needs or barriers to accessing care. If the member advocate identifies SDOH needs, they use our SDOH assessment, discussed below, to understand them.
- ***Data analytics.*** Impact Pro analyzes a variety of data sources to identify the impact of social determinants to member's overall risk.
- ***ICD-10 codes.*** One of the key barriers to expanding access to nonmedical care for social needs is a lack of coding standardization. Implementing ICD-10 codes will help us identify the impact of SDOH on our members' ability to access care and allow us to track the delivery of services to address SDOH, while avoiding additional administrative work for providers.

SDOH Assessment. Many of our care management system's assessments identify members who have SDOH needs, which prompts the member advocate or the member's care manager to use our SDOH assessment to obtain additional information. The assessment asks 16 questions related to SDOH, such as housing, education, employment, safety and income. THP's care managers also have access to WVU Medicine's EHR, Epic, which gives them the ability to collaborate with WVU Medicine providers and care coordinators by allowing them to access information about our members who are enrolled with WVU Medicine. This includes information obtained by Epic's SDOH assessment tool, which identifies SDOH needs across domains, such as financial risk, social connections and intimate partner violence.

CM004. Processes and timeframes for assigning members to a care manager

Once the member agrees to participate in care management, our care management team assigns a care manager to collaborate with each member to coordinate their care and deliver care management services in accordance with Article III, Section 5.3.2 Coordination of Care in the Service Provider Agreement. We take appropriate steps in the initial care manager assignment to confirm a compatible match, including considering cultural or language

We support every care manager with specialized resources that provide additional expertise to address each member's unique concerns, including a member advocate, social worker, pharmacist and medical director.

needs and member requests. We also work to maintain the relationship developed between the member and their member advocate when the member has been identified for participation in care management.

We assign an RN or licensed social worker care manager to every member enrolled in care management. We assign specialized care managers and resources to meet each member's needs for members in our care navigation and complex case navigation programs as follows:

- ***SUD/BH:*** RN or licensed social worker care manager with background in SUD or behavioral health acute care with the support of the THP clinical psychologist.
- ***Perinatal care:*** Perinatal care nurse experienced in labor, delivery, recovery and post-partum.
- ***NAS:*** Perinatal care nurse experienced in labor, delivery, recovery and post-partum and pediatric experience.
- ***High-risk disease management, coordinated care navigation for multiple chronic illnesses, care and complex case navigation:*** RN care manager with a minimum of five years' care experience in related clinical area (e.g., cardiac, intensive care or pediatrics) or a Certified Diabetes Educator or licensed clinical social worker with a minimum of five years' care experience in a hospital, outpatient or skilled nursing facility (SNF) setting.
- ***Health and wellness/low-risk disease management:*** American Lung Association Certified program facilitator, LPN/member advocate.

Once enrolled in care management, we communicate to each member their care manager's name and contact information, their member's level of health risk and their care management program and the next steps in the process, such as completing the comprehensive assessment and developing a member-centered treatment plan.

CM006. Processes for how care managers will establish relationships with members, including frequency and timeliness standards after the initial health assessment

Establishing a trusting relationship between the member and their care manager is a basic tenet of care management and is foundational to helping the member participate in and navigate the healthcare system. The care manager is the member's primary point

of contact and provides each member with individualized, person-centered support. From the initial contact with the member through care planning and the implementation of the member's services and supports, the care manager uses evidence-based approaches, such as motivational interviewing and trauma-informed care, to actively listen to the member and prioritize the member's voice and choice in all decisions regarding their care. Through every member touchpoint, the care manager promotes the member's role in self-determination, encourages them to actively participate in all aspects of coordinating their care and advocates for the member to make decisions about their care and services in meaningful ways.

Frequency and Timeliness Standards after the Initial Health Assessment

Once the member has been enrolled in care management, our care manager engages the member to begin a comprehensive assessment of their needs, goals and preferences for care within 30 days of the completion of the HRA. The care manager collaborates with the member and their planning team to complete the comprehensive assessment as soon as possible after the HRA. The assessment must be completed within a timeframe that allows the member's initial treatment plan to be completed within 60 days of the engagement of the member in care management.

The care manager engages every member at least annually to reassess their needs and update their care plan. They also engage each member at various touchpoints and frequencies based upon the intensity of their needs, such as may be indicated by a high CNI, and the types of opportunities, goals and interventions (OGIs) in their care plan. We discuss OGI development in **CM037**. For instance, a member with newly identified diabetes might require intensive intervention to get their diabetes under control, but the

intensity of intervention may be reduced as the member achieves their goals and is able to manage their diabetes. Care managers work with each member to develop a mutually agreed upon frequency of engagement, but engage members at a minimum as follows: Members with intensive needs – daily to monthly; moderate needs – every 1-5 months; or infrequent needs –every 6-8 months.

CM007. 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

We require specialists serving as the member's PCP to perform the care coordination functions defined in Article III, Section 2.2.1 PCP Responsibilities in the Service Provider Agreement. We document these specialists in our care management system. We monitor utilization and identify members who are not receiving primary care services as follows:

- Identifying members who are not visiting their specialist provider during discussions with the member or by monitoring claims to confirm the member is visiting their specialist provider to receive primary care services.
- Confirming compliance with PCP responsibilities, such as verifying the member visits their PCP within seven days of an inpatient discharge.
- Using our data analytics tools to identify:
  - Members with utilization patterns that indicate a lack of coordination, such as a member with bipolar disorder with no regular behavioral health visits or ER use without associated primary care follow-up.
  - Members with gaps in evidence-based care, such as HEDIS, indicating the specialist provider may not be delivering preventive care services.
  - Members with high healthcare spend or unnecessary or inappropriate utilization that indicate the specialist provider may not be coordinating the member's care and delivering services appropriate to their needs.
- Conducting medical record audits to measure the compliance with THP's Standards for Patient Records Guidelines. Medical records are chosen from statistically valid samples and areas of opportunity in HEDIS, past deficiencies, high volume, no prior review, changes or transitions of care.

Interventions if Adequate Services are Not Being Provided

Our provider engagement team works hand-in-hand with care managers to educate specialists about their care coordination responsibilities when they serve as the member's PCP and monitor their involvement in each member's care. THP tracks and trends claims and utilization data to identify ongoing issues with providers and review and evaluate additional action for providers who are consistently noncompliant with THP clinical standards of care per THP contracting and credentialing guidelines. Corrective actions vary according to the nature and severity of the issue and may include:

- Discussion with the practitioner or a written warning to the practitioner
- Placing the practitioner under a focused medical record or claims-generated review at scheduled intervals
- Requiring the practitioner to enter into a preceptor relationship with another practitioner, whereby the preceptor monitors and observes the practitioner, including examining medical records and interaction with patients
- Requiring the practitioner to complete continuing medical education regarding the treatment, procedure or service in question
- Limiting privileges, such the authority to perform certain procedures

If the corrective actions do not resolve the concern, we forward provider issues to our Quality Improvement Committee (QIC) for further review and recommendations. Recommendations may include termination of the practitioner's contract or that the practitioner be re-credentialed sooner than the practitioner's next routine scheduled date. Our Executive Management Team (EMT), which acts as an oversight committee to the QIC, reviews recommendations for corrective action from QIC. The EMT reports the approved recommendations to THP's board of directors for final decision. If the final determination is that corrective action should be taken, the practitioner will be notified in writing, setting forth the type and nature of the corrective action to be taken.

CM008. Processes to ensure continuity and coordination of care

We confirm and manage the continuity and coordination of each member's care in a variety of circumstances using processes and tools relevant to the member's specific situation. The first way we maintain the continuity of every member's care is through our care management approach. The second way we confirm the continuity of every member's care is by implementing processes that manage transitions of care.

Confirm Continuity of Care through Our Care Management Approach

We recognize the importance of promoting and facilitating collaboration among our care teams, the member and their providers to deliver coordinated and integrated supports that meet each member's needs. In accordance with Article III, Section 5.3, Continuity and Coordination of Care in the Service Provider Agreement, we promote continuity and coordination of care using the following processes and tools:

- Assign a care manager to work with the member to coordinate their care
- Implement care management activities to coordinate member care
- Provide timely communication of clinical information among the care manager, the member and their providers

Assigning a Care Manager to Collaborate with the Member

As we discussed in **CM004**, we assign a care manager to work with the member, their providers and their chosen planning team to assess their needs and goals, develop a treatment plan, implement services and supports and monitor the member's health status and progress toward the completion of their goals. The care manager serves as the member's primary point of contact and provides each member with individualized, person-centered support. We assign a care manager with the relevant experience and expertise to support the member and we support the care manager with additional expertise, such as a medical director and pharmacist.

Care Management Processes and Activities to Coordinate Member Care

As we discuss in **CM013**, the member's care manager collaborates with the member and their ICT to coordinate, enhance and monitor the member's care. Through valuable discussions with the member and their ICT and by using our care management system, the care team and ICT proactively engage members in care management activities, such as assessing the member's needs, developing a treatment plan, implementing interventions, monitoring their health status and progress toward achieving their goals.

Providing Timely Communication of Clinical Information

Our care management system enables the timely flow of information so our care teams and the member's providers and community partners can proactively coordinate, enhance and monitor the member's care. Our tools allow our care manager and ICT participants to collaborate to assess the member's needs and share assessment findings; develop, view and update their treatment plan; view actionable data and take appropriate action based upon that data; monitor the member's progress toward achieving their goals; and validate the member is experiencing improved health outcomes. Our tools maintain the continuity of each member's care by maintaining the member's electronic health record, allowing for the THP care management team to coordinate care and sharing member data and promote collaboration with providers through our provider portal.

Maintaining the Member's Electronic Health Record

Our care management system maintains all information about the member's care and services in their care management record, providing a comprehensive view of their needs and goals and the services and supports being delivered to meet their needs and help them achieve their goals, including:

- ***Member info,*** such as demographics, primary address, Medicaid ID, contact information of ICT members and programs in which the member is enrolled.
- ***Member health,*** such as medical information, service dates and outcomes, provider visits, diagnosis summary; ADT alerts and messages; managed conditions; pharmacy data and medications, health indicators and appointments.
- ***Member gaps in care,*** such as preventive services/required screenings as indicated by HEDIS or EPSDT, follow-up with a PCP within 7 days of behavioral health discharge, utilization patterns that indicate a lack of coordination.
- ***Member treatment plan,*** such as the member's treatment plan, service plan advance directives, referrals, progress notes and case conference notes.
- ***Member activity record,*** including completed and scheduled activities. The record captures notes (e.g., physician orders, persons giving informal support) and documents (e.g., lab reports, X-rays, signed consent forms).

Providing Tools for the THP Care Management Team to Coordinate Care

Our care management system enhances coordination of care, improves communication, reduces fragmentation and offers seamless continuity of care. It does this by providing a mechanism to ***share the member data*** needed to coordinate member care and ***providing tools that promote collaboration*** among the care manager, member, their providers and others involved in the member's care. Our care management system allows the care team to:

- ***View or update the member's treatment plan.*** Facilitates the development of a treatment plan that includes evidence-based OGIs that help each member achieve their goals and desired outcomes.
- ***Monitor the member's progress toward achieving their goals*** using interventions that include specific steps with defined due dates that are assigned to the member or an ICT participant, the member, care manager and ICT can monitor progress toward completion of each of the member's goals.
- ***Respond to actionable data*** that alerts the care manager about changes in the member's health status by continuously integrating claims/utilization data and lab and predictive modeling results.
- ***Monitor the member's adherence to their treatment plan***, such as a member with asthma not filling prescriptions for a rescue inhaler.
- ***Identify and address members experiencing a care setting transition*** by integrating ADT alerts from the WVHIN and provider systems, such as Epic.
- ***Identify and address members who have gaps in care*** by integrating HEDIS and EPSDT measures and predictive modeling results that indicate a care gap, such as a member with a chronic condition who has not visited a PCP.

Sharing Data and Promoting Collaboration with Providers

Our secure provider portal gives providers a variety of capabilities to access member data and collaborate to coordinate member care, including:

- ***Data sharing***. Shares the information in the member's care management record.
- ***Assessment.*** Review and contribute to member assessments.
- ***Care planning.*** Review and contribute to a member's treatment plan.
- ***Communication.*** Securely communicate with care team members and email external users.
- ***Monitoring member care.*** Integrates data analyses and provides this information to the ICT in an actionable way, including monitoring the member's progress toward achieving their goals and their adherence to their treatment plan, identifying at-risk members and responding to ADT alerts from the WVHIN.
- ***Managing care setting transitions*** by providing workflows that help manage care setting transitions, such as prompting for follow-up PCP appointments and tracking the completion of a post-hospital assessment.
- ***Identifying members with gaps in care*** using a customizable Quality Measure Dashboard, which allows providers to view their members with care gaps using HEDIS quality measure data, refreshed twice monthly.
- ***Identifying each member's risk level***, allowing providers to engage their members with the highest risk.

The figure presents the provider portal Population Dashboard. The dashboard is the screen providers see when they log in to the provider portal.

Figure 7. Population Dashboard. This dashboard gives providers quick application access to tools, such as the care planning tool, and provides tiles with summary statistics of the members in the provider's panel.

Processes to Manage Transitions of Care

We have implemented processes and tools to manage transitions of care, including maintaining the member's continuity of care at contract start or for members new to our health plan, maintaining the continuity of each member's care during an inpatient stay and maintaining the continuity of the member's care when they change providers.

Maintaining Continuity of Care for Members New to Our Health Plan

Our continuity of care approach seamlessly facilitates the uninterrupted delivery of medically necessary services. Our approach includes processes and systems to:

- Identify open prior authorizations by working with the state's prior authorization vendor, KEPRO, the fiscal agent and BMS to obtain data that identifies open authorizations.
- Identify members receiving services from out-of-network (OON) providers and continue to deliver services through those providers either via contracting with them, or by using a single case agreement (SCA).
- Identify members in the midst of a treatment plan, such as pregnant members, and continue treatment with the member's provider.
- Identify members who may benefit from care management, enroll them in care management, reassess their needs and update their treatment plan.

We request authorizations for members over the past year, which helps us understand each member's health risk and needs and helps us process service authorizations.

Maintaining Continuity of Care During an Inpatient Stay

Hospitalizations are times of great vulnerability for our members. Through discharge planning, we help members move from the hospital to their next level of care. Our care management and UM teams collaborate with the member and their chosen planning team to develop a discharge plan that helps the member remain safe when they transition to another setting. Discharge planning improves outcomes by anticipating post-discharge issues and identifying interventions to mitigate them.

The discharge plan builds on the member's strengths and identifies the services and supports that meet their needs and help them achieve their goals. The discharge plan addresses financial, psychosocial needs, community resources, medication reconciliation, pain management and concerns that need to be addressed to confirm the member is safe. It addresses any factors that may impede the member from seeking the appropriate follow-up care, such as transportation, financial concerns, access to a PCP or insufficient education about their discharge plan.

We customize our discharge planning process to the needs of our members. SPMI transitional care is for members who have SPMI and have visited the ER or experienced an inpatient stay. We assign a behavioral health UM RN to perform concurrent review and participate in the discharge planning process with the support of a clinical psychologist as appropriate.

Our discharge planning approach includes methods to identify members experiencing an inpatient admission, qualified personnel to lead the discharge planning effort, appropriate assessment tools, care management tools that promote collaboration among ICT participants and share member data and a comprehensive discharge planning process. We assign an experienced behavioral health or medical UM RN to perform concurrent review depending on facility setting, participate in discharge planning, help determine the member's care management needs post-discharge, perform a readmission risk assessment and perform a 72-hour post-discharge assessment. The UM nurse implements our comprehensive discharge planning process, presented in the figure.

Our dedicated behavioral health and medical UM teams provide specialized expertise to address the needs of members with medical and behavioral conditions. The behavioral health UM RN calling the member is the same person who reviewed their SUD residential stay. The medical UM RN calling member is the same person who first reviewed their acute stay, then their medical rehab stay and is now calling them at home.

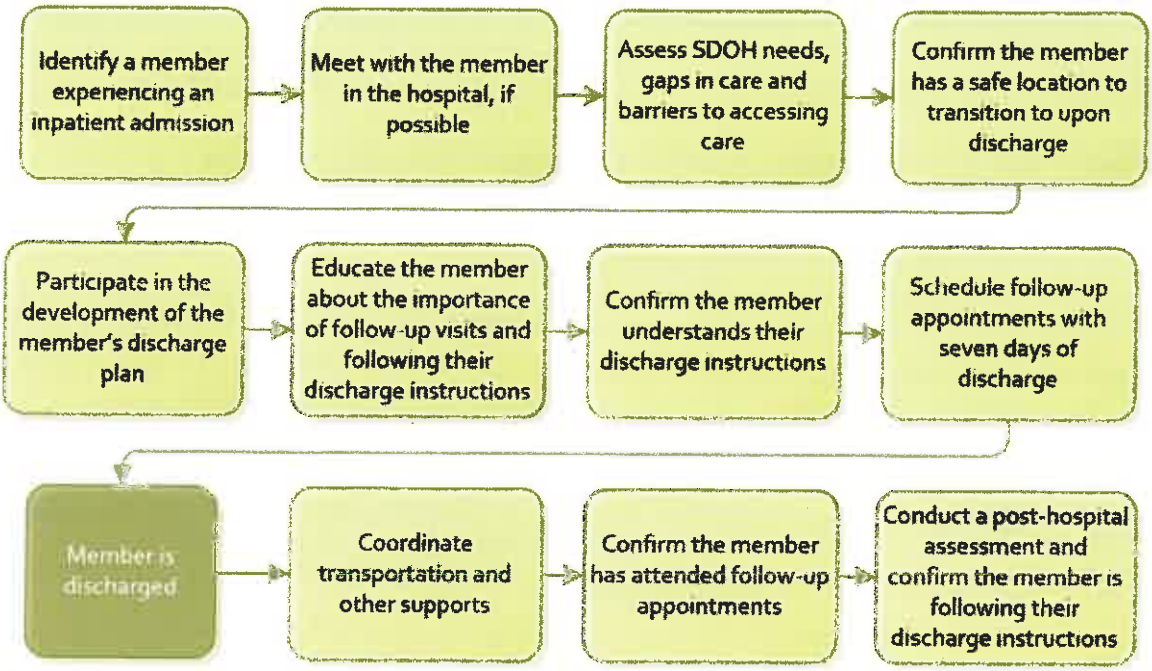


Figure 8. Discharge Planning. Discharge planning begins once we become aware of a member's admission. During the member's inpatient stay, we assess the member's post-discharge needs and goals and support the development of a discharge plan that deploys comprehensive services and supports to meet their needs and help them achieve their goals. The plan helps prevent readmissions by anticipating post-discharge issues and implementing interventions to mitigate them.

Discharging the Member and Post-discharge Follow-up

At the time of discharge, the UM nurse reviews the discharge plan with member, makes final adjustments, arranges services, as needed, and confirms the instructions are understood by the member and shared with the ICT as appropriate. The UM nurse educates the member about the importance of follow-up with their PCP. For members identified as at-risk for readmission during their inpatient stay or who have needs identified at the 72-hour post-hospital assessment, we assign a care manager, member advocate or social worker (depending upon the member's primary needs) to engage the member for up to 30 days post-discharge.

They confirm the member and their caregivers understand the discharge plan, identify and eliminate barriers to care, perform a medication reconciliation, conduct a post-discharge assessment, educate the member about their discharge plan, coordinate

appointments with providers and arrange transportation, if needed. At the end of the 30-day period, we evaluate the member's health risk and the continued need for care management and enroll them in a care management program, if needed.

Automating the Transition Planning Process

Our care management system alerts the care manager and ICT that a member is experiencing a care transition and requires outreach. It provides the care manager and ICT with a customizable workflow to follow when supporting a member through a care setting transition, confirming all steps of the discharge planning or transitional care management processes are completed, such as post-hospital assessments and confirming the member sees their PCP within seven days of discharge.

We implement transitional care navigation for any member who has been identified as at-risk for readmission or who has needs identified at the 72-hour post-hospital assessment. We engage these members for up to 30 days post-discharge to confirm they understand their discharge plan, identify and eliminate barriers to care, perform a medication reconciliation, conduct a post-discharge assessment, educate the member about their discharge plan, coordinate appointments with providers and arrange transportation, if needed.

Maintaining Continuity of Care when Changing Providers

If the member is transitioning to a new provider, our clinical services team assigns a care manager to work closely with the member and their providers to transition their care. For instance, for a member transitioning from an out-of-network (OON) provider to an in-network provider, the care manager works with the member and their OON provider to gradually transition care to a network provider with a comparable certification, specialty and expertise. The care manager contacts the OON provider to gather the clinical information necessary to coordinate the delivery of the member's care with the new provider. The care manager shares this information with the new provider in a variety of ways, such as discussions with the new provider, or by documenting this

information in our care management system, which maintains all information about the member's care and services in their care management EHR and allows providers to see this information through our provider portal.

CM009. Processes to identify pregnant women at enrollment and on an ongoing basis

Recognizing the importance of timeliness for outreach for pregnant members, we have a number of mechanisms to identify pregnant members and their level of pregnancy risk, including:

- ***For new members,*** we analyze state enrollment data to identify pregnant women using the rate code provided and the Comment File we receive from the State and conduct the new member welcome call and HRA.
- ***For new and established members,*** we use Impact Pro to identify members who are pregnant and their level of pregnancy risk, claims-based reports to identify members who have pregnancy diagnoses. We review referrals from members and THP functional areas, such as utilization management and review referrals from providers.

Once identified, we determine the member's risk level using our data analyses, their engagement with an obstetric provider and through our telephonic engagement of the member to conduct a Prenatal Health Risk Assessment. The assessment screens for risk factors, such as prior pre-term birth, substance use, tobacco use, social needs or behavioral health diagnoses.

CM010. Processes to promote "early and often" prenatal care for women identified as being pregnant

Promoting early and often prenatal care for members who have low risk. Our care management team assigns a member advocate from our outreach team to connect pregnant members to perinatal care. During the first 30 days after we become aware of their pregnancy, the member advocate attempts to reach the member three times, calling the member once per week for three weeks. If the member advocate is unable to reach the member, they set a reminder in our care management system to contact the

member again in 30 days. We send the member a letter and a postcard explaining that we are trying to reach them and asking them to call us.

When the member advocate reaches the member, they will continue to engage the member throughout her pregnancy so long as her pregnancy risk remains low. At initial engagement call, the member advocate educates the member about her pregnancy and reminds her about the importance of keeping scheduled appointments and following-up with her provider to address any concerns. The member advocate completes a perinatal outreach survey that identifies information, such as which pregnancy this is for the member, the member's due date, the member's OB, risk factors, such as tobacco use, diabetes, pervious pre-term birth or high blood pressure and whether the member has accessed prenatal care, such as an ultrasound or prenatal visits with her OB.

The member advocate continues to engage the member at least once each trimester to monitor her health status, confirm she is receiving prenatal care and identify and resolve any care gaps or barriers to accessing care. During the second trimester outreach, the member advocate confirms the member's engagement and monitors her health status by asking questions, such as *Has your due date changed? Do you have an appointment for your next prenatal visit? Has your blood pressure increased?*

During the third trimester outreach, the member advocate confirms the member's engagement and monitors her health status by asking questions, such as *Are you attending childbirth classes? Are you planning to breast-feed your baby?* The member advocate also discusses other concerns with the member, such as what to do if her water breaks, how to recognize the symptoms of labor and the symptoms that warrant the member calling her doctor immediately.

Once the mother gives birth, the member advocate calls the member to check in and conduct a postnatal depression screening using the Edinburgh Postnatal Depression Scale (EPDS), which asks 10 questions to determine the member's risk for depression. The member advocate also obtains information about the member's baby so we can confirm the baby is receiving appropriate care.

This includes completing an HRA on the baby and confirming the baby is engaged with a pediatrician and connected to well-child visits. The member advocate educates the member about and confirms the member has applied for services for which she and her child are eligible, such as WIC, refers the member to the Right from the Start program and discusses family planning options with the member.

The member advocate calls the member one month after birth to confirm the mother has notified DHHR about the delivery and the member has received the newborn welcome packet from us. The member advocate verifies the baby and mother have attended postpartum/well-child visits, identifies any gaps in the baby's care, such as immunizations and provides support or assistance with appointments to close the gaps. The member advocate follows the baby to confirm the care gaps are closed.

Tobacco use as an identifier for high-risk pregnancy. Women identified as using tobacco products while pregnant are referred to our high-risk pregnancy program. They are care managed throughout the pregnancy. Referrals are made to smoking cessation counselors at THP and education materials to help with tobacco cessation are made available by mail and on the THP website regardless of whether a woman chooses to enroll in the cessation program. Participants receive proactive calls from the perinatal care nurse, who promotes positive outcomes for the pregnancy through individualized

interventions. A specific plan of care is developed based on the risk status. Ongoing monitoring by the perinatal care coordinator ensures timely intervention in the event of a change in risk status. The frequency of outbound calls to participants by the perinatal care nurse is determined by the severity of pregnancy risks, complications and member preference. This may result in daily contact in times of high risk or concern. When home care is needed in high-risk cases, the perinatal care nurse works with the physician and home care agency to coordinate the necessary care and services.

West Virginia Perinatal Partnership (WVPP)

THP has partnered with the WVPP since 2006 to support its efforts to promote the well-being of women and babies statewide. We have actively participated in projects related to:

- ***Early Elective Delivery:*** A collaborative study across the West Virginia identified a correlation between inductions before 39 weeks and neonatal respiratory complications upon delivery. Through discussions at the WVPP, including state leaders and neonatal experts, focused education to all obstetrical providers was developed to avoid induction before 39 weeks unless absolutely indicated due to maternal or fetal risk or complications. THP also created a prior authorization process that included medical necessity review for elective inductions before 39 weeks gestational age.
- ***Neonatal Abstinence Syndrome (NAS):*** As rates for NAS climbed dramatically across the state, there were little data being captured on this population due to lack of understanding of coding for NAS. Additionally, lack of identification created the barriers to ensure the infant received the appropriate services and follow-up after discharge. Our statewide collaboration helped develop a statewide identification process and education to facilities and OB/GYNs about NAS and created standards for coding to identify babies with NAS, thus allowing identification for referral to services such as Birth to Three and Children with Special Health Care Needs.
- ***Long-acting reversible contraception (LARC):*** With post-partum visits lagging behind national averages, there was concern that women are missing an opportunity to choose contraception to avoid unwanted pregnancies in the future. Encouraging a long acting reversible contraceptive option at the time of delivery was discussed and reviewed, including studying barriers resulting in developing corrective action to develop a process to permit LARC to be performed and prior covered by the MCOs before discharge from an inpatient obstetrical stay.

Promoting early and often prenatal care for pregnant members who have high pregnancy risk. We enroll women identified as high risk in our Perinatal Care Program, which is designed to improve pregnancy outcomes, reduce neonatal hospitalizations and reduce the costs associated with preterm birth and other complications of pregnancy. This is accomplished by providing perinatal education, promoting safe health behaviors and enhancing the management of maternity care for women identified at high-risk for premature labor and delivery.

We assign a perinatal care nurse experienced in labor, delivery, recovery and post-partum to work with the member and her providers to coordinate her care throughout the pregnancy. Throughout her pregnancy, the nurse educates the member about her pregnancy using assessments and educational materials discussed previously. The nurse promotes positive outcomes for the pregnancy through individualized interventions, including conducting a comprehensive assessment using our Maternal Health Risk Assessment and collaborating with the member and her chosen planning team to develop an individualized care plan. The nurse coordinates the delivery of any services identified in the care plan. For instance, when home care is needed in high-risk cases, the perinatal care nurse works with the physician and home care agency to coordinate the necessary care and services.

The nurse provides ongoing monitoring of the member's needs, goals and health risk throughout her pregnancy as described in our approach to managing the care of members with high pregnancy risk. For instance, once the mother gives birth, the nurse conducts a postnatal depression screening, obtains information about the member's baby so we can confirm the baby is receiving appropriate care. The nurse determines the frequency of member engagement based upon the severity of the member's pregnancy risks, potential complications and the member's preference. This may result in daily contact in times of high risk or concern.

CM011. Processes for Supplemental Security Income (SSI) members, if different

We recognize that not all Supplemental Security Income (SSI) members require engagement in care management. We evaluate these members holistically

We conduct an annual HRA for SSI members to identify changes in their health status, needs or circumstances.

to identify their health risk, specific needs and the needs for engagement in care management using the techniques described in **CM003** and **CM005**. As we do with all our member populations, we analyze their needs and goals to determine the need to develop specific health and wellness programs or care management programs to address their needs. Our 2019 analysis of our SSI membership indicates the following:

- 12,075 SSI members had claims for services.
- The average CNI for SSI members is 1.48, but 1,302 SSI members have a CNI greater than 3, which is an indicator of the need for care management.
- 1,913 SSI members were identified for program consideration across all care management programs. 821 members remained active in programs at year-end, 892 member's cases were completed/discharged, 12 members were discharged with goals unmet, 25 members opted out, 32 members were still under review and 131 members were reported as unable to contact.
- The top five principle medical conditions for SSI members who had claims for services are, in order, 1) mental disorders; 2) respiratory conditions; 3) diabetes mellitus; 4) musculoskeletal conditions; and 5) heart and pulmonary conditions.

We have care management programs that address these principle medical conditions. If the SSI member meets the criteria for engagement in care management, we engage them in a care management program appropriate to their needs, such as a diabetes disease management program for members with diabetes and low risk or diabetes care navigation for a member with diabetes and high risk. We coordinate services/resources for SSI members, such as:

Our analysis tells us SSI members tend to have higher use of the ER. We will provide all members, including SSI members, with alternatives to the ER for non-emergent care through Teladoc, a telehealth solution that provides free 24/7 member access to medical and behavioral health care via phone, video or app.

- Connecting members to resources that are specific to the needs of SSI members, such as Donated Dentures or utility assistance or Senior Services and Meals on Wheels as they age.
- Coordinating services available to SSI members, such as personal care services.
- Coordinating third-party insurance for SSI children.
- Coordinating waiver services, such as the IDD waiver.

- Connecting members to West Virginia Disability Advocates to address discrimination issues.
- Connecting members to income-based housing. For example, a member who may live in a remote location and desire to live closer to care. We help get them into low-income housing closer to care, if appropriate.

Important Actions for SSI Children Transitioning into Adulthood

Children who receive SSI often do so for disabilities that are lifelong and cause them to rely upon another individual for even the most basic care needs. That was the case for a transition-age member who was born with a genetic disorder that left him with limited mobility and nonverbal with the inability to communicate his needs. While initiating his service plan, it was noted that his parents had not applied for legal guardianship status despite his age and were having difficulty helping him access care. Our social worker helped the member's parents obtain legal guardianship, medical power of attorney and advance directives. Our social worker helped the family apply for and access IDD waiver services, personal care services and better access medical, behavioral and dental services. Our member's story serves as a reminder to our care team to begin age-related transitional care planning early to ensure that all members and families have full access to care and care related information for this fragile population.

Our care management team understands the characteristics and qualifiers for SSI and we identify and refer all appropriate members to Med-Data, our subcontractor who assists members and families apply for and obtain SSI. Reviews are submitted directly from our care management platform and our Medicaid supervisors and managers directly access Med-Data systems to review notes on successful contacts and review progress notes until SSI status is awarded and shows up in enrollment files.

CM012. Processes for administering care management for both adults and children

Our care management approach recognizes the unique needs of adults and children with delivering care management services. For example.

- Using age-appropriate health risk and comprehensive assessments. Our adult assessments are for members 18 years or older and our pediatric assessments are for members under 18 years.
- Identifying the child's parent/guardian and obtaining permission from the parent/guardian to talk to the child. We work with BMS to address issues with the parent/guardian identified in the enrollment file.
- Understanding appropriate developmental levels to identify and deliver services appropriate to the member's age level.
- Understanding the differences in preventive services, such as EPSDT, which only apply to children, versus HEDIS, which apply to children and adults.

- Understanding resources available only to children, such as Right from the Start, Birth to Three, WIC or the Center for Excellence in Disabilities at WVU that provides resources to parents of children with disabilities.
- Understanding processes for children, such as the CSHCN eligibility determination process.
- Care managers are mandated reporters and must report any cases of abuse or neglect among children and adults who cannot protect themselves.
- Managing the transition of adults aging into Medicare. We help these members transfer to our Medicare or Dual eligible special needs program (D-SNP) programs.

CM013. Processes for administering care management for members with special health care needs, defined as individuals with complex or serious medical conditions

We engage individuals with complex or serious medical conditions in a care navigation or complex case navigation care management program depending upon their specific needs. The objective of care management is to help each member regain optimum health or improved functional capability and to achieve member-defined goals. As presented in the figure, our core care management process implements a series of activities that identify the member's needs, goals and preferences, connect them to services and supports to meet their needs and help them achieve their goals and continually monitor the member's health status and their progress achieving their goals.

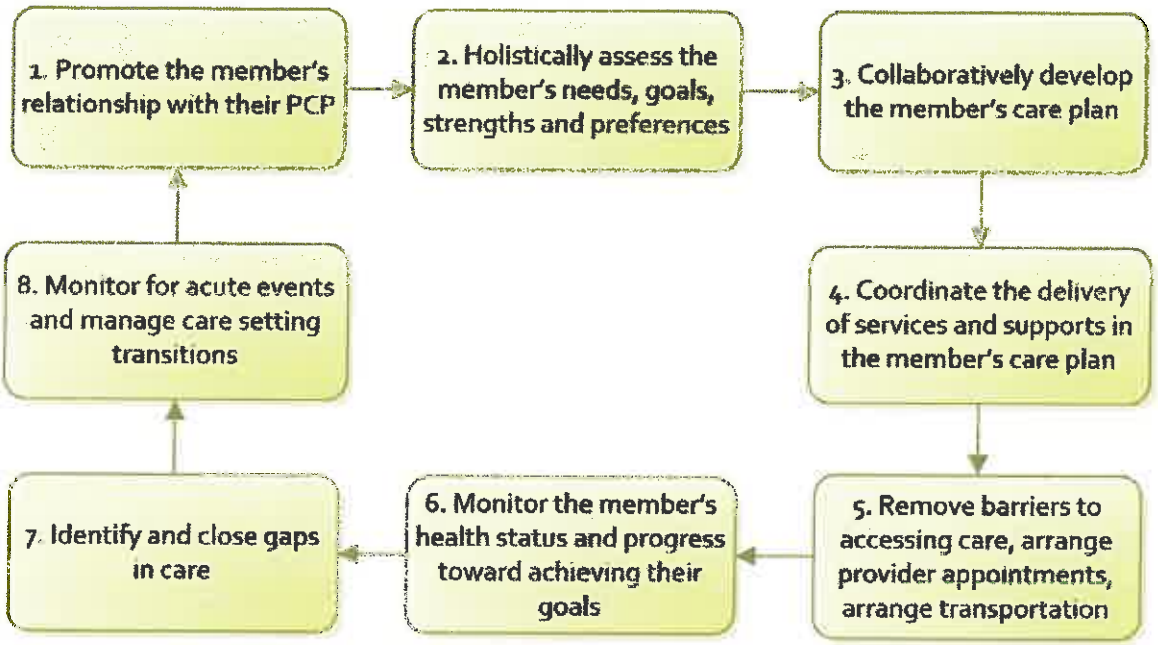


Figure 9. Core care management process. We implement a series of activities that identify the member's needs, goals and preferences, connect them to services and supports to meet their needs and help them achieve their goals and continually monitor the member's health status and their progress achieving their goals. We customize our core process to the individual needs of members, such as babies with NAS or members with multiple chronic conditions.

As we discuss in **CM016** and **CM020**, the care manager conducts a reassessment of the member's needs at least annually. This assessment confirms the member's risk stratification level and provides inputs into any treatment plan updates that may be required. The care manager conducts an assessment for any member experiencing a change in health status, circumstances or condition and updates their treatment plan.

We customize our care management approach to the needs of our members. For instance, we assign a perinatal care nurse experienced in labor, delivery, recovery and post-partum to manage the care of members experiencing a high-risk pregnancy and engage the member in care management activities specific to their pregnancy, as we discuss in **CM010**. We also customize our care management approach to each member's specific circumstances.

For example, for a member with the complex case diagnosis trigger of multiple sclerosis (MS), we recognize it is a life-altering condition the member will be experiencing for the rest of their life. We use disease-specific resources and care standards like those developed by The National Multiple Sclerosis Society or Up to Date to help MS-effected members understand that their disease process will have periods of remission and periods of relapse, but that it is always present. The care manager works with the member to remind them to take their medication, reinforcing adherence even during periods of remission, helps them recognize signs of exacerbation, such as numbness or changes in sensation, teaches them when to call the doctor and what is significant to report and confirms the member attends their neurologist or therapy appointments, including arranging the appointments and transportation, if needed.

The care manager will help the member understand and manage functional decline over time, such as bowel and bladder issues, mobility issues or the need for caregiver assistance that may increase over time. They will help the member understand the importance of getting immunizations, routine services and routine scans and understand and the impact of pregnancy or birth control on their overall health in the case of a woman with multiple sclerosis. The care manager understands the toll the disease process may take on the member's mental health and assesses for depression.

The process of care management for a member with special healthcare needs, as demonstrated above, is development of a personalized, adaptable care plan built on evidence-based standards but characterized by frequent reevaluation with OGIs adapted to meet a member's ever-changing needs.

CM014. Processes for administering care management for children with special health care needs (CSHCN)

In spring 2017, with the implementation of the medical review process, we worked with the Office of Maternal, Child, and Family Health (OMCFH) at the Bureau for Public Health (BPH) to develop the workflows around CSHCN care coordination, the form that must be submitted to the State to determine member eligibility for the CSHCN program, the process to approve medical food or enterals and the letters to educate providers about the prior authorization process for medical food or enterals.

THP was the only MCO chosen to partner with the Bureau of Public Health to develop the workflows and processes for the CSHCN program. Facilitated by The Lewin Group, Susan Klinkoski, our Medical Management Director, and Kim Jordan, our Care Management Director, met with BPH twice a week to monthly for approximately six months to develop the CSHCN program and tools.

The Lewin Group was impressed by the new workflows and processes for CSHCNs and suggested they be adopted for all MCOs statewide. All MCOs in West Virginia must follow the workflows and processes THP developed with BPH.

Processes for Administering Care

When we identify a child who may be a CSHCN, we complete the referral form for the State to determine the child's eligibility for the CSHCN program. We recognize all CSHCNs require additional support and navigation through the healthcare system. We enroll all CSHCNs in our complex case navigation program and assign an RN care manager to coordinate their care. The care manager screens for special health or service needs using the CSHCN screener, a holistic tool endorsed by NCQA and the Agency for Healthcare Research and Quality (AHRQ). The CSHCN screener is a five-item tool that identifies CSHCN and the seven Living with Illness Measure health

domains that help to understand a child's risk factors and assesses the child's need for care management based upon their requirements for prescription medications, use of services above that considered routine, and functional limitations.

While we take the lead to provide care coordination services for children with special healthcare needs, we collaborate extensively with BPH to coordinate their care. This includes identifying children who may require additional therapies or services and connecting these children to services, sharing treatment plans, identifying children with NAS for designation as a CSHCN, participating in planning sessions and identifying those children who may be aging out of the CSHCN program and coordinating their transition to adult health insurance. We meet with the BPH Director of CSHCN, Donna Pauley-Wilson, at least once a month related to various issues facing CSHCN, such as service denials or other services the member may require.

CM015. 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.

We use STARSSolutions, a powerful tool for identifying potential fraud, waste and abuse, identifying claims containing potentially falsified procedure codes, services not rendered, upcoding, overutilization and other common fraud tactics. Using STARSSolutions, we create more than 100 monthly data mining reports to detect inappropriate utilization of controlled prescription medications, such as:

- ***Controlled Substance Report*** identifying utilization of 22 controlled substances with high abuse potential
- ***Prescriber Report by Percentage*** identifying top providers ranked by the percentage of their total prescriptions that are controlled
- ***Prescriber Report by Volume*** identifying top providers ranked by the total volume of controlled prescriptions

The SIU examines reported incidents of suspicious activity from all sources and provides a telephone tip line, a dedicated email address (SIU@healthplan.org), and a website portal to facilitate receipt of referrals. Investigations may be initiated based upon complaints or referrals from internal or external sources, alerts from government agencies or law enforcement, or due to the SIU's proactive efforts such as data mining or routine claims monitoring.

The SIU's fraud analytics specialist conducts in-depth data analysis to vet the allegation and inform decision making as to case status. As the case progresses, the SIU uses their considerable experience and expertise to gather evidence and move the investigation forward. The fraud analytics specialist reviews each of these data mining reports and results, and conducts further data analysis and preliminary investigative activities as warranted. If those efforts support the likelihood of suspicious activity, a full investigation commences.

In addition to the SIU, THP employs in-house pharmacy personnel to monitor pharmacies submitting suspicious claims. Upon review and investigation and when warranted, pharmacies may be barred from billing THP, members may be locked in to only one pharmacy for their controlled substance prescriptions, or a referral may be made to the appropriate law enforcement entities.

investigating potential pharmacy abuse. Our PBM's SIU also conducts both desk and on-site investigations that include reviews of prescriptions, delivery records, quality assurance and other relevant documentation, and employee interviews. Substantiated improper conduct is referred to the appropriate authorities and to the Pharmacy Disciplinary Action Committee for potential discipline up to and including termination.

Managing Members with a History of Prescription Drug Abuse

We engage members with a history of prescription drug abuse in our SUD care navigation care management program and assign an RN care manager with background in SUD acute care, a THP clinical psychologist consultant or a THP social worker to work with the member to manage their care. The care manager:

- Uses screeners specific to the member's needs, such as the DAST, CAGE and PHQ. For postpartum members, we conduct a postnatal depression screening using the EPDS in addition to screeners above.
- Is notified when a member is admitted to a residential treatment facility.
- Participates in discharge planning from a residential treatment facility and follow-up with the member after discharge, such as determining if the member has a safe place to transition and working with the facility to identify placement options.
- Removes barriers to accessing care.
- Reviews and reinforces their relapse prevention plans.
- Reviews intake assessments for Screening, Brief Intervention, and Referral to Treatment (SBIRT) interventions.
- Monitors for potential abuse, such as members in methadone treatment and members receiving Narcan.

Prevention: We educate members about the safe and appropriate use of opioids. For example, we run a daily report of opioids-naïve members or members newly prescribed opioids. The system then generates a letter that explains how to take the medication, when to talk to your doctor if experiencing symptoms, alternative pain management strategies, safe opioid disposal and drop off and the risk of becoming addicted. The letter provides a direct line to a SUD care navigator for questions and issues.

We encourage opioid use disorder (OUD) providers to use medication-assisted treatment (MAT). We fully support the evidence-based use of MAT in facing the OUD crisis in West Virginia. We strongly encourage our OUD providers to treat members with OUD using techniques outlined by the Substance Abuse and Mental Health Services Administration (SAMHSA). We encourage residential SUD providers to collaborate with

THP SUD care managers to facilitate the transition of members who were introduced to MAT services while in the residential program to appropriate community-based maintenance services. In 2019, 5,322 of our members received MAT services.

We connect members to Assertive Community Treatment (ACT). ACT is an evidence-based service with National Fidelity standards that uses a multi-disciplinary outreach team to address the holistic needs of individuals with persistent mental health issues and/or with co-occurring substance use disorders. ACT allows the individual to achieve maximum independent functioning in the most accessible community environment appropriate to the needs and wishes of the member. West Virginia has 10 BMS-certified ACT teams spread across the state, ***all of which are under contract with THP to serve our members***.

Pharmacy lock-in. We receive a monthly file from the state of pharmacy lock-ins that identifies members at high risk for prescription abuse. Our director of pharmacy and supervisor of Medicaid care management check the report against the West Virginia Board of Pharmacy Controlled Substance Monitoring Program to further examine if members may be paying cash for prescriptions to avoid detection of misuse.

Additional PBM Strategies and Process to Consider

In the event DHHR carves pharmacy services into a future MHT contract, our PBM for our other lines of business, Express Scripts Inc. (ESI) has established strategies, policies and procedures to identify pharmacy fraud, abuse or inappropriate utilization. ESI's current strategies are summarized in the following paragraphs. For example, ESI's SIU team investigates fraud related to network pharmacies. They proactively identify suspicious activity, monitor CMS alerts, Medic Risk Assessments, media tips

and fraud tips. ESI also conducts member verifications to confirm the member received the medication, prescriber verifications to confirm the prescriber ordered the medication and purchase verifications to confirm the pharmacy had sufficient inventory to justify the claim volume.

Our PBM conducts a number of audit programs to confirm accurate submission and payment. They implement a collaborative approach that emphasizes the education of network pharmacies in proper claims submission procedures. Their automated predictive model review process aids in the detection of high-risk claims, followed by additional review by network auditors. ESI's desk audit program completes an automated review, using a large number of outlier indicators, of all claims submitted by network pharmacies the previous day.

Our PBM's on-site audits include in-person reviews of prescription claims and operating practices. Our PBM selects pharmacies for on-site audits based on various criteria that may include findings from desk or historical audits, reliable tips or selection via our PBM's proprietary audit selection tool. Claim components verified through the audit process include compliance with all applicable laws, adherence to our PBM's Pharmacy provider agreement and pharmacy provider manual, compliance with specific benefit parameters, claims submissions in accordance with prescriber guidelines and documentation, dispensed as written code usage and refill authorizations, proper quantities dispensed and pricing used, compounds and specialty claims.

CM016. 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:

CM020. Performance of health assessments

Initial screening. As we discussed in **CM003** and **CM005**, we complete the initial HRA within 90 days of enrollment in accordance with Article III, Section 5.3.1 Initial Health Assessment in the Service Provider Agreement. We attempt all initial assessments via our welcome calls within the first 30 days of member enrollment, far exceeding the BMS and NCQA 90-calendar day completion requirement and getting members the care they need quickly.

Initial comprehensive assessment. As we discussed in **CM003** and **CM005**, for newly enrolled members who may benefit from care management, our care management team assigns a care manager to collaborate with the member to coordinate their care and deliver care management services. The member's care manager engages the member to begin to conduct a comprehensive assessment of their needs, goals and preferences for care within 30 days of the completion of the HRA. The comprehensive assessment must be completed within 60 days.

Ongoing assessments. For members enrolled in care management, we conduct an assessment of the member's needs at least annually. This assessment confirms the member's risk stratification level and provides inputs into any treatment plan updates that may be required. We also conduct an assessment for any member we identify as experiencing a change in health status, circumstances or condition. The care manager and ICT monitor these changes through ongoing touchpoints with the member and their family, discussions with ICT participants, ADT alerts and referrals from the member, their family, providers or THP departments, such as our UM team.

We conduct a 72-hour post-hospital assessment for members who have been discharged from an inpatient setting.

We use daily reports and live master lists of active census/concurrent reviews to identify members in various settings who require outreach, such as members with traumatic brain injury in inpatient rehabilitation facilities, members in residential substance use treatment settings or members admitted to an acute care hospital. We conduct a monthly predictive modeling analysis to identify changes to each member's level of health risk, which may indicate a need for care management. Once we identify members experiencing a change in health status, circumstances or condition, members in various settings or members experiencing a change in their health risk, a care manager outreaches to the member and conducts a comprehensive assessment of their needs, as we discussed in the previous section.

Condition-specific assessments. We supplement our HRA and comprehensive assessment with evidenced-based condition-specific assessments (e.g., diabetes or substance use disorder), based upon the member's specific conditions. For example, a member's positive response to questions regarding behavioral health needs triggers specific behavioral health assessments, such as the PHQ9, GAD7 and AUDIT-C).

CM017. Members with special health care needs, defined as individuals with complex or serious medical conditions

We engage individuals with complex or serious medical conditions in care management. Once assigned to the member, the care manager contacts the member to schedule a meeting to begin collaborating with the member and their chosen planning team to complete the assessment process and facilitate the development of the member's treatment plan. During this contact, the care manager works with the member to identify their preferences for the meeting, identify the people the member wants to include in

their planning team and identify any services that may be needed to meet the member's communication needs, such as translation services. The care manager conducts a comprehensive assessment as discussed in **CM016** and **CM020**.

CM018. Children with special health care needs (CSHCN)

When we identify a child who may be a CSHCN, we complete the referral form for the State to determine the child's eligibility for the CSHCN program. We recognize all CSHCNs require additional support and navigation through the healthcare system so we enroll all CSHCNs in our complex case navigation program and assign an RN care manager to coordinate their care. The member's care manager engages the child and their parent/guardian to begin to conduct a comprehensive assessment of their needs using the CSHCN screener, a five-item screening tool that identifies CSHCN and the seven Living with Illness Measure health domains that help to understand a child's risk factors and assesses the child's need for care management based upon their dependency on prescription medications, use of services above that considered usual or routine and any functional limitations.

Children who do not qualify for the state's CSHCN program, but who are defined as having special healthcare needs according to THP's care management program criteria will continue to be managed at the complex case, care navigation, or disease management level as defined by condition, acuity level or identified needs.

CM019. Clinical, social, or other criteria used to determine which members require care management and assignment to care managers

As we discussed in **CM003** and **CM005**, we identify members for engagement in care management programs based upon five core factors: 1) member risk as indicated by a CNI over 3.75 or risk factors, such as high cost (e.g., more than $20,000 in behavioral

health expenses in one year) or identified needs as stated below; 2) inappropriate or unnecessary utilization, such as four or more admissions in prior 12 months; 3) gaps in care, such as a member who has diabetes and an A1cC over eight; 4) specific conditions (e.g., SUD); and 5) the intensity of intervention required (short or longer term). Identified needs appropriate for care navigation include:

- Lack of personal resources, such as housing, food, clothes or utilities
- Lack of support/caregiver, such as no caregiver/ailing caregiver
- Poor linkage to PCP, such poor follow up/no follow-up
- Poorly managed conditions or symptoms, such as dehydration in a cancer patient with uncontrolled vomiting
- End-of-life issues, such as escalating care needs due to severity of illness, palliative care/admission to hospice program or help with a living will
- Benefit issues, such as understanding/accessing appropriate network, provider direction, redirection, appeal process, referral issues
- Functional deficit, such as mobility, self-care (e.g., bathing, cooking, eating)
- Medication adherence, such as compliance with prescription directions

CM021. Implementation of targeted education programs

THP's disease management and health promotion programs are multidisciplinary and continuum-based systems developed to proactively identify populations with, or at risk for, chronic medical conditions. Populations currently being managed include members with diabetes, chronic cardiac conditions and chronic pulmonary disease. Pregnant members are also monitored with the intent to identify those at high risk for premature delivery or other negative outcome for mother or fetus. Members are encouraged to develop healthy behaviors through education in areas, such as exercise, nutrition, tobacco cessation, safe alcohol consumption and flu and pneumonia vaccines.

The diabetes program is designed to modify risk factors associated with diabetes and to slow the progression of microvascular and macrovascular complications. This is

accomplished by promoting treatment plan compliance through education, counseling and support. Members with diabetes require long-term, continual care to maintain appropriate glycemic control and to decrease the risk of long-term complications such as neuropathy, nephropathy and blindness. THP's disease management program is staffed with RNs and Certified Diabetes Educators. They provide the telephonic program and have added face-to-face individual diabetes education. Group or individual on-site programs may be available upon request. Skype and email communication through a secure web server are also available.

The chronic cardiac conditions program is designed to modify cardiovascular risk factors and slow disease progression in members with heart failure or coronary artery disease. Other chronic cardiac conditions may be managed based upon member needs. This is accomplished by promoting treatment plan compliance through education, counseling and support.

The chronic respiratory condition program is designed to modify risk factors associated with respiratory illness and COPD and to slow the progression of the disease. This is accomplished by promoting treatment plan compliance through education, counseling and support. Members with COPD require long-term, continual healthcare to maintain functional status and to help eliminate disease exacerbations.

The Perinatal Care Program improves pregnancy outcomes, reduces neonatal hospitalizations and reduces costs associated with pre-term birth and other complications of pregnancy. The program provides prenatal education, promotes safe health behaviors, and enhances the management of maternity care for women identified at high risk for premature labor and delivery. We discuss this program in **CM010**.

CM022. The Vendor should describe its process for creating educational materials and educating members and care management staff.

CM023. 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.

CM025. Staff qualifications

Our quality educator creates educational material through a collaborative process with other stakeholders at THP. When knowledge deficit is identified through surveys, gap analyses, member requests, departmental requests, or other methods, the quality educator and Community Engagement Director Wendy Hodorowski work with the requester to develop the necessary material. Material is also created for targeted member interventions to meet the standards of NCQA, EQRO, BMS, CMS and other regulatory oversight. Written educational material is offered in alternate formats such as large print, a CD or audiotape for listening and Braille. If members do not understand or speak English, THP provides educational material by using a free interpreter service that can communicate with the member in any language. Access to free sign language interpreter services and a TTY phone number is an option that can be used for member educational material if needed.

The requester submits a ticket through THP's service desk application. The requester provides a brief narrative of the nature of topic for the educational material and the format desired (flyer, booklet, presentation, call scripts, on-hold messaging, individual or mass mailings, newsletters, community-based, web-based). The requester completes dropdowns in the service desk application. The ticket submission dropdowns include Title and brief description, Category, Priority level and due date, line of business (LOB), Impact to the member and THP and File upload capability.

Once completed, the ticket is then reviewed by Ms. Hodorowski who assigns it to the quality educator to collaboratively draft the educational content. Content development aligns with cited evidence-based resources when applicable. Draft material is submitted to BMS for final approval. Once approved, the educational material is put into production and distributed accordingly. THP maintains a health education resource library of all developed material. The educational material is reviewed at least annually for content updates and all identified changes are completed.

Employee training is provided to increase the understanding of health literacy so our employees can provide realistic and impactful ways to meet the demands of our members' educational needs. We post new materials on THP's intranet site along with an alert that informs all employees that new member materials are available or that current member materials have been updated or removed.

Educational Materials for Members

Examples of educational materials for members include:

- For members who have not selected a PCP, we send a letter with a list of available providers. This provider list is customized to the member, including providers near them and providers who are accepting new patients.
- Letter welcoming members to care management that explains care management and provides the name and contact information for their care manager.
- Educational pamphlets that explain the availability of NEMT and how to access it, including how THP can help members arrange this transportation.
- A flyer for members with a disability that connects them to Med-Data, which helps them determine if they are eligible for SSI.
- Our condition-specific assessments include disease-specific education built into the assessment, such as how to talk to your doctor. The member advocate or care manager administers this education during the assessment process.
- A flyer for the families of CSHCN who may be eligible for the program that explains the eligibility determination process and the care management services THP can provide to CSHCN.

- A flyer to educate a new mother about the Birth to Three, Right from the Start and West Virginia Works programs.
- Education flyer for families who have a baby with neonatal abstinence syndrome (NAS). The flyer provides information about our NAS care management program and resources available to families.

As presented in the figure, we developed a cobranded flyer with the American Cancer Society that helps members who have cancer understand the resources available to them through the American Cancer Society.

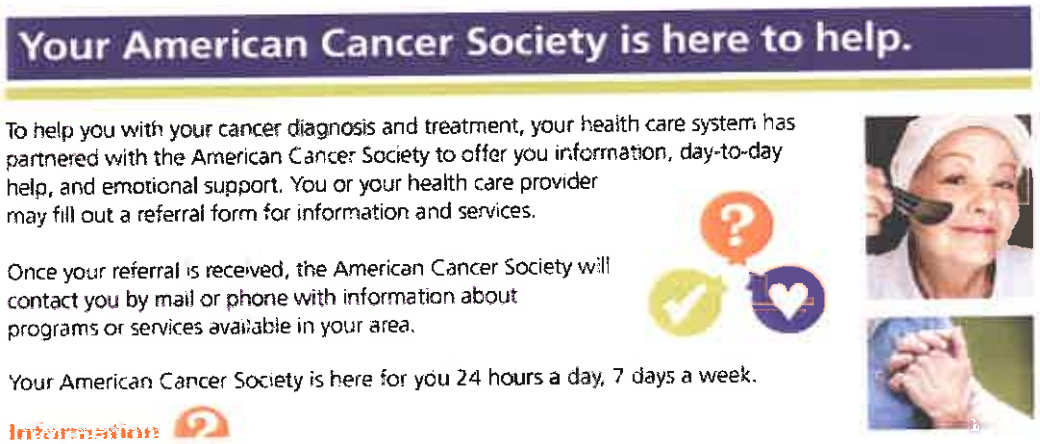


Figure 10. We developed a cobranded flyer with the American Cancer Society that helps members who have cancer understand the resources available to them through the American Cancer Society.

Educational Materials for Our Staff/Staff Training (CM023/CM025)

Training is a critical component of our MHT program and includes initial and ongoing training for our UM and clinical staff and member advocates using classroom, web-based and self-paced, role-playing and person-centered teaching approaches. Trainees are required to complete classroom exercises and manual worksheets on all training material to assure they understand how the system applications work. Testing is completed on all subjects trained. A review of each trainee is sent to their supervisor, manager and director each week to keep managers informed of progress and needs. Training completion is documented in THP's HEART electronic information system.

Initial Training: UM and clinical staff and member advocates are required to complete an orientation program that covers a variety of topics as presented in the table.

Initial Training
Initial Orientation Training
▪ Organization chart ▪ New employee – introductory orientation checklist ▪ Job description, licensure requirements ▪ Orientation program – mission, goals, purpose ▪ Current Julian calendar ▪ Human resource Employee Handbook
Telephone Directory Training
▪ Clinical service department phone list with alphabet list ▪ Language Line use ▪ Telephone directory – (800 #'s) provider calls for benefits, eligibility, etc. ▪ Nurse information line ▪ Voicemail Quick Start Guide ▪ Example of RN voice mailbox message
Overview of Clinical Services Department Training
▪ Clinical services department staff and committee overview (Transplant and New Technology Assessment Committee, Medical Directors Oversight Committee, Physician Advisory Committee) ▪ Provider Manual THP website ▪ Provider Manual – Section 7 Medical Management Program ▪ Provider Manual – Section 3 Member Benefits ▪ Provider Manual – Section 10 Pharmacy ▪ Provider Manual – Section 4 Medicare ▪ Provider Manual – Section 5 Medicaid ▪ Provider Manual – Section 8 Quality Improvement/NCQA ▪ Provider Manual – Section 9 Behavioral Health
PolicyStat Overview Training
▪ Clinical services policy review
Crisis Management Training
▪ CL-217 Handling a Crisis Call and CL-200 Crisis Reporting
General Information Training
▪ Types of plans ▪ Glossary of health coverage and medical terms ▪ Basic terminology ▪ Definitions of health insurance terms ▪ How You and Your Insurer Share Costs – example ▪ Abbreviations ▪ Coordination of benefits ▪ Group numbers ▪ Network information ▪ Customer service application

Utilization Management Training
▪ Referral checklist ▪ Preauthorization list ▪ CPT tool ▪ Census (concurrent facility review checklist) ▪ eviCore/Palladian/SKYGEN (subcontractors) ▪ Clinical criteria algorithm ▪ Hospital matrix ▪ Facility heart screens ▪ West Virginia Health Information Network (WVHIN) ▪ Interqual Guidelines (Change Healthcare) ▪ Hayes technology ▪ Transplant and technology guidelines ▪ UM interrater tools ▪ ASAM modules ▪ Timeliness review/denial decision notification requirements ▪ Appeals and grievances
Care Management Programs Training
▪ Outreach ▪ HEDIS (gap in care closure, landing page review) ▪ Health risk assessments ▪ Complex case management criteria and workflow ▪ Care navigation criteria and workflow ▪ Disease management programs and workflow ▪ Tobacco cessation ▪ Clinical analytical toolsCoordinated Care Assessments (Change Healthcare) ▪ Care coordination interrater tool ▪ Cost savings tool ▪ Community resources (social worker referral; Aunt Bertha, our social services resource tool) ▪ Disability outreach (SSI, SSDI support for members) ▪ Children with Special Health Care Needs (CSHCN) role, referral and workflow ▪ DXC technology website
Required Testing of all Care Managers, UM RNs, Medical Directors and Member Advocates
▪ Motivational interviewing and trauma-informed care ▪ Cultural Competency, including social determinants of health (SDOH) and access for members with disabilities or limited English proficiency (annual) ▪ Medicaid Contract (annual) ▪ D-SNP Model of Care (annual) ▪ Interqual Modules (UM in orientation) ▪ ASAM Modules (UM in orientation) ▪ HIPAA Privacy and Security (Annual) ▪ Compliance and Fraud, Waste and Abuse (Annual) ▪ Anti-Harassment (Orientation)

Ongoing training. We perform ongoing training, such as annual cultural competency trainings. We conducted the following Lunch and Learn sessions for our staff in 2019:

- Home Health Basics presented by Stonerise
- Transplantation presented by CignaLifeSource
- Program Update presented by WIC
- Organ Transplantation presented by Lifetrac
- Children with Special Health Care Needs Enrollment and Overview of Disability Outreach presented by Kim Jordan
- Population Health and Epic Access presented by WVU Medicine
- Behavioral Health Case Management Basics presented by Sheila Kelly and Amy Bott
- Reinsurance/High Cost Review and Documentation presented by Kim Jordan
- Behavioral Health Services and Resources Overview presented by Sheila Kelly
- Case Management 101 presented by Kim Jordan
- Managed Care and Insurance Basics presented by Cindy Matthews

In June 2019, a representative from the Ohio County WIC office visited our office to provide training in the WIC program to our care managers, perinatal team and outreach staff. The training covered a variety of topics, including:

- Who is eligible for WIC and how to encourage members to participate.
- How to refer members to the WIC program.
- Nutrition education.
- Additional programs for WIC-eligible members, such as Right from the Start or pregnancy assistance programs.
- WIC-eligible foods.
- WIC clinics across West Virginia.

Cultural Competency Training

Every THP employee is required to complete annual cultural competency training, attested to with an 80 percent passing score. We last completed this training in January 2020. This training reinforces that cultural competency requires effort. As individuals, we must keep an open mind and ask questions. Our cultural competency training is web-based and covers several important topics, including:

- ***Cultural Competence:*** Defines BMS, CMS and NCQA expectations, culture and how culture influences care.
- ***Language Competence:*** Explains the value of communicating effectively with diverse audiences, including persons with limited English proficiency, persons who are not literate or those with low literacy skills, individuals with disabilities and individuals who are deaf or hard of hearing.

- ***Social Determinants:*** Defines SDOH and explains why they are important and how they can impact a member's care.
- ***Ageism:*** Defines ageism as the use of derogatory images to discriminate against a certain group, and the importance of treating people as individuals.
- ***Learning Cultural Competence:*** Includes the national standards for Culturally and Linguistically Appropriate Services (CLAS) in healthcare, and provides information on how to conduct a cultural assessment.

Staff Qualifications (CM023)

Per NCQA standards and THP policy, THP confirms appropriately licensed health professionals are engaged to perform care management functions. The table presents the qualifications of our care managers, social workers and member advocates.

Staff Qualifications
Level 1 Care Manager
▪ 5-9 Year RN Clinical Experience (AD or Diploma, 2 may be as LPN, CNA or clinically related field all else must be RN) ▪ Ohio and West Virginia license upon hire; all others within one year as required by line of business
Level 2 Care Manager
▪ BSN (or other 4 year degree BA/BS combined with RN) with 5+ Year Clinical Experience (2 of them may be as LPN, AD, or Diploma RN) OR ▪ 10-14 Year RN Clinical Experience (AD, Diploma) OR 3+ Year Managed Care RN Experience (in addition to total RN clinical experience of at least 5 years, may be THP or outside) ▪ Ohio and West Virginia license upon hire; all others within one year as required by line of business
Level 3 Care Manager
▪ BSN (or other 4 year degree BA/BS combined with RN) with 10+ Year Clinical Experience OR RN with 15+Year Clinical RN Experience OR ▪ Advance Practice Nurse (MSN, FNP, PNP, CNM, PHD) with minimum 5 year RN Clinical Experience ▪ Managed Care Experience ▪ Certification in area of clinical expertise related to current work (CDE, CCM, CMCN, Gerontology, Mental Health, Oncology) with proof of maintenance. ▪ Ohio and West Virginia license upon hire, all others within one year as required by line of business ▪ Maintains satisfactory evaluation and interrater meets benchmarks
Level 4 Care Manager
▪ BSN (or other 4 year degree BA/BS combined with RN) with 10+ Year Clinical Experience OR RN with 15+ Year Clinical Experience OR Advance Practice Nurse (MSN, FNP, PNP, CNM, PHD) with 5+ year RN Clinical Experience ▪ Managed Care Experience (of 2+ years at THP) and demonstrated expertise in a particular program, protocol, workflow or line of business supported by a letter of recommendation from the direct supervisor ▪ Certification in area of clinical expertise related to current work (CDE, CCM, CMCN, Gerontology, Mental Health, Oncology) with proof of maintenance ▪ Satisfactory completion one year at level 3 with documentation of successful project/analysis ▪ Ohio and West Virginia license upon hire, all others within one year as required by line of business

Staff Qualifications

- Satisfactory annual evaluation and interrater meets benchmarks
- Documented annual participation/attendance at community events, professional organizations, health fairs, community action committees at eight hours per year (events preapproved)
- Intention to apply: Written Summary of Preapproved Clinical Service/THP Improvement Project (self-proposed or as requested by Supervisor/Clinical Manager); monthly/quarterly updates as appropriate and annual documentation of clinical support projects with analysis at annual performance evaluation
- Participate in mentoring and staff training as assigned and submit log of hours demonstrating staff training/mentoring annually

Social Worker

The Social Worker collaborates with RN care managers, medical directors, pharmacists, member advocates and external providers to access resources and address all psychosocial needs and social determinants of health impacting member care and outcomes. Qualifications include:

- Possess and maintain in-depth knowledge and skills related to care resources, community resources, discharge planning and healthcare financial environments through continuing education at conferences, workshops and profession networking.
- Should possess excellent oral, written, telephonic and interpersonal skills, balancing an independent and team working environment.
- Should be flexible and able to multi-task, work in a fast-paced environment and adapt to changing processes.
- Should possess a superior work ethic and a commitment to excellence and accountability.
- Should possess ability to exercise independent and sound judgment in decision making, using all relevant information with proactive identification and resolution of issues.
- Should possess proficient keyboarding skills and computer literacy with the ability to navigate through multiple systems.
- Masters of Social Work desired but not required.

Member Advocate 1 – Clinical Services

The Member Advocate 1 is responsible for completing outreach activities for member engagement into the program. The Member Advocate is responsible for coordinating administrative functions within the program that may include but not limited to: administering HRAs, scheduling care team meetings and completing meeting agendas and minutes, performing initial outreach and education, generating documents and reports, conducting mailings and assisting with phone coverage for the nurses.

Required qualifications include:

- Post high school course work in business, social service, healthcare, behavioral health or health administration is helpful. Undergraduate degree in related health field is preferred.
- Possess strong speaking, written and analytical skills, motivation and initiative, and ability to work independently.
- Proficiency in Microsoft Word, Excel and other related programs/personal computer usage.

Desired qualifications include:

- Post high school course work in business, social service, healthcare, behavioral health or health administration is helpful. Undergraduate degree in related health field is preferred.
- Should possess strong speaking, written and analytical skills, motivation and initiative, and ability to work independently.
- Proficiency in Microsoft Word, Excel and other related programs/personal computer usage.

Member Advocate 2 – Clinical Services

Under the general direction of the Unit Manager or Unit Supervisor, the Member Advocate 2 is an experienced level and is responsible for completing outreach activities for member engagement into the program as well as performing additional program, unit and interdepartmental support functions. The Member Advocate is responsible for coordinating administrative functions within the program that may

Staff Qualifications
include but not limited to: administering HRAs, scheduling care team meetings and completing meeting agendas and minutes, performing initial outreach and education, generating documents and reports, conducting mailings and assisting with phone coverage for the nurses. Required qualifications include: ▪ High School Diploma. ▪ Managed care experience and demonstrates meets all Member Advocate Level 1 qualifications, functions and responsibilities Desired qualifications include: ▪ Post high school course work in business, social service, healthcare, behavioral health or health administration is helpful. Undergraduate degree in related health field is preferred. ▪ Possess strong speaking, written and analytical skills, motivation and initiative, and ability to work independently. ▪ Proficiency in Microsoft Word, Excel and other related programs/personal computer usage.
Member Advocate 3 – Clinical Services
The Member Advocate 3 is an advanced level and is responsible for completing outreach activities for member engagement into the program as well as performing additional program, unit and interdepartmental support functions. This employee may function as a lead or senior worker or special accounts person. The Member Advocate is responsible for coordinating administrative functions within the program that may include but not limited to: administering HRAs, scheduling care team meetings and completing meeting agendas and minutes, performing initial outreach and education, generating documents and reports, conducting mailings and assisting with phone coverage for the nurses. Required qualifications include: ▪ High School Diploma required. ▪ Managed care experience and demonstrates meets all Member Advocate Level 2 qualifications, functions and responsibilities Desired qualifications include: ▪ Post high school course work in business, social service, healthcare, behavioral health or health administration is helpful. Undergraduate degree in related health field is preferred. ▪ LPN is desirable. ▪ Should possess strong speaking, written and analytical skills, motivation and initiative, and ability to work independently. ▪ Proficiency in Microsoft Word, Excel and other related programs/personal computer usage.

CM024. The Vendor should describe its process for hiring care management staff including, but not limited to, the following:

CM026. Plan for hiring

CM027. Timeframe for hiring

CM028. Total number of care managers to be hired

THP currently is staffed to handle our existing Medicaid membership. In preparation for the award, we anticipate needing to hire an additional 11 FTE positions across all departments that would be required to fulfill the contract requirements, including the addition of WVCHIP and to successfully deliver on the enhanced services that we are offering in our proposal. This includes two care managers. This position is posted online

and we are reviewing applicants. We are prepared to make contingent offers as we find the ideal candidates.

CM029. Maximum case loads and ratios per care manager for Vendor-defined risk tiers

We develop care manager staffing ratios based upon our experience serving members with complex chronic conditions and through ongoing monitoring and data collection, such as member surveys, customer service contacts, complaints and requests, clinical outcome data, workforce analysis and observation and time studies. Our overriding goal is to ensure sufficient staffing with qualified and high performing care managers who can effectively address member needs and meet contract requirements.

A key tenet of our staffing approach is to allow staff to work "at the top of their license." For that reason, we support our care management team with administrative coordinators to lessen the burden of non-clinical work so the care management teams can remain focused on the member and collaborating with the ICT to meet the needs of our members and help them achieve their goals and desired outcomes.

Our care management staffing ratios are based upon member lives and assume 100,000 lives including WVCHIP members. Our ratios are as follows:

- 1 RN or social worker to every 5,550 members enrolled in a care management program.
- 1 RN to every 50 members for members enrolled in the complex case navigation level of care management.
- 1 RN or social worker to every 150 members enrolled in the care navigation level of care management.

CM030. 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.

To verify the consistent delivery of care management services and the authorization of services, we conduct monthly inter-rater reliability (IRR) reviews for care managers,

inpatient concurrent review nurses, medical directors and clinical member advocates and quarterly IRR reviews for pre-authorization RNs. IRR testing determines if our care managers and UM staff are following care management and UM policies and procedures. Staff must achieve a score of at least 90% on IRR testing to be considered competent. Each of our care managers, UM nurses, medical directors and clinical member advocates exceeded the minimum required score of 90% in 2019.

As an example of the value of these monthly reviews, IRR testing for care managers monitors their adherence to care management requirements, such as completion of the initial assessment within 60 calendar days, engagement of the member's providers, completion of the member's care plan and proper documentation of the member's health information in our care management system. We perform this testing monthly.

Staff not meeting benchmark are educated and placed on a performance improvement plan (PIP) that has measurable performance goals, specific timeframes for objectives and an end date to achieve improvement objectives. Failure to achieve performance goals can result in extension of the PIP and disciplinary action, up to and including termination. PIPs are reviewed, signed and dated by the staff member and their direct supervisor and kept on file in the employee's folder in our human resources department.

CM031. 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 who would benefit from a care manager: Once the member agrees to participate in care management, our clinical services team assigns an RN care manager within seven days to collaborate with each member to coordinate their care and deliver care management services in accordance with the Service Provider Agreement, Article

III, Section 5.3.2 Coordination of Care. We take appropriate steps in the initial care manager assignment to confirm a compatible match, including considering cultural or primary language needs and member requests.

Members who do not want a care manager. We flag these members at a "following" level and work with their primary or specialty care provider to help engage them in care. We set reminders for services they may need and attempt to engage these members at those intervals. We monitor when their level of care changes or when they access healthcare services, such as an inpatient admission, to outreach to them and see if they have changed their minds about participating in care management.

Members who cannot be reached. We take advantage of every member interaction with the healthcare system to engage members who couldn't be reached with a care manager if they will benefit from care management. For instance:

- When a member calls our customer service, our care management system identifies that we have been trying to engage the member, so our CSR can connect the member to our clinical team.
- Analyzing claims data to identify the member's PCP and other recent providers. If we are unable to reach the member, a care manager will engage the member's providers to help us locate or conduct outreach to engage the member.
- Identifying members when they engage with the healthcare system, such as a member who or is experiencing an inpatient admission. Our care managers attempt to engage the member where they are accessing services.
- We analyze pharmacy data to identify refill dates and service locations. Our care managers engage the member's pharmacy to help us locate or conduct outreach to engage the member.
- Contracting with Episource to reach and engage the member to perform in-home health risk assessments that are based on CMS best practices.
- Engaging members in the community through a community-based health navigator with the Prestera Center and a community health worker we have embedded as part of an ICT at Community Care.

Members who Have Missed Medical Appointments. The care manager monitors missed appointment using our care management system and by following up with the member and their provider. When the member misses an appointment, the care manager engages the member to determine why they did not attend the appointment and to help overcome any barriers to care.

CM032. 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.

CM033. The Vendor should describe its process for the development of member treatment plans, including, but not limited to, the following:

We recognize the importance of developing treatment plans that comprehensively identify the services and supports, and the providers who will deliver them, to meet the member's medical, behavioral and social needs; their preferences for care; and help them achieve their goals. Our comprehensive care planning approach meets the care planning requirements in the Service Provider Agreement, Article II, Section 5.3.4 Coordination of Care for Persons with Special Health Care Needs and SSI Eligibles.

Process for Identifying Members in Need of Treatment Plans

We identify members in need of treatment plans in a variety of ways, including:

- During the new member welcome call and initial HRA, the member advocate in our member outreach team asks the member about their treatment plans.
- Once we have identified a member who may benefit from care management, we assign a member advocate to engage the member's providers to obtain information, such as a provider treatment plan.
- During the comprehensive assessment, the member's care manager will identify any treatment plans the member may have.

Additionally, we identify members who may need a course of treatment or regular care monitoring as we discussed in **CM003** and **CM005**. For instance, we coordinate care for members with cancer through development of a treatment plan that specifies chemotherapy at set intervals and a plan for specialist visits, lab draws and PET scans.

The treatment plan includes standing referrals with oncologists, tertiary facilities and PCPs to confirm care is easily accessed and smoothly delivered so members and their families focus strictly on care and recovery and providers can focus on delivering care rather than service authorizations and referrals.

Developing Treatment Plans

Our comprehensive care planning approach promotes the member's role in care self-determination and encourages and empowers them to lead the planning process and actively participate in all aspects of care planning. The member's care manager, supported by the member's chosen planning team (e.g., providers, family, caregivers), advocates for the member to make decisions about their care and services in meaningful ways. The member directs the development of a treatment plan that includes services and supports that meet their needs and preferences and helps them achieve their expressed goals and desired outcomes. The treatment plan highlights the member's strengths that can serve as a foundation for achieving positive outcomes based upon their unique situation and needs. The developed treatment plan is not static, but is continually updated with the member and their planning team based upon their changing needs and preferences or as they achieve their goals.

The care manager implements our care planning process, as presented in the figure.

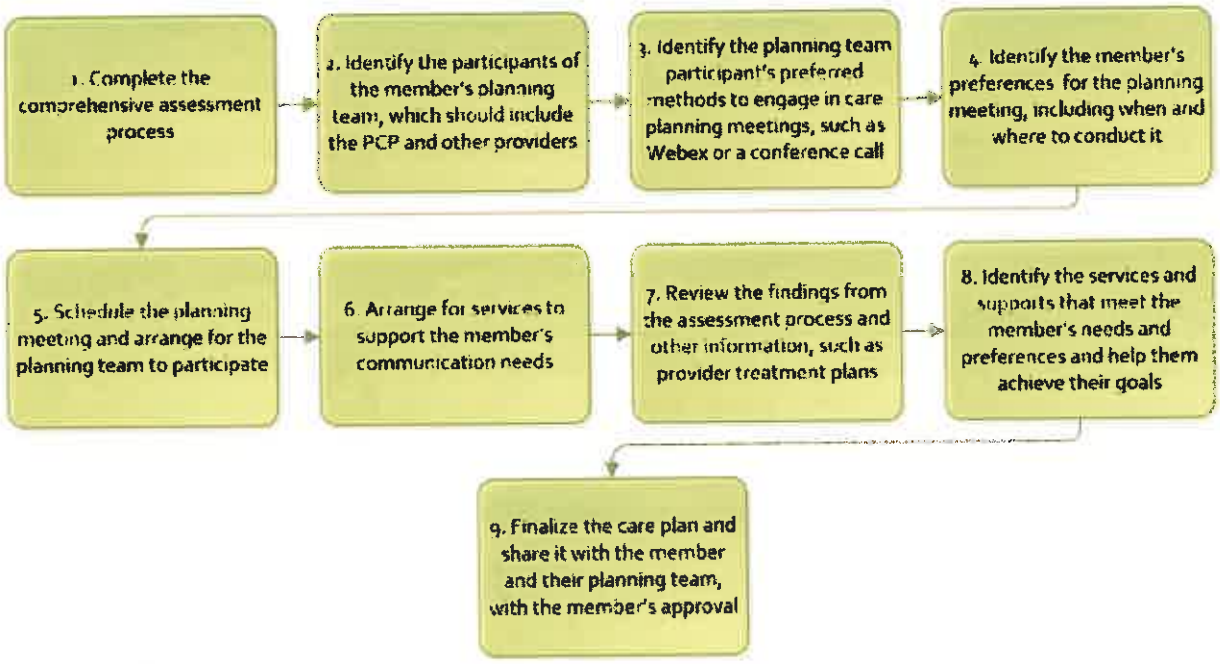


Figure 11. Care Planning Process. Using our care planning process, the care manager facilitates the development of the member's treatment plan. The treatment plan includes the social, behavioral and medical services and supports that meet the member's needs and preferences and help the member achieve their goals and desired outcomes.

Updating Treatment Plans

Treatment plans are living documents that can be updated at any time. The care manager updates the treatment plan at least annually or when there is a change in health status. Care managers look for indications the member's treatment plan may need to be updated by continually monitoring the member's health status, including changes in condition or risk score, and the member's progress toward achieving their goals. Through this monitoring, the care manager identifies situations that will lead to a reassessment of the member's needs and an update of their treatment plan, such as:

- The member has achieved their goals and is managing their conditions leading to lower level of health risk
- The member experiences an acute event, such as an inpatient admission
- The member has finished a course of treatment
- Member has experienced a change in their living situation
- The member requests changes to their treatment plan
- The member's desire to participate in care management changes
- Changes in Medicaid status before their next eligibility redetermination

To update the treatment plan, the care manager implements our care planning process, discussed in the previous section.

Implementing Treatment Plans

The care manager implements the services and supports in the member's treatment plans as follows:

- Processing service authorizations or working with providers to confirm they are submitting service authorizations
- Coordinating with providers to setup the delivery of services and supports and confirming the services and supports have been implemented in accordance with the treatment plan
- Identifying, during discussions with the member, any services that are not being provided that should be or additional services the member may need based upon changes in their health status or living situation and discussing same with member's provider
- Care manager follows up with members to remind them to attend scheduled provider visits
- Care manager educates members to be compliant with treatment and case management plans of care
- Engaging the member's providers based upon member visits, such as well-child visits or follow-ups after appointments

CM034. Including Primary Care Providers (PCPs) in the development of treatment plans

CM035. Sharing treatment plans with the member's PCP or other providers, as applicable

CM036. Staff responsible for sharing treatment plans with the member's PCP

We identify the member's PCP in a variety of ways, including information in the State's enrollment file, during the new member welcome call and HRA, during the comprehensive assessment process and through an analysis of claims. We begin to engage the member's PCP when we assign

The care manager shares the treatment plan with the member's PCP and other providers as applicable, with the member's agreement. Our secure provider portal gives all authorized providers a variety of capabilities to participate in the member's assessments and in development of the member's treatment plan, including:

- Securely sharing the information in the member's care management record.
- Allowing the PCP to review, acknowledge, sign and contribute to member assessments and the member's treatment plan.

a member advocate to engage the member's providers to obtain information about the member, such as a provider treatment plan. The care manager includes the PCP in the development of the member's treatment plan by scheduling the planning meetings and arranging for the PCP to attend as we discussed previously.

Additionally, through grand rounds, our ICT of medical directors, pharmacists and nurses reviews the member's case. Each of these ICT members brings a unique viewpoint on the member's needs, such as a deep understanding of pharmacy issues and available behavioral health services or approaches. The ICT discusses chronic conditions, developmental challenges, emotional and behavioral issues, pharmacy utilization and any special considerations unique to the member. The ICT also discusses care opportunities, goals and interventions for inclusion on the member's treatment plan. We include the PCP in the process through peer-to-peer discussions with our medical directors and pharmacist to discuss treatment options presented during grand rounds.

CM037. Tracking of completion of treatment plans

The care manager tracks the completion of the member's treatment plan through discussions with the member and their PCP. The care manager also tracks completion of the member's treatment plan by developing a plan that includes goals, milestones and accountability. Our care management system supports the creation of the member's treatment plan by using the findings from the comprehensive assessment to recommend a list of suggested

Our secure provider portal allows the provider to monitor the member's progress toward achieving the goals in their care plan.

opportunities, goals and interventions (OGIs) that can be reviewed by the member and their planning team for inclusion in the treatment plan.

For example, a member who reports cigarette smoking may receive a suggestion of tobacco cessation as an intervention, with a goal to quit smoking in six months and discuss tobacco cessation options with their PCP as an intervention. We use evidence-based care management practices, such as motivational interviewing, to help the member restate and prioritize their own identified OGIs. OGIs include:

- ***Opportunities*** are based upon the member's needs identified through the comprehensive assessment process.
- ***Goals*** include the desired or anticipated results based upon identified opportunities. Goals are measurable, achievable and time-bound. Member participation in goal setting is a foundational component of the treatment plan.
- ***Interventions*** include specific steps to achieve a goal. They have defined time frames for completion and are assigned to a specific person (e.g., the member, their PCP) for completion.

Because each intervention includes specific steps with defined due dates that are assigned to a specific person for completion, the member, care manager, PCP and the member's ICT can monitor progress toward completion of each OGI intervention.

Helping members track the completion of treatment plans. Our care management system's member portal, available in English and Spanish, engages members in their healthcare by providing tools to communicate with their THP care team and ICT, view and track the completion of goals in their treatment plan, keep track of appointments in their calendar and complete assessments.

CM038. Identification, tracking, and remediation of gaps in care

We identify members who have gaps in care using a variety of methods, including through the new member welcome call and HRA, ongoing discussions with the member, an analysis of HEDIS and EPSDT measures and using our advanced data analytics,

described in **CM003** and **CM005**. Our member outreach team maintains a gap in care report that identifies members with care gaps so they can be engaged by a member advocate as discussed later in this section. Our analytics identify members who have gaps in care, such as a member with a chronic condition who has not seen a PCP in the prior six months or a member with atypical utilization patterns, such as a member with bipolar disorder with no regular behavioral health visits, or ER use without associated primary care follow-up.

We send PCPs an EPSDT letter that informs them they have members who are due for HealthCheck exam and the names of those members so the PCP can outreach to them and complete the exam.

Tracking/Remediating Gaps in Care for Members in Care Management

Our care management system monitors compliance with preventive and chronic care standards, such as EPSDT screenings. It uses data analytics to identify members who have not received required screenings, allowing the care manager to conduct targeted outreach to members with gaps in care. As presented in the figure, our care management system presents the care manager with the members with care gaps and allows the care manager to take action, such as working with the member and their providers to include interventions to close the member's care gap.

Figure 12: Quality measures scorecard. Care managers and member advocates can view members with gaps in care in our care management system and use this information to take action to close the care gaps, such as scheduling an appointment for the member with their PCP. Note: This screen shot does not include actual member data.

This might include creating an OGI for each required preventive service. The care manager documents the OGI in the member's treatment plan. For example:

- ***Opportunity:*** Member well-child and EPSDT checkups are not up-to-date
  - ***Goal:*** Well-child checkup and EPSDT services are up-to-date
    - ***Intervention 1:*** Educate member/caregiver about importance of well-child checkup and/or help member set up appointment (Duration: 60 days)
    - ***Intervention 2:*** Confirm member has completed office visits for well-child checkup and EPSDT (Duration: 60 days)

The care management system helps the care manager monitor the completion of the interventions in the member's care plan. The member can track the completion of interventions assigned to them through the secure member portal.

Member Outreach to Close Gaps in Care

For members who are not enrolled in care management, but who have gaps in care or who are pregnant, member advocates on our outreach team engage those members to close care gaps, such as diabetic screenings, preventive health screenings and screenings for event-driven services, such as DEXA scans after a fracture. The member advocates also help members continue to manage chronic conditions, provide services and supports to help pregnant members access perinatal care and refer members to resources, such as WIC, Birth to Threeor West Virginia Works. If the member has significant SDOH needs, the member advocate can engage a THP social worker to help the member access socially necessary services and close SDOH gaps.

After an outreach team member advocate talks to the member to help close gaps in care, we send a letter to the member encouraging them to make an appointment with their PCP to follow-up on topics that were discussed. We also send a letter to the member's PCP informing them we discussed the member's care gaps with them and encourage them to follow up with their PCP.

Helping Providers Track and Remediate Gaps in Care

Our secure provider portal gives authorized providers a variety of capabilities to track and remediate gaps in care. It integrates data analyses and provides this information to the ICT in an actionable way. For instance, the portal helps the PCP monitor the member's adherence to their treatment plan, such as a member not filling a prescription. The portal also helps providers identify members with gaps in care using a customizable Quality Measure Dashboard, presented in the figure, which allows providers to view their members with care gaps using HEDIS quality measure data, refreshed twice monthly.

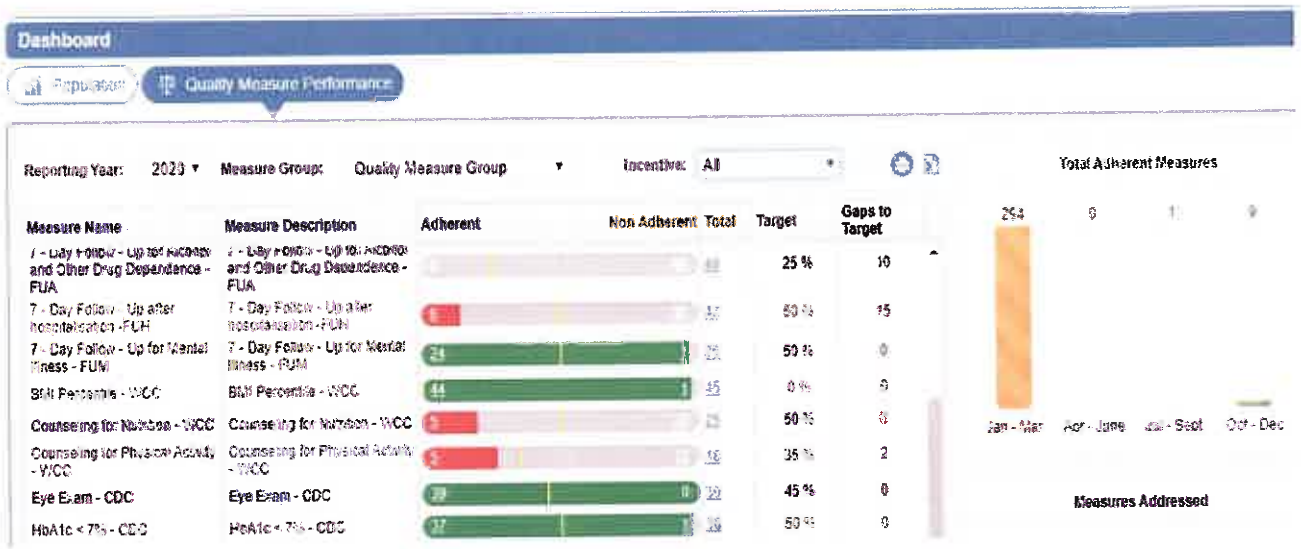


Figure 13: Quality Measures Dashboard. The dashboard provides summary scorecard of performance against HEDIS or EPSDT measures with quick-access links to identify those members in the provider's panel who have gaps in care. Note: This screen shot does not include actual member data.

CM039. Processes for episodic and/or catastrophic care management interventions

We understand some members may require episodic care, or members who may need a course of treatment or regular care monitoring, such as members receiving chemotherapy at set intervals. We identify these members during the new member welcome call and initial HRA and when the member's care manager completes comprehensive assessment of the member's needs. We also identify these members

during our monthly identification and stratification process using Impact Pro. For members who are in care management, their care manager implements interventions to manage their care. For members who are not enrolled in care management, we identify them for care management as we described in **CM003**.

During care planning, the care manager collaborates with the member and their planning team to identify the episodic services the member may require and establishes standing referrals for these services in our care management system. These standing referrals allow members to receive timely episodic care and providers to focus on delivering care rather than service authorizations and referrals.

When a member experiences a catastrophic event, such as a severe car accident, we assign a care manager to help manage the member's care. The care manager works with the member and their ICT to comprehensively assess the member's needs and develop a treatment plan that identifies the services and supports needed to meet the member's needs and goals.

To help members prevent the need for catastrophic interventions, care managers collaborate with members to develop crisis plans that help members understand what to do in emergency situations. For example, a crisis plan for member with a behavioral health concern will help the member know to do when experiencing a crisis, including helping the member understand signs they are going to decompensate, who to call when they see these signs and what to do to stay safe.

CM040. 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. Identification

Recognizing the importance of engaging providers to enhance, coordinate and monitor the member's care, we confirm the member's provider is performing care coordination functions defined in Article III, Section 2.2.1 PCP Responsibilities in the Service Provider Agreement. We do this in a variety of ways, including:

- Care navigators identify providers who are not performing care coordination activities by identifying indications that the member's care is not being coordinated, such as monitoring claims to confirm the member is visiting their PCP or confirming the member visits their PCP within seven days of an inpatient discharge through discussions with the member or the PCP.
- Using our advance data analytics tools to identify members with characteristics that indicate a lack of coordination. For example, we look for members with atypical utilization patterns, such as a member with bipolar disorder with no regular behavioral health visits, members with gaps in evidence-based care, such as HEDIS or EPSDT or members with high healthcare spend or inappropriate utilization.
- Monitoring member complaints or satisfaction with provider services through surveys, such as CAHPS.

24/7 access. PCPs are required to provide 24 hour/ seven day a week access. Compliance of this is monitored through a statistically valid sample chosen from data collection through member complaints, provider and member surveys and after-hours survey calls to the provider. PCPs are required to respond within one hour after normal office hours. THP conducts a quantitative analysis against the defined accessibility standards and a qualitative analysis of the performance results. If the analysis reveals issues at the organizational level, THP conducts a practitioner-level analysis across all PCPs and practices or a statistically valid sample of them. A threshold of less than 90% will result in a practitioner corrective action.

Maintaining a current medical record. THP conducts medical record audits for PCPs. The audit aligns to measure the compliance with THP's Standards for Patient Records Guidelines. Medical records are chosen from statistically valid samples and any of the following: areas of opportunity in HEDIS, past deficiencies, high volume, no prior review, changes or transitions of care.

Medical records are reviewed for member identification, advance directives, problem lists, medication lists and medication reconciliation, allergies and adverse reactions. Provider identification on each date of service is also audited. The records are reviewed for legibility, thorough assessment including vital signs, history and physical, labs, diagnostic testing and clinical findings and evaluation.

Continuity and coordination of care for referrals, specialists, hospital visits and ER visits are also reviewed. Medical records must include review of preventive health, tobacco/drug/alcohol use past or present as well as safeguards in place for the use of EHR systems. Providers must meet a passing score of 85%. Corrective actions are instituted when medical record audits reveal substandard documentation.

CM042 Actions taken to improve coordination

Our provider engagement team works hand-in-hand with care managers to educate PCPs about their care coordination responsibilities and monitor their involvement in each member's care. The team will meet with the provider and complete appropriate education. THP tracks and trends claims and utilization data to identify ongoing issues with providers and will review and evaluate additional action for providers who are consistently noncompliant with THP clinical standards of care per THP contracting and credentialing guidelines.

Provider issues will be reported to our quality management team for further review. The medical director or peer review specialist may review the provider scenario and applicable case file, audit, or medical records. The findings will be forwarded to the Quality Improvement Committee (QIC) for further review and recommendations. Any recommendations for corrective action from QIC will be reviewed by EMT who acts as an oversight committee to QIC. In turn, the EMT reports these approved recommendations made by the QIC to THP's board of directors.

Corrective actions may vary according to the situation and the nature and severity, but are not limited to, one or more of the following as they relate to the treatment, procedure or services:

- Written warning to the practitioner
- Discussion with the practitioner
- Placing the practitioner under a focused review via medical record review or reviews generated by claims data at scheduled intervals; results to be reported to the QIC who will direct further action of the corrective action plan
- Requiring the practitioner to enter into a preceptor relationship with another practitioner, whereby the practitioner acting as the preceptor monitors and observes the practitioner subject to corrective action, including examining medical records and interaction with patients
- Requiring the practitioner to complete continuing medical education regarding the treatment, procedure or service in question
- Limiting the practitioner's privileges, such as limiting the authority to perform certain procedures)

If the above corrective actions are not met to the satisfaction of the QIC, the EMT will be notified with a request to prohibit the practitioner from accepting new THP members of until the corrective action has been satisfied. If the final determination is that corrective action should be taken, the practitioner will be notified in writing, setting forth the type and nature of the corrective action to be taken.

CM043. The Vendor should describe its programs for coordination of care with community resources and social services for members.

Coordination with agencies and resources providing social services to members, such as reducing food insecurity and improving access to appropriate housing, is integral to addressing members' quality of life. Our approach to coordinating care with community resources and social services includes identifying gaps in community-based resources, finding innovative solutions to close these gaps and providing our staff with tools to help members locate and access social services.

During our most recent survey, NCQA staff stated that we had "remarkable" community involvement and contributions.

- Source: NCQA survey report Fall 2019

Coordinating with FRNs

We engage and coordinate with agencies by region, with an emphasis on participating fully in county-based Family Resource Networks (FRNs) and associated projects and committees. FRNs, by design, exist to respond to local needs and opportunities by partnering with community members and public/private organizations to address the needs of their community.

Sharing Ideas, Moving Forward

"The Health Plan is willing to share ideas and move forward with implementing those ideas to better West Virginia. One example is the Healthy Grandfamilies program being implemented across the state. Through partnership, we were able to host a training at The Health Plan to more than 30 participants seeking to bring Healthy Grandfamilies to their county....Their involvement in the community and assistance with families is valuable...The Health Plan shows compassion and dedication to the citizens of Ohio County and are among the most helpful committee members working to improve West Virginia."

– Claudia Raymer, Executive Director, Ohio FRN, 12/12/2019 letter

We view FRNs as hubs for community engagement and convening in West Virginia's counties. As such, we do not seek to duplicate meetings, committees or projects but align our outreach efforts with FRNs wherever feasible. We are continuing this successful engagement with FRNs and other agencies under the new MHT contract.

Our statewide participation in these meetings is represented by the number of events and attendees by region in 2019:

- ***Southeastern West Virginia:*** 105 events, 8,468 attendees
- ***Northern West Virginia:*** 138 events, 7,011 attendees
- ***Western and Central West Virginia:*** 50 events, 2,755 attendees (note that these numbers are lower as they represent West Virginia only; our provider engagement team also works with organizations in Ohio)

"Our Family Resource Network has worked closely with [T]he Health Plan over the past several years. Our Provider Engagement Representatives have always been enthusiastic about sharing all updates in program and consumer services.

They also volunteer at the various health fairs and community engagement events held throughout the year and share their knowledge with all in attendance.

Continuation of the services provided through [T]he Health Plan is critical to all our communities within the state."

- *Debbie Thompson*
FRN Director, Pleasants County
12/2019 letter

Coordinating with Local Coalitions and Collaboratives

In addition to FRNs, we engage with other agencies and resources to coordinate care, identify and close gaps in complimentary services. Our 2019 community engagement efforts with local coalitions and collaboratives represent the most wide-reaching organizations offering social services to support holistic MHT member health. These organizations include Healthy Grandfamilies Coalition, West Virginia Medicaid Coalition, Lewis County Community Collaborative, Marshall County Adult Services Coalition, North Central Collaborative Committee, Family Ways Collaborative, Pleasants County Coalition, Intermountain Collaborative and Putnam Wellness Coalition. We also participated in mental health events with the Fayette County Substance Abuse Task Force, Youth Mental Health Meadowbrook Mall, Mental Health Summit, Mason Substance Abuse Coalition and Upshur Partners in Prevention.

Coordinating Care with Community Resources and Social Services for Members

As presented in the figure, we have implemented a two-pronged approach to coordinating care with community resources and connecting members to those resources. This includes 1) community and stakeholder engagement to identify and engage community-based organizations providing services to our members, and 2) care management processes to connect members to social services.

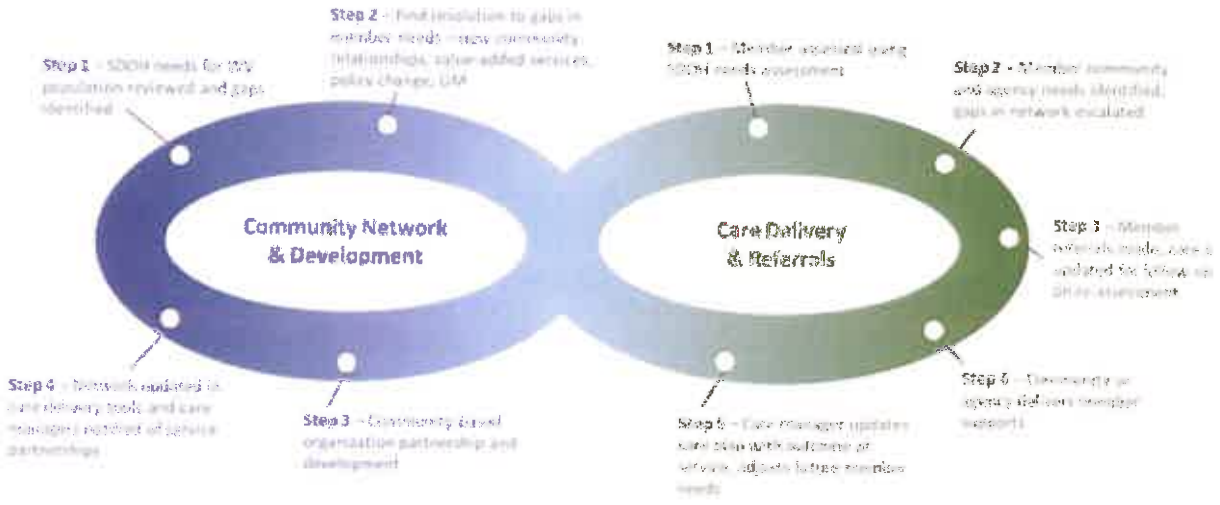


Figure 14. Two-pronged approach. We use a cross-functional team to identify gaps in community-based resources and implement activities that engage community resources that can deliver social services to our members. Our member advocates and care managers use our SDOH assessment to understand the member's social services needs, identify resources to meet those needs, refer the member to those resources and confirm the member's social services needs has been addressed.

Community and stakeholder engagement.

Our population health team, provider engagement team and Community Engagement Director Wendy Hodorowski, MHT Member Advocate Jeanette Williams, Medical Management Director Susan Klinkoski and Quality Director Michelle Poland (Community Engagement Team) identify gaps in community-based resources that deliver social services to our members. As we discuss in **CM044**, the team uses a combination of data analytics, its knowledge of the community, population health analysis and input from BMS and other key stakeholders to learn about the community-based capabilities and expertise.

In 2019, our provider engagement team attended nearly 300 community events comprising 18,000+ attendees, including 110 FRN meetings in 39 counties. We also attended a variety of other events, from a Berkeley Heights community block party to a Pleasants County Town Hall meeting to the Hancock County Table Treating.

Once identified, the team conducts customized outreach to community-based organizations to introduce THP and begin developing an ongoing relationship that meets the needs of the organization and the members they serve. During meetings with community-based organizations, our team learns about the organization, including its mission, values, populations served and scope of services provided and explores ways to work together, such as informal relationships, referrals, subsidized events or contracting for services.

Care management processes to connect members to social services. As we discussed in **CM003** and **CM005**, our member advocate or the member's care manager uses our SDOH assessment to obtain additional information about the member's social services needs. The assessment asks 16 questions related to SDOH, such as housing, education, employment and safety. The member advocate or the member's care

manager can automatically identify community-based resources that can address the member's SDOH needs.

Our care management system integrates with Aunt Bertha, a social care network tool that connects people and programs. Aunt Bertha makes it easy for people to find social services in their communities and for local organizations to coordinate their efforts. Aunt Bertha's database includes information about food, housing, transit, financial, education, work and legal programs in its West Virginia database. The member advocate or the member's care manager use Aunt Bertha to identify resources to meet the member's social services needs based upon the SDOH assessment, make the referral to the community-based organization that can meet those needs and track the referral so they can follow-up with the member and community-based organization to confirm the member's social services need has been addressed.

The team uses Aunt Bertha, the industry-standard community resource collaboration tool, to quickly map community resources to member needs. Aunt Bertha's social care network connects people and programs — making it easy for people to find social services in their communities and for nonprofits to coordinate their efforts.

CM044. The Vendor should describe its approach to address Social Determinants of Health (SDOH).

There is widespread recognition and evidence that SDOH are primary drivers for health outcomes, healthcare costs and quality. Our population health management (PHM) program identifies social, economic and environmental barriers that stand in the way of members meeting their healthcare goals, as discussed in **CM054**. Generally, we address SDOH by:

- Continually evaluating our membership to identify their SDOH needs
- Engaging community stakeholders to understand the SDOH needs they address and how we can refer members to them

- Connecting members to community-based organizations to address their needs

Continually Evaluating our Membership to Identify their SDOH Needs

We have implemented a variety of methods to identify our members' SDOH needs, at the individual and population level. They include the following:

- ***New member welcome call and initial screening.*** Our adult and pediatric HRAs each include questions related to SDOH. If SDOH needs are identified, the member advocate may use our SDOH assessment to obtain additional information about the member's SDOH needs.
- ***SDOH assessment.*** Member advocates and care managers use our SDOH assessment to obtain additional information about the member's SDOH needs. The assessment asks 16 questions related to SDOH, such as housing, education, employment, safety and income. We discussed our SDOH assessment in **CM003** and **CM005**.
- ***WVU Medicine's EHR, Epic.*** THP's care managers also have access to Epic, which gives them the ability to collaborate with WVU Medicine providers and care coordinators by allowing them to access information about our members who are seen at WVU Medicine. This includes information obtained by Epic's SDOH assessment tool. The tool identifies SDOH needs across domains, including education, financial risk, social connections, intimate partner violence, food insecurity and transportation needs.
- ***ICD-10 codes*** help us identify the impact of SDOH on our members' ability to access care and track the delivery of services to address SDOH, while avoiding additional administrative work for providers.
- ***Data analytics.*** Impact Pro analyzes a variety of data sources to identify the impact of SDOH to the health risk of our members. Each month we perform an analysis and develop reporting on those members who have completed an initial HRA and those members who have claims that indicate they have an SDOH concern based upon the presence of ICD-10 codes. For example:
  - We run reports on member's completing HRAs and send identified members to our care navigation team for review based on self-identified risk factors for SDOH and diagnosis-driven concerns.
  - We run reports for ICD-10 reported SDOH codes and crosswalk the results with risk scores to identify additional opportunities for outreach and engagement. Reports are sent to clinical managers for review and forwarded to social workers for follow up assessment when not already engaged in a program or to a nurse navigator or member advocate when engaged.

Engaging Community Stakeholders to Understand the SDOH Needs They Address and How we Can Refer Members to Them

Our population health team, provider engagement team, our community engagement director, MHT member advocate, medical management director and quality director

(referred to as our community engagement team) identify gaps in community-based resources that deliver social services to our members. The team will identify community-based organizations with which we can partner and conduct customized outreach to the organizations. At outreach calls or meetings with the organization, THP begins developing a relationship that meets the needs of the organization, and the members we mutually serve. We continue to identify opportunities to work with community-based organizations and identify member access to SDOH resources as follows:

Daily: Our member-facing staff works with our members, they document members with individualized issues we are unable to resolve effectively using existing benefits or community resources. We log these concerns for discussion at community engagement team meetings. Counties and communities with no resources are captured. Ad hoc meetings may be called for urgent unmet needs.

Quarterly and on demand: The community engagement team meets to review resource referral patterns, discuss and prioritize community opportunities for engagement and formulate plans for resource development internally, externally or in a partnered fashion.

At least annually: Our PHM team evaluates our member population using our data analytics tools to integrate data from a variety of sources and then analyze variables at the member- and population-level to stratify members into care management levels in alignment with their health risk and identify population trends and member sub-populations within the larger member population so we can deliver interventions relevant to our members.

The PHM team compares the analysis to national numbers to identify statistically significant concerns relevant to West Virginians. The team breaks down the data into county- and regionally specific data when able, to heat map within the state and identify areas for targeted programs relevant to our member population. Annualized THP claim and self-reported member data are also reviewed at this time, under and overutilization patterns are examined and consideration and planning is initiated for any newly identified needs in health and wellness programming, disease management programming or care management programming. Program builds are undertaken in cooperation across the PHM and clinical services teams based upon identified needs.

CM045. The Vendor should describe its care coordination efforts that identify and address member access including, but not limited to, the following:

We use a variety of member touch points to identify their SDOH needs and connect them to resources. Recognizing the importance of identifying and addressing these needs, we begin to identify them as soon as the member is enrolled with us. Our SDOH care coordination efforts include:

The member advocate or the member's care manager can automatically identify community-based resources that can address the member's SDOH needs using Aunt Bertha to identify resources, make the referral to the community-based resource and track the referral to confirm the member's SDOH need has been addressed.

- Collaborating with BMS to confirm the member is enrolled in the correct program to connect members to services, such as personal care services.
- During calls to members to complete an initial HRA or close care gaps, a THP member advocate assesses the members' SDOH needs using our SDOH assessment and refers the member to the SDOH resources using Aunt Bertha and WV-211.
- For members not identified for care management, we assign a member advocate team to work with them to identify and resolve barriers to accessing care, close their gaps in care or engage them in

Our member advocates and care managers can connect the member to a THP social worker to address more complex social needs.

a maternity management program.

- For members who may benefit from care management, we assign a clinical member advocate to engage the member to:
  - Identify and resolve concerns that may be leading to increased health risk, such as a lack of transportation.
  - Engage the member's providers to obtain information, such as a provider treatment plan, which will inform the comprehensive assessment and care planning processes.
  - Provide additional information to the care manager who will coordinate the member's care, such as provider assessment findings or treatment plans.
- For members in care management, their care manager incorporates SDOH resources into the treatment plan so they can monitor member's progress toward addressing SDOH concerns and resolving barriers to accessing care.

CM046 Employment

CM047. Food security

CM048. Housing stability

CM049. Education

CM050. Social cohesion

CM051. Resources that connect members to social supports and healthcare

CM052. Environmental needs

We identify and address member access to social services as we discussed in **CM043** and connect members to the resources presented in the table.

Care Coordination Efforts that Identify and Address Member Access
CM046. Employment
▪ Provide support and collaborate with BMS as it explores a Work and Community Engagement Requirements Waiver option for Expansion members. ▪ We direct members to West Virginia Works for job support and retraining initiatives and to WorkForce West Virginia. ▪ For members in recovery and/or with a drug-related criminal record, THP care managers will link members with the Jobs & Hope West Virginia Program. This program offers support through a statewide collaboration of agencies that provide West Virginians in recovery the opportunity to obtain career training and to ultimately secure meaningful employment. ▪ We will continue to advance BMS policies such as the SUD Waiver and Work and Community Engagement Requirements Waiver options and facilitate upcoming THP procedure or policy changes.
CM047. Food insecurity
▪ We help members qualify and apply for SSI. ▪ THP had WIC onsite to educate our care managers and advocates on how to engage their services. ▪ Referrals to Meals On Wheels, local food pantries, WIC program.
CM048. Housing stability

Care Coordination Efforts that Identify and Address Member Access
▪ Sponsored Project Hope for Women and Children to provide transitional housing and treatment to women in recovery and their families. ▪ We work with the Centers for Independent Living (CILs) to do home modifications (e.g., ramps, safety bars). ▪ Referrals to Homeless Coalition. ▪ Referrals to low income home energy assistance programs (LIEAP) that assist in paying electricity, gas, and/or water bills. ▪ Referrals to churches that have emergency fund or other utility assistance programs. ▪ Referrals to Rapid Rehousing.
CM049. Education
▪ Fund scholarships for WVU and Marshall University medical and nursing students who commit to working in West Virginia after graduation/residency
CM050. Social cohesion
▪ Scholarships to Camp Kno Koma for children with diabetes ages 7-15 (value-added service). ▪ Memberships to Boy Scouts and Girl Scouts for members ages 5-18 (value-added service). ▪ Annual THP donation to each of the eight West Virginia Boys & Girls Clubs to be used for membership dues for children and youth in need (value-added service). ▪ Referrals to churches, natural support groups, such as Alcoholics Anonymous and self-help programs.
CM051. Resources that connect members to social supports and healthcare
▪ THP social workers engage members with complex SDOH needs ▪ Aunt Bertha to identify resources and referral tracking in our care management system ▪ 24/7 nurse line connecting members with a THP nurse ▪ 24/7 telehealth services from Teladoc (medical, behavioral health, dermatology) (value-added service) ▪ Free cell phone with free minutes for text and voice, unlimited calls to customer service and free wellness and appointment reminder text messages (value-added service) ▪ Connecting members to health homes ▪ Linking members with SUD to peer supports ▪ Behavioral health community engagement specialists ▪ West Virginia 211
CM052. Environmental needs
▪ Tobacco cessation health and wellness program ▪ Members with asthma – we educate members on environmental triggers for asthma ▪ Referrals to green spaces, sidewalks, place to exercise ▪ Referrals to lead/mold/asbestos abatement ▪ Referrals to West Virginia Community Action and weather proofing programs

CM053. The Vendor should describe its plan to develop additional programs for Social Determinants of Health (SDOH).

Recognizing social, economic and environmental factors are primary drivers for health outcomes, healthcare costs and quality, we continually evaluate our member engagement programs to identify new opportunities to connect members to social

resources. We are enhancing our ability to identify and address our members' SDOH needs as follows:

- Increasing our focus on SDOH through the adoption of an enhanced care management system and SDOH assessment.
- Providing additional support to members in the community through the implementation of a community-based health navigator program.
- Locating and connecting difficult-to-engage members to care management.
- Focusing on members who are homeless or precariously housed.

Increasing our Focus on SDOH through the Adoption of an Enhanced Care Management System and SDOH Assessments

We are implementing an enhanced care management system. One of the enhancements it brings to our MHT members and providers is its assessment suite. Our care management system's assessment suite includes more than 80 standard assessments, including all assessments relevant to the MHT program. Many of these assessments identify members who have unmet SDOH needs.

Depending upon the member responses to these questions, the member advocate or the member's care manager use our SDOH assessment to obtain additional information about the member's SDOH needs. As discussed in **CM003** and **CM005**, the assessment asks 16 questions related to SDOH, such as housing, education, employment, safety and income.

Providing Additional Support to Members in the Community

In September 2018, we partnered with Marshall University, Community Care of West Virginia, Inc. and the Claude Worthington Benedum Foundation to implement a community health worker program. THP is supporting the program by covering 25% of the cost to

Comparing the period November 1, 2018, to October 31, 2019, the average per member health care spending dropped from $26,639 to $14,135 in the first year, a substantial reduction of 46.9%.

employ a community health worker for year one at Community Care of West Virginia sites. Marshall University covers the remaining 75% of costs through grant funding. The program incorporates a community health worker as part of an interdisciplinary care team. The community health worker conducts home visits with patients or meets with patients after primary care appointments in office—based on the patient's preference—to help them with a range of chronic conditions, including diabetes, high blood pressure and obesity, among others.

Locating and Connecting Difficult-to-Engage Members to Care Management

We are partnering with Episource to help us locate and engage members who are high risk and may benefit from care management. We currently partner with Episource in our Medicare line of business. For our MHT members, Episource will leverage technology to build comprehensive member profiles, tailor our message based upon the member's needs and engage members via multiple channels (e.g., telephone, direct mail, email and/or text message).

After locating a member, Episource's outreach teams answer member questions and obtain feedback about their experience; this increases member buy-in and reduces risk of dropping out of the program. Once the member is engaged, an Episource clinician performs an onsite comprehensive physical exam to collect relevant information about the health status and risk factors of the members. The clinician performs a medication review, a review of their preventive services and social environment, assesses and documents all

> Episource clinicians will perform a face-to-face visit with members to comprehensively understand their needs and connect them to care, including reviewing their social environment and other risks that can be difficult to capture during office visits.

significant and chronic diseases, performs labs, if indicated, and refers the member to THP for engagement in a care management program.

Focusing on Members Who are Homeless or Precariously Housed

It is not uncommon that we have a member who is homeless. Homelessness is typically the result of some other issue, such as the loss of a job, unreliable income or an inability to work due to physical or behavioral health reasons. We are dedicated to assisting all of our members who struggle with basic needs, including those who are homeless or precariously housed. Our care managers and social workers are the linkage for our members to access already available resources. They collaborate to help members with their housing needs, using wvnavigate.org, sponsored by the Aging and Disability Resource Network, West Virginia 211 and Aunt Bertha, to find agencies to assist our members. Some common resources that we leverage include:

- The West Virginia Coalition to End Homelessness, which serves 44 counties.
- West Virginia Division of Rehabilitation Services offers training and employment assistance to people with a disability.
- Local DHHR agencies provide assistance through WorkForce West Virginia, SNAP and the low income energy assistance program (LIEAP).
- West Virginia Community Action Partnerships assist individuals with community links and also provide Supportive Services for Veteran Families.
- Med-Data helps our members who may qualify for SSI to apply for SSI and they also assist them with appeals if they are initially denied.

In instances where our member is struggling with a behavioral health or SUD concerns, our care managers and social workers help them find appropriate treatment. Members are encouraged to use their non-emergent transportation benefit or other community resources to attend appointments. Medication adherence is an important part of member treatment, and we keep in touch with our members regarding any problems with securing medications, including difficulty accessing their medications. Community

pharmacies, especially ones that deliver, are useful to those without readily available transportation. All behavioral health agencies provide additional care management services through the community engagement specialist program. We coordinate with the specialists to better serve our members where they are accessing care.

Pursuing Additional Opportunities

We are aware of pilot initiatives that address members with SDOH needs, such as the CMS Accountable Health Communities Model. This model is testing whether systematically identifying and addressing the health-related social needs of Medicare and Medicaid beneficiaries through screening, referral and community navigation services will impact healthcare costs and reduce healthcare utilization. Additionally, Partners in Health, Inc. in Charleston is an Assistance Track Participant in West Virginia that provides community service navigation services to assist high-risk beneficiaries with accessing services to address health-related social needs.

We will continue monitoring activities and programs related to addressing each member's SDOH needs and partner with successful programs to bring those resources to our MHT members. Future activities may include aligning the SDOH screening instruments/questions with the CMS Accountable Health Communities' instrument or other nationally recognized tools, such as the National Association of Community Health Center's SDPH tool Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences (PRAPARE), which is used by several federally qualified health centers in the state.

CM054. The Vendor should describe its population health approach including, but not limited to, the following:

CM055. Engaging members across the entire care continuum

CM059. The Vendor should describe its process to evaluate the member population and coordinate prevention and wellness programs available to all members.

We recognize the importance of PHM in identifying and addressing the social, behavioral, medical and functional needs of our members served through the MHT program. PHM is a model of care that addresses individuals' health needs at all points along the continuum of care, including in the community setting, through participation, engagement and targeted interventions for a defined population. The goal of PHM is to maintain or improve the physical and psychosocial well-being of individuals and address health disparities through cost-effective and tailored health solutions. As we will discuss, THP's PHM program includes the following five components:

- ***Component 1: Our PHM Strategy*** guides our care management program.
- ***Component 2: Population Stratification*** allows us to evaluate our member population and stratify members according to their health risk and needs.
- ***Component 3: Targeted Interventions Across the Care Continuum***, from prevention and wellness programs that empower members to managing their health to care management for at-risk members.
- ***Component 4: Delivery System Support and Alignment***, through the implementation of VBP programs that align with BMS' vision and priorities for the implementation of VBPs in West Virginia.
- ***Component 5: Measurement,*** which helps us evaluate the effectiveness of service delivery through the adoption of objective performance standards, such as CAHPS, surveys, HEDIS measures and CMS-specified Core Measures.

Component 1: Our PHM Strategy

Our PHM strategy informs and guides our managed care program, helping us identify the services, supports and programs members across West Virginia need and the providers and community-based organizations qualified to deliver them. Our strategy helps us understand the social, behavioral and medical needs, circumstances, health risk and level of intensity of care management services of our members in the MHT

program. We engage members across the care continuum, maximizing their health by providing all members with preventive services and tools that promote wellness. We provide more intensive supports to at-risk members and those with complex conditions to help them better manage their conditions, leading to improved health outcomes.

Our PHM strategy is the basis of identifying trends among our members and developing interventions that:

- Address population health concerns, such as SUD, obesity or infant and maternal mortality.
- Recognize cultural and linguistic demographics, such as age, race, ethnicity, gender identity, sexual orientation, religion, primary language, disability status.
- Incorporate SDOH, such as such as food insecurity, unsafe and unstable housing, lack of transportation, unemployment and financial instability.
- Confirm each member receives services and supports most appropriate to meeting their needs and helping them achieve their goals and desired outcomes.

Component 2: Population Stratification (CM059)

We evaluate our member population using our data analytics tools to integrate data from a variety of sources to:

- Stratify members into care management levels in alignment with their health risk by identifying drivers common to members who require intensive clinical intervention, such as unmanaged complex medical or behavioral conditions. It also identifies members with conditions targeted by a specific program, such as members who have diabetes or are pregnant.
- Identify population trends and member sub-populations within the larger member population so we can deliver interventions relevant to our members. We identify sub-populations within our member population based upon a variety of factors, such as region, geographic area, ability to access care, health disparities, demographics, utilization and children and youth with specific needs.

We will integrate data from the WVHIN into Impact Pro's analysis and into our care management system. For instance, we will integrate WVHIN's ADT data, which will automatically notify our care team about these members through an alert in our care management system.

Our PHM team reviews Impact Pro analyses at the population level and at the member, provider and facility level to identify opportunities for improvement in the quality of care, member experience, member outcomes and the cost of care rendered to members. For

example, we analyzed geographic variations and provider relationships to screening rates and identified barriers to care that may influence screening rates in our population. The figure presents an analysis of gaps in care for our MHT members related to rates of breast cancer screening, cervical cancer screening and chlamydia cancer screening. Red and orange represent the counties with the highest rates of these care gaps.

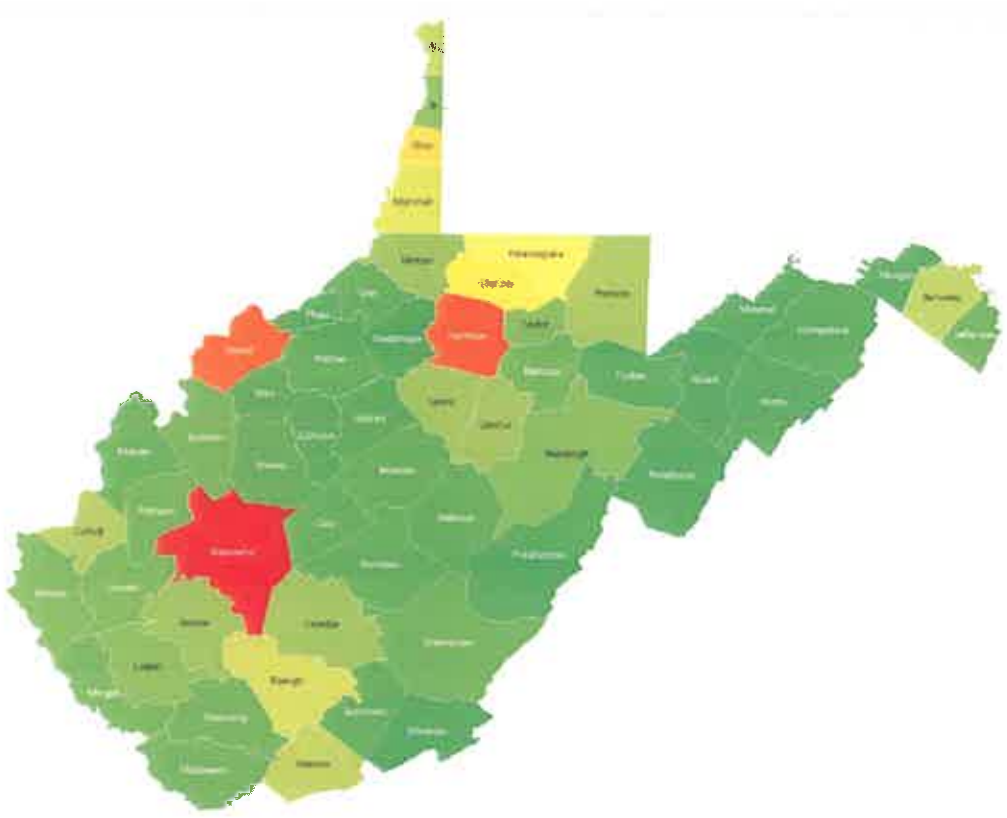


Figure 15. We completed an analysis of quality gaps in care for our MHT members related to rates of breast cancer screening, cervical cancer screening and chlamydia cancer screening. Red and orange represent the counties with the highest rates of these care gaps. Based upon this analysis, we developed the Women's Health Initiative to connect women to these services.

After reviewing several years of trends on closing gaps in care on these measures specifically for women, rates were reviewed by our OB/GYN medical director. After discussion and review of variations in regions, further drill down analysis is being completed to target areas where there may be issues with access to care, comorbidities

related to behavioral health conditions, and lack of understanding of the importance of screening. Improvement activities will include:

- Provider engagement conducting face-to-face education to providers on how to identify the women with gaps in care and the need to engage women in preventive screening
- Member advocates outreaching to members with all three gaps in care
- Engaging specialists who are providing care to women with all three gaps in care, including OB/GYN and behavioral health providers
- Leveraging our VBP relationships to close these care gaps
- Implementing community-based health navigators to work with members and providers in the community to close these care gaps

Component 3: Targeted Interventions Across the Continuum of Care (CM055)

Based upon our understanding of each member, we deliver a range of interventions to meet their needs across the entire care continuum as we discussed in the section titled, "Care Management Risk Levels/Tiers," in **CM003** and **CM005**. For instance, for members with low risk, we connect them to a PCP and deliver prevention and wellness programs that empower them as they take responsibility for managing their health. For members who are at risk, we enroll them in an intensity of care management appropriate to their needs and assign a care manager to work with the member to coordinate their care. For members who have specialized needs, such as members who are pregnant and have high-risk factors, such as previous pre-term birth, SUD or advanced maternal age, we engage them in our Perinatal Care Management Program and assign a perinatal care nurse experienced in labor, delivery, recovery and post-partum to coordinate their care.

We are offering all our members Teladoc, a telehealth solution that provides free 24/7 member access to medical, behavioral health and dermatology care via phone, video or app. Teladoc is the first telehealth provider to receive certification from the NCQA for its physician credentialing process. Teladoc is the only telehealth provider to receive NCQA certification twice and to pass both certifications with a perfect score of 100%. Teladoc physicians are board-certified and state-licensed with an average of 25 years of practice.

Component 4: Delivery System Support and Alignment

Our providers are at the frontline of care and influence member outcomes, utilization and quality. Providers often have different capabilities, and we engage with and support our providers to achieve PHM strategy goals through the sharing of member data and by providing incentives for providers to deliver quality, cost-effective care. We have implemented a robust Value-Based Payment (VBP) program in West Virginia that aligns with BMS' vision and priorities for the implementation of VBPs in West Virginia.

We currently have three contracted VBP relationships in West Virginia and are in discussions with providers and major academic centers in the state to implement additional VBP contracts. Our VBP contracted relationships include the following.

Total Cost of Care Pilot Project with the Prestera Center. THP is piloting a total cost of care arrangement with Prestera Center, a major comprehensive behavioral health center that serves Southwestern West Virginia. This pilot facilitates the integrated delivery of physical health and behavioral/mental health for Medicaid members determined mutually by THP and Prestera Center using an analysis of high ER utilization. We pay a coordination fee to Prestera Center and a portion of the shared savings if they reduce the patient risk score by 10% or more, reduce ER visit total by 10% or greater, or 88% or more assigned members have a claim originating in a primary care setting during the performance year.

WVU Medicine is the largest integrated healthcare delivery system in West Virginia. Our VBP with WVU Medicine covers an average monthly Medicaid membership of 16,945 members. It is a shared savings arrangement in category 3A. In THP's shared savings arrangements, providers receive contracted fee-for-service reimbursement, a

per member per month care coordination fee, and increased access to claims and population health and risk stratification data (e.g., member health risk scores, HEDIS care gap reports, and customized data analytics, by request of the provider). In turn, providers are expected to build out care coordination infrastructure and manage the needs of the assigned membership. Our VBP with WVU Medicine tracks attainment of six HEDIS measures.

Community Care of West Virginia, Inc. is the second largest federally qualified health center (FQHC) in West Virginia. They are also a level 3 NCQA-accredited PCMH.. Our VBP with Community Care, which began Jan. 1, 2020, covers an average monthly Medicaid membership of 1,970. It is a shared savings arrangement in category 3A and tracks attainment of seven HEDIS measures.

Component 5: Measurement

Our PHM team uses baseline measures and key performance indicators to compare the health outcome measures of our MHT population against state and national rates and other MCOs in West Virginia. With the data, we identify areas of opportunity to engage specific subpopulations of our members.

Baseline measures. We evaluate the effectiveness of service delivery through the adoption of objective performance standards to assess our performance, such as CAHPS, surveys, Medicaid HEDIS measures, CMS-specified Core Measures and EPSDT. We will track the measures in the 2020 PMV Report and incorporate the 2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) into our QI activities.

We have established ***key performance indicators*** that allow us to monitor our performance and identify opportunities for improvement, such as access to primary care (e.g., the percentage of members who have had well-child checks and received preventive vaccines), utilization (e.g., admissions/1,000 members, ER utilization), readmission rates, members connected to appropriate care (e.g., the percentage of members who visited their PCP within seven days post-discharge), the number of complaints and appeals per 1,000 members and members who have high cost of care.

Using Data Analytics to Increase Annual Dental Visits among Children

In Q1 2018, we implemented a PIP to improve access to dental services among children as measured by the Annual Dental Visits for 2-3 Year Olds (HEDIS) measure and the Percentage of Eligibles Who Received Preventive Dental Services (Child Core Set Measure). At initiation, we implemented the following interventions:

- Developed and a mailed a dental postcard to parents/guardians, "Taking Care of Your Teeth is as Easy as...," to provide dental awareness and member education on the importance of early screenings and cleanings.
- Member advocates on our member outreach team contacted parents/guardians whose children have not had a dental appointment to educate them about the importance of dental care and using non-emergency transportation (NEMT) to get their child to dental appointments. Member advocates also helped parents/guardians find a provider and arrange transportation to visits.
- Provider engagement representatives participated at events to provide educational opportunities for members and families, such as the Marshall County Back to School Fun Fair or the Medina County Senior Walk & Health Fair.
- Used social media posts on Facebook to educate and encourage change in member's dental habits with emphasis on dental during February for Children's Dental Health Month.

We have continually evaluated and modified the PIP interventions as we identified barriers to connecting members to these services. For instance, in Q1 2019, we began offering a $25 gift card incentive for these members who completed a dental visit. The

PIP has been successful, increasing Annual Dental Visits from 27.40% in 2018 (MY2017) to 36.29% in 2019 (MY2018).

CM056. Promoting and incentivizing healthy behaviors and disease self-management

Our care management approach emphasizes preventive care for every member to manage health conditions, improve health outcomes, improve member satisfaction, keep members from escalating to a higher risk level and avoid unnecessary utilization. Our goals are to empower and support each member to take responsibility for managing their healthcare and to maintain or lower every member's health risk by reinforcing wellness and helping them take an active role in managing their health and well-being. We focus on preventive care using a variety of methods, including the following.

Promoting the relationship between every member and their PCP. Core to delivering preventive care and healthy behaviors is the importance of engaging the PCP to enhance, coordinate and monitor the member's care. We leverage every member interaction to confirm the member has a PCP, connect the member to their PCP and confirm the member is actively engaged with their PCP. If a member does not have a PCP, we help them select and connect with one.

Working with PCPs to close gaps in care. We connect members to preventive care by verifying they receive recommended preventive care in alignment with national standards, such as HEDIS. Our provider engagement team engages provider practices that have significant numbers of members who have not received recommended preventive care. We have developed reports to help PCPs understand their performance closing care gaps compared to their peers. Through our secure provider

portal, providers can see all their members with gaps in care and use its planning tools to close those gaps.

Help members manage chronic conditions. We identify members with chronic conditions and enroll them in disease management programs to help them proactively manage their conditions. We provide disease management programs for members who have low risk and diabetes, a chronic cardiac condition, COPD or smoking or tobacco use. We engage members who have high-risk and chronic conditions in care management as discussed in **CM003** and **CM005**. We identify and engage members who are pregnant and engage them in perinatal programs, as discussed in **CM009** and **CM010**.

Help members take an active role in managing their care. We encourage all members to take action on their health using a variety of strategies and tactics. Our prevention and wellness programs engage all members. As discussed in **CM003** and **CM005**, we use a multimodal approach and an array of health promotion tools and resources to actively engage every member and provide support tailored to each member's circumstances. For example, we provide tobacco cessation packets for members ages 12 and older that include a workbook, relaxation exercises CD and quit smoking survival kit.

CM057. Integrating care management

Delivering person-centered, holistic care means that all care management approaches must be holistic, culturally aware and integrated. Physical and behavioral risks, such as SUDs and medication mismanagement need to be addressed as part of screening, assessment and interventions addressing each member's relevant medical and

behavioral priorities. We have integrated our care management program in a variety of ways, as discussed in this section.

Our care management program combines separate behavioral health and medical units into one with a unified job description for all variants of care management staff. The goal is to personalize the member experience to maximize engagement rather than confusing the member with multiple care management contacts. PHM data indicates that most members who have a behavioral health condition experience co-occurring medical issues and vice versa. All care managers manage member care holistically and have been cross-trained to encompass behavioral, medical and social care management and resources.

Our care managers can engage THP social workers to assist members who require assistance with SDOH supports. Additionally, we employ behavioral health staff who serve as information resource to the team as a whole.

Integrated Care Management System

Our care management system maintains all information, including medical, behavioral and social information, about the member's care and services in their individual care management record, providing a comprehensive view of their needs and goals and the services and supports being delivered to meet their needs and help them achieve their goals. The information collected in each individual care management record is reportable at the aggregate level.

Care Manager Integration

Care managers employ a variety of strategies to promote constant and efficient communication between all stakeholders, members, practitioners, providers, and

caregivers. They work with other departments to integrate medical and behavioral healthcare. For instance, care managers:

- Refer to and receive referrals for review from social workers, disease navigators, pre-authorization, inpatient navigation, and pharmacy through the use of our care management system.
- Coordinate care and resources, provide alternatives to hospital care, facilitate care across the continuum and prevent duplication and fragmentation of healthcare services.
- Work with community care management staff in various areas to coordinate member care including care managers in homeless coalitions, Health Right care managers, shelter care managers, community engagement specialists, medical home staff and health home staff.

Employing Integrated Data Analytics

Impact Pro analyzes medical, behavioral and pharmacy data and variables, such as gender, age, future inpatient risk, prior year total cost of care spending, acute inpatient admissions, ER visits, pharmacy, behavioral conditions, total chronic conditions, SDOH-related data, census data and demographics. It applies more than 300 clinical rules to identify members with gaps in care, condition-specific triggering events, high utilization, risk markers and substance use concerns.

Impact Pro also analyzes behavioral risks and related costs to confirm behavioral risks are not masked or eclipsed by more costly physical health comorbidities during population risk analysis. It analyzes service utilization patterns and characteristics that allow us to identify members with behavioral conditions, including members with co-occurring, mood or psychotic disorders or SUDs. This allows us to begin to tailor services and supports to the intensity of each member's needs, the appropriate setting for care delivery and the scope of services required.

Using Integrated Assessments

Our assessments are holistic and identify each member's medical, behavioral and SDOH needs. For example, our adult HRA includes validated tools, such as the AUDIT-C and PHQ-2 and our pediatric HRA assesses trauma using the CSDC-SF, assesses trauma using the CSDC-SF.

Total Cost of Care Pilot Project with the Prestera Center

As discussed in **CM054**, **CM055** and **CM059**, THP is piloting a total cost of care arrangement with Prestera Center that facilitates the integrated delivery of physical health and behavioral/mental health for Medicaid members identified mutually by THP and Prestera Center using an analysis of high ER utilization.

CM058. Advancing evidence-based practices

Adopting evidence-based guidelines. We advance evidence-based practices in a variety of ways. We begin by adopting evidence-based guidelines that serve as the framework for clinical decisions and service provision that optimizes member care and outcomes in accordance with Article III, Section 5.7, Practice Guidelines and New Technology in the Service Provider Agreement. We select evidence-based guidelines from a variety of sources that address physical and behavioral health, such as InterQual Criteria and American Society of Addiction Medicine (ASAM) criteria for SUD.

We use nationally recognized measures to monitor the effectiveness of our health plan operations. Our Quality Assessment and Performance Improvement (QAPI) program evaluates the effectiveness of service delivery through the adoption of objective performance standards, such as CAHPS, surveys, Medicaid HEDIS measures, CMS-specified Core Measures and EPSDT. We will track the measures in

the 2020 PMV Report and incorporate the 2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) into our QM activities.

Disseminating our guidelines to providers. We share our guidelines with providers by placing them on our healthplan.org website under the For Providers tab and notifying providers of the availability of the updated guidelines via THP's Provider Focus quarterly provider newsletter, provider training seminars (including BMS' bi-annual provider workshops) and on-site visits by THP's provider engagement representatives during provider on-site reviews. Our provider engagement representatives educate new providers about our guidelines when they join our network.

Motivational interviewing. We have trained our member-facing staff to use motivational interviewing with our members. Motivational interviewing is a counseling method that helps members find the internal motivation needed to change their behavior. It is often used to address addiction and the management of chronic physical health conditions, and helps people become motivated to change the behaviors that are preventing them from making healthier choices.

We use evidence-based assessments to understand each member's needs. For example, our adult HRA includes validated tools, such as the AUDIT-C, PHQ-2, CSDC-SF, DAST and CAGE.

Encouraging OUD providers to use MAT. We fully support the evidence-based use of MAT in facing the OUD crisis in West Virginia, and encourage OUD providers to treat members with OUD using techniques outlined by SAMHSA. THP SUD care managers collaborate with residential SUD providers to facilitate the transition of members who

received MAT services while in a residential program to appropriate community-based maintenance services. In 2019, 5,322 of our members received MAT services.

CM060. 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.

We collect member self-reported demographic and needs assessment data during a variety of member interactions. We document the information collected during these interactions in our care management system. Examples of member interactions include:

- ***Our HRA*** for new members identifies their health risk and specific concerns, such as pregnancy, chronic conditions or SDOH needs. The member advocate may use our SDOH assessment to understand the member's SDOH needs.
- ***SDOH Assessment.*** Our SDOH assessment obtains additional information about the member's social services needs. The assessment asks 16 questions related to SDOH, such as housing, education, employment, safety and income.
- ***Customer service.*** When a member contacts customer service, the CSR documents member-provided information in our care management system.
- ***ICD-10 codes*** help us identify the impact of SDOH on our members' ability to access care and track the delivery of services to address SDOH.

Maintaining the Data

As discussed in **CM008**, our care management system maintains all information about the member's care and services in their individual care management record, providing a comprehensive view of their needs and goals and the services and supports being delivered to meet their needs and help them achieve their goals. The information collected in each individual care management record is reportable at the aggregate level. Each member's care management record includes member information, such as demographics, member health data, such as service dates, member gaps in care, the member treatment plan and the Member Activity Record, such as scheduled activities, case notes and prior authorizations.

Using the Data in PHM and Network Adequacy Determination

Annually, our PHM team evaluates the needs of our members and uses that information to assess whether current programs need modification to better address the needs of its membership. We examine data to evaluate the needs of member subpopulations:

- Evaluation of the characteristics and needs of the member population including demographic data and an analysis of the impact of SDOH.
- Evaluation of health status and risks by using utilization data broken out into at least the following cohorts based on the enrolled product lines: ages 2 to 19, ages 20 to 64, and ages 65 and over.
- Evaluation of the needs of members with disabilities.
- Evaluation of the needs of members with specific needs, such as members who have SPMI and CSHCN.

The PHM team reports separately by product line to facilitate an understanding of similarities and differences in health needs and status by product line. When the data analysis is complete, our PHM and clinical services teams determine if changes are required to care management programs or resources. In addition, there is an evaluation of the extent to which our programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings.

Population Stratification. The PHM team evaluates our member population using data analytics tools to integrate data from a variety of sources and analyze variables at the member- and population-level to develop risk scores on each individual based on patterns of care, gaps in care, frequency of admissions and ER utilization. Quarterly, we segment and risk-stratify the entire enrolled population into meaningful subsets for targeted interventions. Information about the process used is defined in the description of specific programs in the selections that follow.

Using the Data in Quality Improvement Activities

Our QAPI program serves as a gateway to care management, disease management and wellness program by identifying members who have not been connected to care. As we discussed, our PHM team will evaluate our member population using our data analytics tools to stratify members into care management levels in alignment with their health risk and identify population trends and member sub-populations within the larger member population so we can deliver interventions relevant to our members. This evaluation includes an analysis of member self-reported data. Our QM team reviews PHM analyses to identify gaps in the social services available to our members and the available community-based organizations that can meet our members' needs.

For example and as previously mentioned, in Q1 2018, we implemented a PIP to improve access to dental services among children ages 2-3 years. During its first year of implementation, each quarter we modified the PIP interventions as we identified barriers to connecting members to these services. For example, we discovered that members may not be aware of or may not be able to access free transportation services for members to attend dental exam visits. To resolve this concern, we:

- Are working with DHHR to obtain the number of members who have used transportation services, the regions or locations of these services, and member issues, dissatisfaction or complaints regarding transportation services for our members to identify issues obtaining transportation.
- Augmented our education to members about the availability of transportation services and how to access them by posting information about transportation on our website, including transportation information in our new member welcome packet and in our Member Handbook, including education about transportation member outreach team calls and providing educational materials to provider offices for office staff and members.

CM061. 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.

As we discussed in **CM010**, for pregnant members with low risk, our clinical services team assigns a member advocate to engage the member and connect them to perinatal care. For pregnant members with high risk, the team assigns a perinatal RN care manager to coordinate the member's care. Our member advocate or the member's care manager engages the member throughout her pregnancy. This engagement includes educating the member about WIC and confirming the member has applied for services for which she and her child are eligible, such as WIC, and referring the member to Birth to Three or the Right from the Start program.

In June 2019, a representative from the Ohio County WIC office visited our office to provider training in the WIC program to our care managers, perinatal team and outreach staff.

We are actively identifying ways to communicate available resources to our members. Christy Donohue, VP Medicaid, initiated collaboration with BPH to discuss ways to notify members of other available public resources such as WIC (through the Office of Nutrition Services) and Birth to Three (through the Office of Maternal, Child, and Family Health). As a result of this collaboration, we send brochures describing the WIC, Birth to Three and Right from the Start programs with each new member's welcome packet. We continue to attend quarterly meetings with these agencies to identify ways to continue promoting these valuable services.

CM062. 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.

We collaborate with these agencies in accordance with Article III, Section 5.3.4.1, Care Coordination with the Title V State Agency in the Service Provider Agreement to bring a variety of resources to our members, such as referring pregnant members to WIC and the Right from the Start program and referring members who want to quit smoking to

the DHHR Tobacco Cessation Program. Our process to coordinate with these agencies is to identify the services they provide so we understand the services available to our members. We then collaborate with the agencies to understand how we can best coordinate the delivery of these services to our members.

For example, in spring 2017, we worked with OMCFH at BPH to develop the workflows around CSHCN care coordination, the form that must be submitted to the State to determine member eligibility for the CSHCN program, the process to approve medical food or enterals and the letters to educate providers about the prior authorization process for medical food or enterals. THP was the only MCO chosen to partner with BPH to develop the workflows and processes for the CSHCN program. All MCOs in West Virginia must follow these CSHCN workflows and processes.

We collaborate extensively with BPH to coordinate the care of CSHCN. This includes identifying children who may require additional therapies or services and connecting these children to services, sharing treatment plans, identifying children with NAS for designation as a CSHCN, participating in planning sessions and identifying those children who may be aging out of the CSHCN program and coordinating their transition to adult health insurance. We meet with the BPH Director of CSHCN, Donna Pauley-Wilson, at least once a month related to various issues facing CSHCN.

CM063. 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).

CM064. 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

We identify members who are receiving SNS several different ways, file from BMS that indicates members who are receiving SNS and have not been placed into foster care,

during the new member welcome call and the HRA. When we receive notification from BMS that a member is receiving SNS, we enroll the member receiving SNS in care management. The member's care manager will identify and clarify the SNS the member is receiving during the comprehensive assessment of their needs and the development of their treatment plan.

When we receive notification from BMS that a member is receiving SNS, we will enroll the member receiving SNS in care management. The member's care manager will identify and clarify the SNS services the member is receiving during the comprehensive assessment of their needs and the development of their treatment plan.

In the event a THP member receiving SNS transitions into foster care, we will work with the Mountain Health Promise Program to identify these members and exchange any data we have about them. As we do with all the MCOs in West Virginia, we have a working relationship with them to exchange data needed to coordinate the care of the members through the BMS approved portal.

TheHealthPlan

Attachment 6
Community and Stakeholder Engagement

4. Community/Stakeholder Engagement

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

From jointly established care models for children with special healthcare needs to new educational pieces for accessing Narcan/naloxone, The Health Plan's (THP's) deep organizational and professional relationships with stakeholders at state, regional and grassroots levels improve Mountain Health Trust (MHT) members' health in a meaningful, cohesive manner. In 2019, we attended nearly 300 community events comprising 18,000+ attendees, from a Berkeley Heights community block party to a Pleasants County Town Hall meeting to the Hancock County Table Treating.

> During our most recent survey, NCQA staff stated that we had "remarkable" community involvement and contributions.
>
> *- Source: NCQA survey report Fall 2019*

Bureau for Medical Services (BMS), Medicaid stakeholders and members have benefited from our commitment to community and stakeholder engagement that goes beyond contractual requirements for collaboration and ranges from designing new programs with the Department of Health and Human Resources (DHHR) to organizing charity events for individual members. We highlight a few examples of how we impact the various stakeholders through our engagement activities in the following table.

THP Stakeholder Engagement Supports Meaningful Advances to the MHT Program	
Stakeholder	**THP Collaboration = Meaningful Results**
BMS	Coordinating on behalf of DHHR/BMS a workgroup on how to clarify scope of service for billing of Peer Recovery Support Specialist Services for substance use disorder (SUD).
Associated Agencies	Developed a Children with Special Health Care Needs (CSHCN) program with Bureau for Public Health (BPH) in 2017; included information exchange, enteral feedings and care coordination workflows for treatment plans and affiliated documents.
Stakeholder Advocacy	With Ohio County Family Resource Network (FRN), developed a

THP Stakeholder Engagement Supports Meaningful Advances to the MHT Program	
Stakeholder	**THP Collaboration = Meaningful Results**
Groups	community flyer on how to acquire Narcan/naloxone from local pharmacies; a flyer was also developed for providers and insertion in new member mailings.
Members	Our newly formed Member Advisory Committee will include a diverse representation of MHT members, including WVCHIP members and/or their parents. Committee members will provide recommendations and feedback on initiatives, programs, services and materials, including prospective value-added services. On a broader member level, THP has worked with organizations like the Healthy Grandfamilies program sponsored by West Virginia State University to facilitate trainings and establish local coalitions to support member needs in similar ways. We also help individual members through formal and informal assistance.
Taxpayers/Members and BMS	Our newly formed SIU Healthcare Fraud Workgroup, created and facilitated by Trina Crowder, Program Integrity Lead, is a bimonthly meeting of MHT MCO SIU representatives. The purpose of this workgroup is to discuss FWA trends, share best practices and identify solutions to shared challenges. Ultimately, our goal is to protect patients, promote MHT program integrity and be good stewards of federal and state funds.

For the new contract period, our approach to community and stakeholder engagement is threefold:

1. ***Leverage professional relationships*** with BMS, associated agencies, advocacy groups and medical associations to advance MHT, support program efficiencies and improve effectiveness and retention at the program, plan, provider and member levels. See **CS001-CS003** for details.
2. ***Organize community engagement via a cross-functional team reliant on a data-driven process*** to prioritize and address community gaps in care with community stakeholders. The team includes population health experts and will coordinate with the Community Engagement Director Wendy Hodorowski as team activities result in member outreach materials per BMS' approved marketing plan and contract requirements. See **CS004** for details.
3. ***Use Aunt Bertha, the industry-standard*** community resource collaboration tool to quickly map community resources to member needs. Aunt Bertha's social care network connects people and programs, making it easy for people to find social services in their communities and for local organizations to coordinate their efforts. Aunt Bertha's database includes information about food, housing, transit, financial, education, work and legal programs in its West Virginia database. See **CS004** for details.

From our contract liaison/MHT administrator to care managers, complex case managers and customer service representatives, every employee does whatever it takes to improve MHT members' health in a meaningful, cohesive manner.

CS001: The Vendor should describe its approach to establishing and maintaining relationships with associated Department agencies and State advocacy groups.

Relationships with Department Agencies, Advocacy Groups

THP's tenure with Medicaid means we have already established strong relationships with critical associated department agencies and state advocacy groups. Into the next MHT contract, our approach is to enhance these existing relationships and build new ones that reflect new needs of the WVCHIP population and SUD Waiver. We will seek out BMS to enhance relationships with other state agencies, as well as community and professional stakeholder groups. Below are examples of our existing relationships with Department agencies and state advocacy groups.

Christy Donohue, VP Medicaid, has more than 15 years of direct, hands-on operational West Virginia Medicaid experience and work with DHHR, BPH and BMS. For example, Ms. Donohue collaborated with BPH to discuss ways to notify members of all their offerings such as WIC (through the Office of Nutrition Services) and Birth to Three (through the Office of Maternal, Child and Family Health). Ms. Donohue will continue to be actively involved in the MHT program.

Joshua Austin, Director of Provider Strategic Initiatives, served on the WVCHIP oversight board for two years (2016-2018) and coordinated an expert summit for the program's 20th anniversary. Mr. Austin has a history of partnering with WVCHIP. In 2018, in a previous position, he worked with WVCHIP, the West Virginia University School of Public Health and West Virginia KIDS Count, with funding from the Claude

Worthington Benedum Foundation, to develop a WVCHIP Parent's Guide. This guide educated parents on WVCHIP eligibility guidelines and the application and enrollment processes. He will leverage his relationships with WVCHIP and child health experts to facilitate the WVCHIP expansion under this contract.

Trina Crowder, Program Integrity Lead, has a long history of working with West Virginia Medicaid. As the former Medicaid Fraud Control Unit (MFCU) Director (2011-2018) and in her former role with Lewin as their Health Care Fraud/Program Integrity subject matter expert, Ms. Crowder worked closely with and provided training to BMS and their Office of Program Integrity. During Ms. Crowder's tenure as the MFCU Director, CMS cited the working relationship between MFCU and the Office of Program Integrity as a "best practice."

Sheila Kelly, Clinical Psychologist, has served on several workgroups to support various Department agencies. Ms. Kelly currently facilitates the Peer Recovery Support Specialist Services Workgroup for BMS. She also works with DHHR and Office of Drug Control Policy on two CMS Support Grants, including the Provider Capacity Workgroup and the West Virginia Center of Excellence Workgroup.

In addition to these examples, our relationship with BMS, associated Department agencies and advocacy groups over the last several years has resulted in many program improvements, such as:

- ***For all MCOs in MHT:*** THP helped introduce risk adjustment payments for all MCOs per Navigant's risk adjustment methodology to BMS.
- ***For all MHT Providers:*** THP helped implement the provider enrollment MEGA rule via technical assistance to, and partnership with, BMS.
- ***For SUD:*** THP increased the provider survey response rates by more than 25% for a WVU/Marshall University collaboration under the State Opioid Response

grant about treatment for opioids/SUD; survey findings aim to support new policy/legislation development regarding medication assisted treatment (MAT).

- ***For Children:*** THP participated in West Virginians for Affordable Health Care Kids' Health Roundtable Series. Mr. Austin moderated the first discussion in September of 2019 that brought together experts in health and policy across several disciplines at WVU. During this roundtable, experts shared their insights regarding the health effects of the opioid epidemic on children, along with potential solutions.
- ***For Extended Families:*** THP sponsored training with West Virginia State University on the Healthy Grandfamilies program; this was one of several trainings around the state but has resulted in program expansion into Marshall and Ohio counties this year.

Figure 1: Sharing Insights. In Sept. 2019, Mr. Austin moderated a roundtable discussion by experts regarding the health effects of the opioid epidemic on children, along with potential solutions.

Figure 2: Healthy Grandfamilies training. Bonnie Dunn, Project Director of the Healthy Grandfamilies program at West Virginia State University, conducts a Healthy Grandfamilies Training session at THP's headquarters in October 2019.

CS002: The Vendor should describe its approach to establishing and maintaining relationships with applicable provider and medical associations.

Relationships with Provider and Medical Associations

Our approach with the new contract is to enhance our established relationships with West Virginia provider and medical associations. Additionally, we are establishing and growing new relationships as needed to further BMS initiatives and to serve the changing population needs, for example, with the addition of the WVCHIP membership.

Established Relationships

The following table highlights some of the relationships our staff have with key provider and medical associations. These associations represent the healthcare industry and areas of focus such as SUD, population health, pediatric/maternal care and prescription drug use.

THP Stakeholder Engagement Supports Meaningful Advances to the MHT program	
Association	**THP Staffer Long-standing Relationship with…**
West Virginia State Medical Association	Barbara Good, Provider Relations Director
West Virginia Hospital Association	Jason Landers, Contract Liaison/MHT Administrator
West Virginia Primary Care Association	Jason Landers, Contract Liaison/MHT Administrator
West Virginia Behavioral Healthcare Providers Association	Sheila Kelly, Clinical Psychologist
The Coalition for a Tobacco Free West Virginia	Bobbi Rauschenberg, Tobacco Cessation Coordinator
Pediatric Advisory Committee through BPH	Christy Donohue, VP Medicaid
Statewide Epidemiological Outcomes Workgroup	Christy Donohue, VP Medicaid
West Virginia Medicaid Coalition	Jeanette Williams, MHT Member Advocate
West Virginia Perinatal Partnership	Brenda Cappellini, Assistant VP of Population Health
Office of Maternal, Child and Family Health, Children with Special Health Care Needs Program	Kim Jordan, Care Management Director
West Virginia Medicaid Pharmacy & Therapeutics Committee	Steve Neal, R.Ph., Pharmacy Sales Consultant

Real Outcomes

Our established relationships with key provider and medical associations benefit the MHT program by supporting initiatives such as provider retention and enhanced services to members. Examples of real outcomes as a result of our relationships:

- Our behavioral health pilot, a value-based payment model integrating physical and behavioral health at Prestera Center for Mental Health Services in Southwestern West Virginia, is the direct result of our relationship with the West Virginia Behavioral Healthcare Providers Association.
- We have introduced long-acting reversible contraceptives (LARC) to our members through our relationship with the West Virginia Perinatal Partnership and provided an in-service to providers seeing women in recovery at the WVU Medicine Comprehensive Opioid Addiction Treat (COAT) program. Dr. Robert Wetzel, OB/GYN and one of THP's Medical Directors, understands the importance of LARC and shared his knowledge with COAT program staff in December 2019.

Figure 3: Partnerships in Action. Dr. Robert Wetzel, OB/GYN and a THP Medical Director, speaks to COAT program staff about LARC and other contraceptive options.

Collaborating with WVU Medicine to Expand LARC to Women in Recovery

"As a Medical Director at The Health Plan and a practicing gynecologist, I know that the best way to prevent a substance-exposed pregnancy is to offer women LARC and other contraceptive options. We know that LARC is the best for compliance versus other contraceptives. The Health Plan is excited to partner with WVU Medicine to expand LARC and other contraceptives to women in recovery, especially those receiving MAT." - Dr. Robert Wetzel, OB/GYN, THP Medical Director

- Neonatal abstinence syndrome (NAS) education has been facilitated by that same West Virginia Perinatal Partnership.

Building Upon Existing Relationships

We will continue to leverage these relationships for the new contract to advance BMS policies (e.g., expansion of value-based payments and implementation of Section 1115 waivers of relevance, such as SUD and Work and Community Engagement Requirements Options) and to facilitate upcoming THP procedure or policy changes.

Changing the Health Landscape
"The Health Plan has been a true partner in changing our health landscape in the Tri-State..."

– Linda Holmes
Director of Development and Alumni Affairs
Joan C. Edwards Marshall University School of Medicine
1/6/20 email

In addition to the required BMS trainings in accordance with in **MD013**, we routinely attend, present at and sponsor provider and medical association meetings (e.g., 2019 West Virginia State Medical Association Healthcare Summit). For example, Ms. Cappellini presented "Payment Model for Sustainable Community Health Worker Funding" in May of 2019 at the 42nd Annual National Rural Healthcare Conference in Atlanta. In November 2019, Ms. Kelly served on a panel regarding ways to implement evidence-based policy regarding SUD treatment with the Bureau for Behavioral Health Commissioner Christina Mullins at the West Virginia Policy and Research Engagement Symposium.

Shared Commitment
"We appreciate the opportunity to work with The Health Plan on our shared commitment to improving health outcomes of pregnant women and newborns in our state. The Partnership is especially appreciative of The Health Plan's participation on the NAS Data Workgroup, the Tobacco Free Families Advisory Council, and the Perinatal Payers Workgroup. Your dedication and expertise in helping us analyze and better understand healthcare data related to costs and prevalence of maternal substance use and their infants are especially appreciated."

– Amy N. Tolliver, MS
Executive Director
West Virginia Perinatal Partnership
1/21/20 letter

We are actively involved in helping to define the future of healthcare in West Virginia. We support local provider association efforts and future providers through sponsorships of scholarships at the WVU Schools of Medicine and Nursing and Joan C. Edwards School of Medicine at Marshall University. To date, we have awarded $2.5 million in scholarships to 50 students.

Figure 4: Investing in West Virginia healthcare. Since its inception, THP has awarded $2.5M in medical college scholarships.

Moreover, we engage the next generation of MCO staff by hosting a Patient Navigation Day for students in the WVU School of Public Health. On November 15, 2019, undergraduate students who are focusing their studies in the Patient Navigation area of emphasis traveled to THP in Wheeling for a day of learning. Throughout the day, students had the opportunity to hear from senior staff representing different divisions of THP to learn about the history of health maintenance organizations (HMOs), clinical services

Figure 5: Learning about managed care first hand. For an entire day at THP's headquarters in Wheeling, these students from West Virginia University's School of Public Health learned about healthcare and insurance.

provided to members throughout the state and work being done by THP's Population Health Team. The students were also able to spend time with then CEO James Pennington, a WVU alumnus, who advised the students to be adaptable and know that the healthcare and insurance industries are constantly evolving.

Educating Our Future about West Virginia's Healthcare Industry

"One thing I learned is that if I go into this career [that] I have to be able to change when the world around me changes, or I'll be left behind." – One student's feedback after attending our Patient Navigation Day

Additional Associations

We are actively involved in other associations that advance healthcare in West Virginia. While not technically provider or medical associations, they are valuable components of our local healthcare ecosystem. Our participation and leadership in these associations demonstrates our ability to collaborate with other organizations to enhance the quality of care for MHT members.

A representative sample of these associations are listed in the following table.

THP Stakeholder Engagement Supports Meaningful Advances to the MHT Program

Association	THP Staffer Relationship with...
West Virginia Association of Health Plans	Jason Landers, Contract Liaison/MHT Administrator
Special Investigations Workgroup of MCOs	Trina Crowder, Program Integrity Lead
West Virginia Medical Group Management Associations	Roxanne Loughery, Director, Provider Training & Education THP's Provider Engagement Managers

As an example of how our leadership is reflected, Program Integrity Lead Ms. Crowder created and is facilitating the newly-formed SIU Healthcare Fraud Workgroup. This group is a bimonthly meeting of MHT MCO SIU representatives. The purpose of this workgroup is to discuss FWA trends, share best practices and identify solutions to shared challenges to magnify our impact on fraud, waste and abuse. Ultimately, our

goal is to protect patients, promote MHT program integrity and be good stewards of federal and state funds.

CS003: The Vendor should describe its approach to establishing and maintaining relationships with applicable professional boards.

Relationships with Professional Boards

THP's approach for professional board relationships currently focuses on ensuring appropriate, credentialed providers and on the protection of our members through initiatives such as investigating potential fraud, waste and abuse. Additionally, we verify new clinical or licensed staff credentials with these boards. We look for adverse actions, appropriate licensure, sanctions, etc.

In 2020, we are enhancing our approach to deepen these relationships through targeted outreach to specific professional boards, including West Virginia Board of Medicine, West Virginia Board of Osteopathic Medicine, West Virginia Board of Examiners for Registered Professional Nurses, West Virginia Board of Pharmacy and West Virginia Board of Chiropractic. Examples of targeted outreach with the aforementioned licensure boards includes:

- Connecting with representatives of each West Virginia-based board to host a "Legislative Wrap Up" webinar, or combined highlights webinar, to discuss regulatory or scope of practice issues emanating from the 2020 legislative session and future legislative sessions. The timeframe for this is August 2020—plus each August for the subsequent contract years—to allow legislation to become effective and the rulemaking process to begin.
- THP Credentialing, Clinical and Pharmacy staff meeting in-person at least annually with the boards to discuss issues of mutual interest. Potential topics for discussion in 2020 include but are not limited to delivery of telehealth/telemedicine, e-prescribing of controlled substances and collaboration on continuing medical/pharmacy education.
- Ensuring that the boards recognize and call upon THP to share urgent regulatory or guidance updates with our contracted providers. This can be on an ad hoc basis or through planned inclusion in THP's provider newsletter or provider portal.

Building Upon a Solid Foundational Relationships

While our 2020 approach is exciting, it is important to note that our ability to do this is because of our strong foundational relationships with various boards at several levels within our organization. We routinely contact the boards of medicine (allopathic and osteopathic) and nursing both in West Virginia and in five contiguous states to ensure licensure in good standing, determine adverse or disciplinary action taken, as well as support fraud investigations and to ensure adherence to accessing the Prescription Drug Monitoring Program.

For example, we identify from state licensure boards who is newly active so we can recruit that provider into our network; conversely, if we terminate a provider for cause, we notify the appropriate board. Locally, we consult, work with and make referrals to any regulatory or licensing board, including but not limited to:

- West Virginia Board of Medicine
- West Virginia Board of Osteopathic Medicine
- West Virginia Board of Examiners for Registered Professional Nurses
- West Virginia Board of Pharmacy (e.g., Prescription Drug Monitoring Program)
- West Virginia Board of Chiropractic
- State-matching boards in Pennsylvania, Ohio, Kentucky, Maryland and Virginia

We look forward to working with these professional boards to enhance the MHT program and ensure that Medicaid members continue to receive quality, cost-effective care that improves overall health.

CS004: The Vendor should describe its process to coordinate with agencies providing complimentary services to the member.

Coordination with Agencies Providing Complimentary Services

Collaboration with agencies providing complimentary services to members, particularly for social determinants of health (SDOH) such as food insecurity and housing, is integral to addressing members' quality of life. Our process for addressing SDOH looks

at the population health and member-specific levels to identify and close gaps in services. As presented in the figure, our two-pronged process coordinates with community resources and connects members to those resources.

This process includes 1) community and stakeholder engagement to identify and engage community-based organizations providing services to our members and 2) care management processes to connect members to social services.

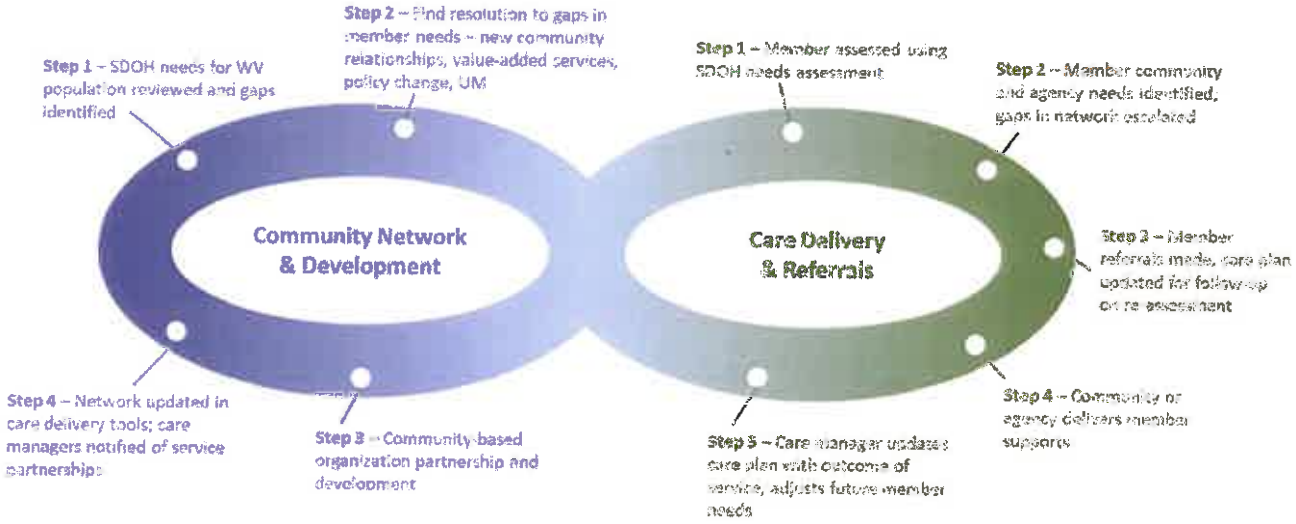


Figure 6: Two-pronged process. We use a cross-functional team to identify gaps in community-based resources and implement activities that engage community resources that can deliver social services to our members. Our member advocates and care managers use our SDOH assessment to understand the member's social needs, identify resources to meet those needs, refer the member to those resources and confirm the member's social services needs have been addressed.

We leverage Aunt Bertha, our database of social care resources, to help members locate services, and also coordinate with agencies statewide to identify gaps in services. Once gaps are identified, we partner with community stakeholders to develop innovative solutions to close these gaps and help enhance member lives.

As an example of this, we recently partnered with the Ohio County Family Resource Network (FRN) to create a community flyer on how to acquire Narcan/naloxone from

local pharmacies; flyers have been developed for providers and will be inserted in new member mailings.

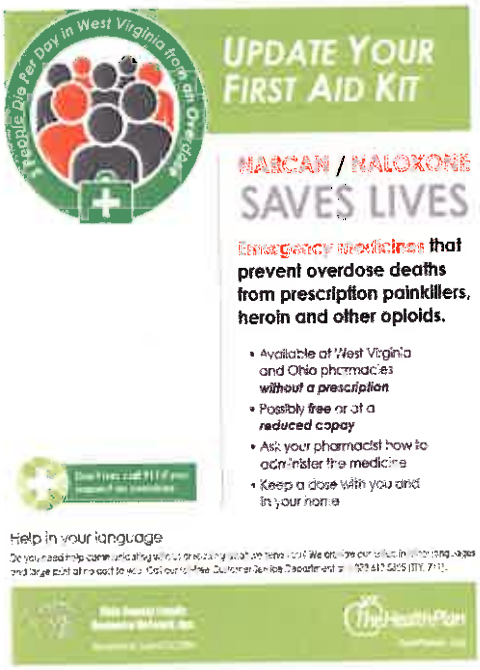


Figure 7: Innovative partnerships to help local communities. Recently, we collaborated with Ohio County FRN to develop this educational Narcan/naloxone flyer.

Process to Coordinate Complimentary Services for Members

Our internal process for prioritizing and addressing member needs with community stakeholders is worked through a cross-functional SDOH/community engagement team comprising representatives from our population health and provider engagement teams and including key staff Susan Klinkoski, Medical Management Director; Michelle Poland, Quality Director; and Jeanette Williams, MHT Member Advocate. The team coordinates with Community Engagement Director Ms. Hodorowski for team activities that result in enhanced marketing efforts as part of membership awareness and ownership of whole-person health.

Maintaining Strong Relationships with Agencies that Provide Complimentary Services

Collaboration supporting the above process is sustained by the deep ties we have throughout our state. We engage and coordinate with agencies by region, with an emphasis in participating fully in county-based FRNs and associated projects and committees. FRNs, by design, exist to respond to the needs and opportunities of the community by partnering with community members and public and private organizations to address those needs.

Sharing Ideas, Moving Forward

"The Health Plan is willing to share ideas and move forward with implementing those ideas to better West Virginia. One example is the Healthy Grandfamilies program being implemented across the state. Through partnership, we were able to host a training at The Health Plan to more than 30 participants seeking to bring Healthy Grandfamilies to their county …Their involvement in the community and assistance with families is valuable.. The Health Plan shows compassion and dedication to the citizens of Ohio County and are among the most helpful committee members working to improve West Virginia."

– Claudia Raymer, Executive Director, Ohio FRN, 12/12/2019 letter

We view FRNs as hubs for community engagement and convening in West Virginia's counties. As such, we do not seek to duplicate meetings, committees or projects but align our outreach efforts with FRNs wherever feasible. We are continuing this successful engagement with FRNs and other agencies under the new MHT contract.

Strong Community Presence

In 2019, our provider engagement team attended nearly 300 community events comprising 18,000+ attendees, including 110 FRN meetings in 39 counties. We also attended a variety of other events, from a Berkeley Heights community block party to a Pleasants County Town Hall meeting to the Hancock County Table Treating.

Our statewide participation in these meetings is represented by the number of events and attendees by region in 2019:

- ***Southeastern West Virginia:*** 105 events, 8,468 attendees
- ***Northern West Virginia:*** 138 events, 7,011 attendees
- ***Western and Central West Virginia:*** 50 events, 2,755 attendees (note that these numbers are lower as they represent West Virginia only; our provider engagement team also works with organizations in Ohio)

Appreciating the Collaboration with Our Provider Engagement Team

"Our Family Resource Network has worked closely with [T]he Health Plan over the past several years. Our Provider Engagement Representatives have always been enthusiastic about sharing all updates in program and consumer services. They also volunteer at the various health fairs and community engagement events held throughout the year and share their knowledge with all in attendance.

Continuation of the services provided through [T]he Health Plan is critical to all our communities within the state."

-Debbie Thompson
FRN Director, Pleasants County

Coordinating with Local Coalitions and Collaboratives

Besides FRNs, we engage with other agencies to identify and close gaps in complimentary services. The following tables highlight additional 2019 community engagement efforts with local coalitions and collaboratives that represent the most wide-reaching organizations offering complimentary services to support holistic MHT member health.

THP's Collaborative and Coalition Events in 2019	County	Attendance
Healthy Grandfamilies Coalition Training	Berkeley Jefferson Morgan	25
Intermountain Collaborative Meeting	Braxton Harrison Lewis Upshur	32
West Virginia Medicaid Coalition	Kanawha	25
Lewis County Community Collaborative (4)	Lewis	74
Marshall County Adult Services Coalition	Marshall	15
North Central Collaborative Committee Meeting	Marion Monongalia	18
Healthy Grandfamilies Coalition Meeting	Morgan	20
Family Ways Collaborative Meeting (3 meetings)	Ohio	95
Pleasants County Coalition Meeting	Pleasants	19
Putnam Wellness Coalition (2 meetings)	Putnam	40
Intermountain Collaborative IMC Meeting (4 meetings)	Barbour Braxton Harrison Lewis Preston Randolph Taylor Tucker Upshur	109
Wood County Coalition (4 meetings)	Wood	110
Total Attendees		**582**

Mental Health 2019 Events Reaching 343 Individuals	County	Attendance
Fayette County Substance Abuse Task Force	Fayette	26

Mental Health 2019 Events Reaching 343 Individuals	County	Attendance
Youth Mental Health Meadowbrook Mall	Harrison	100
Mental Health Summit (2 meetings)	Berkeley Jefferson	180
Mason Substance Abuse Coalition	Mason	17
Upshur Partners in Prevention (3 meetings)	Upshur	20
Total Attendees		**343**

Sponsorships and Other Activities to Address Complimentary Services

THP engages in community events and activities in other ways. For example, we sponsor, volunteer at and provide scholarships for events such as Camp Kno Koma. We also partner with community stakeholders on specific initiatives, for example, the Diaper Drop Charities. Details include:

- ***Camp Kno Koma:*** A week-long summer camp for children ages 7-15 with a diagnosis of diabetes. The camp is held at the Greenbrier Youth Camp in the Monongahela National Forest and allows campers to experience adventure, education and friendship. Campers are introduced to new diabetes management skills during a week of canoeing, swimming, biking and more.
- ***Diaper Drop Charities:*** In partnership with THP, Diaper Drop Charities distributes diapers to established organizations, including non-profits, churches and women's centers for moms in need of diapers for their babies/children. Examples of recipient organizations include CAMC Women's and Children's, Covenant House, YWCA Charleston and Recovery Point. The diapers include helpful tips for parents, depending upon the diaper size and the age of the baby/child. (See the figure for an example of a tip sheet for newborns.) Since November of 2019, Diaper Drop Charities has provided over 40,000 packages that include the THP tips. They have distributed diapers in the following counties:
  - Boone
  - Cabell
  - Fayette
  - Kanawha

> "On behalf of the Board of Directors, I would sincerely like to thank The Health Plan for their continuous support to Camp Kno Koma. The support has allowed us to continue our mission of providing a summer camping experience for children with diabetes in and around the state of West Virginia. In 2019 we had a record attendance of 154 campers."
>
> *Stephanie Hall*
> *Board President*
> *Diabetes Camp of West Virginia*
> *1/23/20 letter*

- Lincoln
- Logan
- Mingo
- Putnam

We are proud of our involvement with these community events and activities and will continue exploring similar events for future participation.

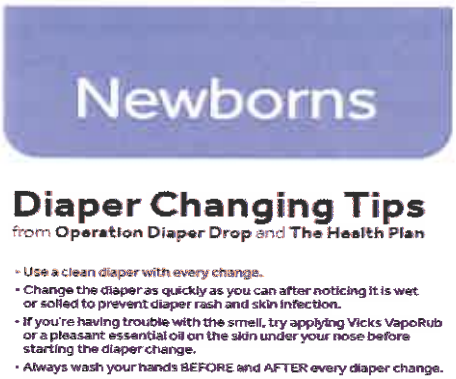


Figure 8: Helpful diaper-changing tips. In the packages of diapers given to moms with babies/children, THP and Diaper Drop Charities provide helpful age-appropriate tips for changing diapers.

Member Advisory Committee

Our newly formed Member Advisory Committee will include a diverse representation of MHT members, including WVCHIP members and/or their parents. Committee members will provide recommendations and feedback on initiatives, programs, services and materials, including prospective value-added services/benefits. We also will ask Committee members about complimentary services in their area and how they hear about and use these services.

Meeting quarterly, we envision our Member Advisory Committee will provide us with a fresh perspective on programmatic issues.

Member-Specific Coordination for Complimentary Services

To address member-specific needs for complimentary services, THP will continue to use Aunt Bertha to help our members find social services and resources. Care managers, complex case managers and outreach member advocates all have access and use Aunt Bertha to support members with complimentary services. We also go beyond Aunt Bertha by coordinating with county FRNs. The information gleaned from

our in-field presence across the nearly 300 events we attended in 2019, for example, supplements Aunt Bertha.

Finally, member-specific needs are met by our dedicated care management team and, importantly, other THP employees who simply want to help fellow West Virginians. For instance, we coordinated with a local fire department to establish a benefit to fund transportation and housing to support the distant tertiary medical needs for the spouse of a deceased firefighter. Moreover, THP has numerous stories about organizing GoFundMe® pages, hospital charity events, local church fundraisers and other ways to support members with their holistic care needs, as illustrated below.

Our Staff Go the Extra Mile to Help Members in Need: Jeanette Williams

Jeanette Williams, MHT Member Advocate, received a call from a member whose provider was unavailable to send a prescription authorization to a pharmacy for a necessary prescription. Without this authorization, the member would have had to pay $200, which she was unable to afford. Ms. Williams researched and identified additional resources and eventually obtained a coupon for the medication to be provided to the member at no charge. The member was very appreciative and obtained her prescription.

This is just one example of why Ms. Williams received an iCare award from the West Virginia Association of Health Plans (WVAHP) in September of 2019. The iCare Awards are given to front-line employees of WVAHP member-MCOs who have demonstrated exemplary care and service to West Virginia Medicaid members by helping them achieve positive outcomes in their healthcare delivery. Ms. Williams was recognized for using her experience receiving Medicaid services to help others as a care manager.

Figure 9: iCare Awards. Jeanette Williams, MHT Member Advocate, accepts her iCare Award from the West Virginia Association of Health Plans in September of 2019. Ms. Williams was recognized for using her experience receiving Medicaid services to help others.

Our Staff Go the Extra Mile to Help Members in Need: Thanksgiving Cheer

In another example, one of our social workers in THP's Clinical Department connected with a Morgantown office staff member to secure a food basket for a family in need during Thanksgiving of 2019. The family did not qualify for food assistance or charitable aid from food pantries located near their home in Preston County. The THP staff member coordinated with a food bank located in neighboring Monongalia County to meet the family's needs. The staff member collected the food basket on a Sunday afternoon, added supplemental items that he personally purchased, then delivered it that same day.

TheHealthPlan

Attachment 6
Member Services

5. Member Services

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Member Services (MS) as part of their bid. The Vendor's narrative response should not exceed 100 pages.

Effective member services is critical to educating members and help them understand and use their health benefits. The Health Plan's (THP's) member services approach aims to exceed several Bureau for Medical Services (BMS) standards as demonstrated in service level agreement (SLA) scores detailed in the table. In 2020, we are building upon this success through enhanced medical management integration and through new initiatives. By continuing to deliver on our excellent customer service and significant integration for both our member services staff and members themselves, we maximize every touchpoint and better support member ownership in care to ultimately improve health outcomes.

The results in the following table demonstrate our ability to consistently meet or exceed BMS service requirements, providing us with a solid foundation from which to successfully implement enhancements.

THP's Member Services Approach Scores Across the Board		
Indications of Strong Member Service Model	**SLA (Per Service Provider Agreement)**	**2019 THP Results**
Call Center Standards	▪ 83% of calls answered within 30 seconds (Section 3.3.1) ▪ 5% abandonment rate (Section 3.3.1)	▪ 85.35% ▪ 1.27%
Initial Health Risk Assessment (HRA)	▪ Best effort to conduct initial screening within 90 calendar days of enrollment (Section 5.3.1)	▪ 100% initial attempts (via mail, telephone, postcard follow-up) within 30 calendar days of enrollment
PCP Assignment	▪ PCP assignment within 10 calendar days of enrollment (Sections 2.2.3, 3.2.2)	▪ 100% within 5 calendar days

In addition to the contractually required standards, we monitor other customer service indicators to confirm that we are performing as expected. These additional indicators, and our 2019 results, are illustrated in the table.

THP's Member Services Approach Scores Across the Board	
Indications of Strong Member Service Model	**THP Internal Standard and 2019 Results (Not Required SLAs)**
Member Satisfaction	▪ Only 28 complaints, including quality of care and administrative, across our 94,000 Medicaid members, representing 0.02% of our Medicaid membership ▪ Less than 1% of THP members request disenrollment due to dissatisfaction (churn rate, measured as members who moved to another managed care organization [MCO])
Other Standards **First-call resolution rate**	▪ 85%

One of our more exciting initiatives is enhanced medical management integration into the call center. Customer service representatives (CSRs) can set up primary care provider (PCP) appointments, see member gaps in care to recommend closure, direct members to complimentary community resources and more. More details, including specific capabilities, are provided in response to the detailed specifications in this section.

Member Services Model

Our member services model is executed via these customer service staff (excluding care management team, which the RFP delineates as a separate discussion):

- ***Twelve inbound CSRs*** dedicated to Medicaid. In 2019, this team received 144,542 member and provider calls.
- ***Six member advocates on our outreach team*** make outbound calls to serve as health promoters and health navigators. In 2019, this team completed 72,421 outbound member calls to welcome members and connect them to care.
- ***Certified health education specialists*** to provide member education on specific topics (e.g., dietician, diabetes educator).
- ***Provider engagement staff*** who serve across the plan as outreach specialists for both providers and members. For members, they develop and sustain complimentary community service partnerships well beyond Aunt Bertha, our

database of social care resources, to support Medicaid-wide membership. They also support population-health initiatives by leveraging community events/resources to improve member health.

With the new contract, we are prepared to expand our coverage to WVCHIP members, including adding customer service staff to handle the increased WVCHIP call volume. Additionally, we have customer service staff with WVCHIP experience. Lisa Hawkins, Member Services Director, was the manager of the WVCHIP account at a previous employer. Plus, two CSRs have experience taking WVCHIP member calls at their former jobs.

Throughout the following pages, we provide details regarding our existing processes and proposed enhancements to continue providing services to members that consistently meet or exceed BMS requirements.

MS001: The Vendor should describe how they will collaborate with stakeholders to design materials that best meet the needs of the populations being served.

Stakeholder Collaboration to Design Medicaid Materials

Collaborating with stakeholders to design materials for Medicaid populations is critical to ensuring those materials are actionable. We receive feedback and define the need for a material based upon requests from BMS or an associated agency, community partners, members and providers. We also consider claims analyses, population health analyses, website and social media hits, community partner initiatives and routine reviews of existing materials compared with current events, newly identified best practices, etc.

Collaboration with key stakeholders provides valuable insight to validate that materials are needed, readable and comprehensible and reflect West Virginia Medicaid demographics. THP's process continually engages various stakeholders as follows:

- ***BMS, Department of Health and Human Resources (DHHR), Bureau for Public Health (BPH) and other agencies:*** We collaborate with government

agencies to develop materials that help improve health outcomes for members. For example, Ms. Donohue initiated collaboration with BPH to discuss ways to notify members of other available public resources such as WIC (through the Office of Nutrition Services) and Birth to Three (through the Office of Maternal, Child, and Family Health). We continue to attend quarterly meetings with these agencies to identify ways to continue member education.

- ***Providers:*** We seek input on educational materials from local board-certified provider representatives on our Quality Improvement Committee that serves as our Quality Assessment and Performance Improvement (QAPI) program oversight body. Additionally and as another example of collaboration, we worked with a large federally qualified health center in West Virginia to help us offer well-child visit services through school-based clinics. We jointly developed a postcard that was mailed to parents/guardians to educate them about the availability of these services at the school at no cost to them. And finally, through our provider engagement specialists, we regularly meet with providers and discuss ways to better serve members. For example, we recently worked with providers to design a poster to hang in provider offices. The poster reminds MHT members to stay enrolled to maintain continuity of care. We offer this poster to providers at no charge.
- ***Community organizations:*** Our ongoing participation and engagement in local community events allow us to easily partner with organizations on initiatives that are important to their area. For example, we recently collaborated with the Ohio County Family Resource Network (FRN) on how to educate members about obtaining Narcan/naloxone from local pharmacies. As a result of this collaboration, we developed a community flyer, a provider-focused flyer and a flyer for insertion in new member mailings.
- ***Members:*** Historically, we received member feedback through normal channels such as community events, incoming customer service calls and outbound welcome and care coordination calls. Recently, we launched our Member Advisory Committee. Meeting quarterly, we ask Committee members to make recommendations or provide feedback on materials and other educational items, initiatives, programs and services. Through representation of diverse MHT members, our Member Advisory Committee provides us with a fresh perspective on programmatic issues.

Figure 1: Innovative partnerships to help local communities. Recently, we collaborated with Ohio County FRN to develop this educational Narcan/naloxone flyer.

Process to Develop Member Materials

One we define a need for a new or revised material, we follow a defined process:

- Review if existing material exists from, in descending order:
  - THP's library across our lines of business for adaptability
  - Stakeholder libraries (e.g., state agencies, state organizations, community partners)
  - National libraries (e.g., CDC, NIH, American Cancer Society)
- If materials exist, work internally to adapt materials quickly to meet BMS marketing standards per Section 3.1.3 Marketing Materials of the Service Provider Agreement.
  - The process includes member review/revision/approval via member representation on THP's Member Advisory Committee; and review/revision/approval from the stakeholder most closely aligned with said material
- If materials do not exist, Community Engagement Director Wendy Hodorowski and VP Medicaid Christy Donohue lead the work with other THP team members to identify the most appropriate stakeholder(s) to engage in narrowly defining the target audience and communication aim (e.g., what action do we want them to take from this?), content development and review/revision/approval.
- Once materials are approved, we send them for BMS approval; once approval is received, we produce and distribute the materials.
- Engage vendors to translate materials into other languages, in Braille and large print, and produce materials in an audio format.
- Distribute materials ongoing and for widespread access via web and mobile app in an ADA Section 508, WCAG and HIPAA-compliant manner (website), in provider offices, in schools and in community partner centers.
- Distribute materials in a targeted manner (e.g., geography, health condition, demographics) via our member advocates and care managers for those with care management needs.

MS002: The Vendor should describe how they will leverage information technology (IT) solutions to improve access to member information.

Leveraging IT Solutions to Improve Member Access to Information

Leveraging IT solutions to improve access to member information in a secure fashion is integral to coordinating member care. Members are increasingly tech-savvy and rely on the ability to quickly access the correct information online. THP's meaningful use of information technology (IT) solutions includes six distinct systems to engage and support members:

- ***Enhanced care management system:*** Provides improved care coordination through data sharing using our care management system. This data sharing

promotes collaboration among our care managers and the member's interdisciplinary care team (ICT) and others involved in the member's care.

- ***THP website:*** Members use a website, healthplan.org, to obtain information such as the Member Handbook, provider directory and health education materials. Broader information is available through the public part of the website, while plan- and member-specific information is protected through secure access via myplan.healthplan.org.
- ***Mobile app:*** Provides members with smartphone access to a mobile app to help them quickly find information. For example, members can request ID cards, and view member's explanation of benefit that correlates to the services that were rendered. Our website, healthplan.org, is also mobile-friendly.
- **WVHIN engagement:** Sharing of electronic health record (EHR) data is growing across health systems. Currently, 33 participating hospitals contribute data to the WVHIN. Sharing key health information across systems informs providers and enhances the quality and continuity of care that members receive.
- ***HEART system:*** Our customized HEART system supports enrollment and disenrollment, including enrollment file information and maintaining contact data for ongoing outreach. While members do not directly access HEART, this system facilitates information-sharing, supporting the continuum of care with another MCO or with fee-for-service (FFS) if the member is disenrolled, and transferring information to the new MCO.
- ***Fiscal agent MMIS system:*** THP accesses the MMIS website to support transitions of care to enhance the member's continuity of care, e.g., pharmacy or prior authorizations from the fiscal agent. We also access the MMIS system for eligibility inquiries, MCO assignment, risk stratification with information review of past claims and prescriptions.

The following paragraphs provide additional details on our ability to effectively leverage IT systems to improve access to member information.

Enhanced Care Management System

Most significant in leveraging IT is our enhanced care management system that improves care coordination.

Our care management system enables timely data sharing needed to coordinate, enhance and monitor the member's care. Using our care management system, we share data and promote collaboration among our care managers and the member's ICT and others involved in the member's care.

Our care management system facilitates the delivery of timely, integrated and coordinated services and supports across varied populations and delivery systems. It maintains all information about the member's care and services in their care management record, providing a comprehensive view of their needs and goals and the services and supports being delivered to them. It provides tools to collaboratively develop a treatment plan that meets each member's needs and goals, monitor the member's progress toward achieving their goals and identify acute events so we can coordinate relevant and timely member interventions.

Delivering a range of programs and interventions to meet member needs across the entire care continuum. Based upon our understanding of each member, we deliver a range of interventions to meet their needs across the entire care continuum. For instance, for members with low risk, we connect them with a PCP and deliver prevention and wellness programs that empower them as they take responsibility for managing their health. For members who are at risk, we enroll them in an intensity of care management appropriate to their needs and assign a care manager to work with the member to coordinate their care. For members who have specialized needs, such as members who are pregnant and have high-risk factors, such as previous pre-term birth, SUD or advanced maternal age, we engage them in our Perinatal Care Management Program and assign a perinatal care nurse experienced in labor, delivery, recovery and post-partum to coordinate their care.

Helping Members Actively Engage in Managing Their Care

Our care management system's member portal engages members in their health by providing a variety of tools to communicate with their THP care team and ICT, track the

completion of goals in their treatment plan, keep track of appointments in their calendar and complete assessments. The member also sees the member care plan as a simplified version of the ICT care plan. The portal is available in English and Spanish, representing 99% of our existing member population.

THP Website

We understand that members sometimes want quick access to information, including educational materials, without having to enter a user name and password. Therefore, we keep an abundance of information on our public website, healthplan.org, available to any visitors. Our website provides general information about the Medicaid managed care programs, the provider network and customer service, in compliance with Section 3.4.5 MCO Internet Website of the Service Provider Agreement.

Easy to Navigate

Our THP website is ADA Section 508-compliant, HIPAA-compliant and WCAG (Web Content Accessibility Guidelines)-compliant for easy navigation. We will continue to build upon our knowledge of local demographic and cultural needs to engage members with web content and features that increase member empowerment and knowledge.

When members and potential members access our home page, they can easily identify their area of interest. Our home page is illustrated in the following figure.

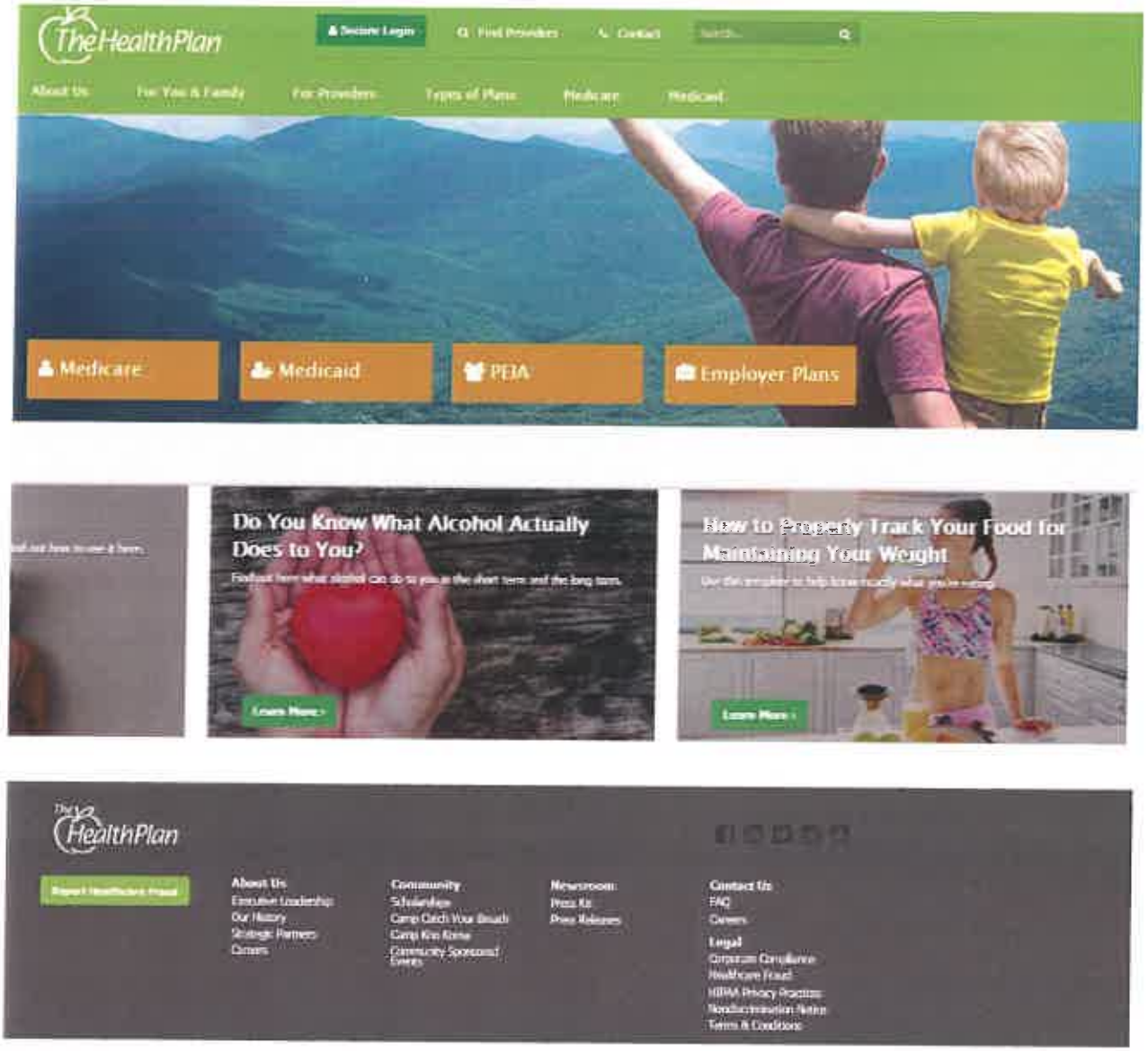
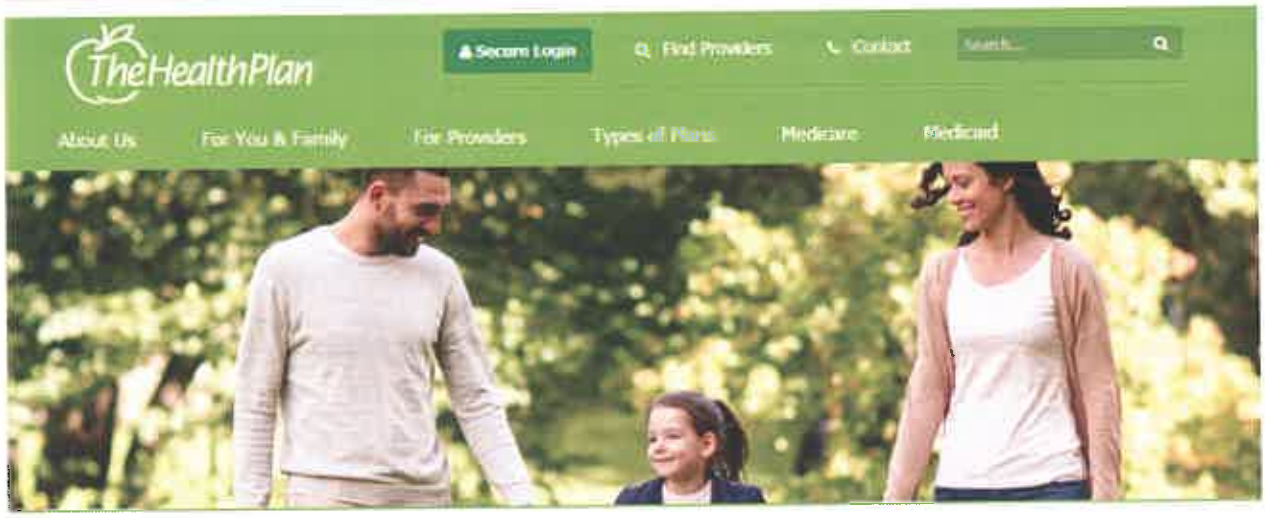


Figure 2: Easy website navigation. THP's home page, healthplan.org, easily and quickly directs members to their area of interest.

When members or potential members click on the Medicaid button from our home page, they are directed to a landing page with an overview of member-specific information. It also provides links for quick access to popular member resources, such as the Medicaid Member Handbook, member rights and responsibilities (per Section 3.6 Enrollee Rights in the Service Provider Agreement) and appeals procedures. A screenshot of our Medicaid landing page follows.



HOME TYPES OF PLANS MEDICAID MEMBER OVERVIEW

Member Overview

The Health Plan's practice guidelines and criteria for medical necessity are based on well-supported clinical evidence. These guidelines or criteria are reviewed and updated on a regular basis or when new scientific evidence is published. They are available to our members or potential members upon request. Based on these guidelines, The Health Plan makes decisions including:

- Utilization Management
- Enrollee Education
- Coverage Services
- Other Areas

In addition to the links to this information on our website, you can call our Customer Service Department at 1.888.613.8385 (TTY: 711) to request a printed copy or ask any questions or concerns. Our customer service representatives can also assist you with any of the following topics related to your coverage:

- Specialty care and other benefits, not provided by the PCP
- Mental health and non-emergency transportation are covered benefits available through Medicaid
- Benefits covered by The Health Plan
- How and where to access emergency care and post-stabilization services
- Providing benefit information in an alternative language or format due to special needs such as vision, read impairments, or language translation difficulties. Translation services are available at no cost for members.

Member Resources

Click on any of the links below to check out important information about your coverage through The Health Plan:

- Medicaid Member Handbook
- EPSDT/Well-Child Visits
- Well-Child Visits
- Medicaid Member Rights and Responsibilities
- Appeal Procedures
- Preventive Health Guidelines
- Supplemental Vision
- Newsletters

Call our Customer Service Department at 1.888.613.8385 (TTY: 711) if you need a printed copy for any of these materials or if you have any questions.

Other information that is available without a secure logon includes more than 180 pieces of health and wellness information, including health risk assessments, quizzes, blogs, quarterly newsletters and resources. Visitors access these resources through the "For You & Family" tab at the top of our website. In this tab, visitors can quickly toggle to their topic of interest. Current topics are designed to help members and potential

members enhance their lifestyle choices and better understand the healthcare system.

Resources include:

- Health and Wellness
  - ***CoreWellness:*** Information on tobacco cessation and alcohol screening, plus access to our secure member portal, myplan.healthplan.org.
  - ***Self-Management Tools:*** Tools to help individuals manage their care and enhance self-responsibility of their health and well-being. Tools cover topics such as healthy weight, smoking and tobacco use, encouraging physical activity, healthy eating, managing stress, avoiding at-risk drinking and identifying depressive symptoms.
  - ***Health Library:*** A collection of health and wellness resources created for learning and accessibility. Topics include exercise and activity, diabetes, mental health, pregnancy, substance use, congestive heart failure, autism, healthy eating and preventive health. The figure illustrates our Health Library landing page.
- Planning Ahead
  - ***Understanding Advance Directives:*** An overview of advance directives and what they are, and links to websites (CaringInfo, West Virginia Center for End-of-Life Care and Aging With Dignity) to obtain more information.

Figure 3: Extensive Health Library. Our Health Library includes resources for a variety of topics.

Other materials available on our website are provided in the following table.

Tools, Resources, and Education Materials Available on *Healthplan.org*		
Tools & Resources ▪ Appeals and Grievances ▪ Find a Provider ▪ Member Rights and Responsibilities ▪ The MyPlan Mobile App	**HealthBite Blog** ▪ Eating Healthy ▪ Fitness ▪ Living Well ▪ Mental Health ▪ Men's Health	**Pharmacy** ▪ Diabetes Testing Supplies ▪ Find a Pharmacy ▪ Formularies ▪ Home Delivery/Mail Order ▪ Medication Review

Tools, Resources, and Education Materials Available on *Healthplan.org*		
▪ Newsletters ▪ Quality Improvement ▪ Referrals and Prior Authorization ▪ Your Financial Responsibility	▪ Women's Health	▪ Obtaining a Prescription ▪ Specialty Drugs
Type of Care ▪ Behavioral Health ▪ Disease Management ▪ Prenatal and Pregnancy	**Get Care** ▪ Clinical Services ▪ Talk to a Nurse	**Forms** ▪ Accident ▪ Emergency Medical Information ▪ Member Care management

Secure Login

Members access their myplan.healthplan.org secure login from our home page at healthplan.org. Members simply click on the dark green "Secure Login" button at the top of the page, as illustrated in the figure.

Figure 4. Easy website navigation. THP's home page, healthplan.org, easily directs members to their area of interest. Members who wish to log in to the secure portal simply click on the dark green Secure Login button at the top of the page.

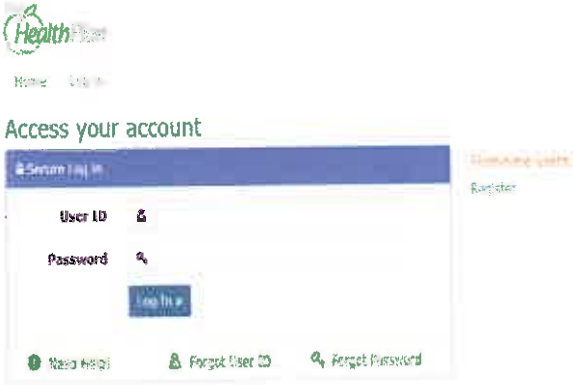


Figure 5: Secure log-in page. Our page easily directs members to either register (for first-time users) or log in, offering assistance as needed.

Once members click on this button, a popup appears that requires the user to enter a user ID and password. For first-time users or those needing assistance with logging on, this popup provides easy-to-follow instructions. See the figure to understand the information provided on our secure login popup.

Our secure member portal allows members to log in and access member-specific benefit information through myplan.healthplan.org.

Additional details about our secure login are provided in response to **MS033**, later in this section. We do not repeat here for brevity.

THP Mobile App

Users can download our mobile app from either the Apple App Store or Google Play. Once downloaded, users simply log in using their MyPlan user ID and password to gain access to useful information, including:

- Access to ID cards
- Find a provider
- View claims
- View coverage
- Find plan documents for important information

Figure 6: Easy-to-use mobile app. Users can access useful information through our mobile app, available on the Apple App Store and on Google Play.

West Virginia Health Information Network (WVHIN) Engagement

The secure electronic exchange of patient health information among healthcare providers enhances the quality and continuity of care that members receive. Through the WVHIN, key hospitals and other healthcare providers, including urgent care providers like MedExpress, are already sharing medical records electronically. This includes viewing in real-time:

- Admission and discharge
- Limited lab and test results
- Alerts via e-mail when a member under care management is admitted
- End of Life Registry

We are supportive of continued WVHIN enhancements and understand the benefits of sharing this useful information. For example, with our enhanced care management system, we will integrate WVHIN alerts (e.g., immediate notifications that THP receives through network provider EHR information regarding patient access to services such as

emergency room, outpatient surgery or admissions) into our care management system to confirm our care management team is alerted to these encounters to coordinate appropriate follow-up care for the member.

HEART System

Our customized HEART system supports enrollment and disenrollment, including enrollment file information and maintaining contact data for ongoing outreach. HEART also facilitates information-sharing, supporting the continuum of care with another MCO or with FFS if the member is disenrolled, and transferring information to the new MCO. Our HEART system will be especially useful for WVCHIP members as they transition from FFS. Maintaining key enrollment and contact data in HEART will facilitate the transition process, for example, our system stores authorization information from the fiscal agent to ensure a smooth 90-day transition of care process.

The figure illustrates our HEART system and all the modules that are included in HEART.

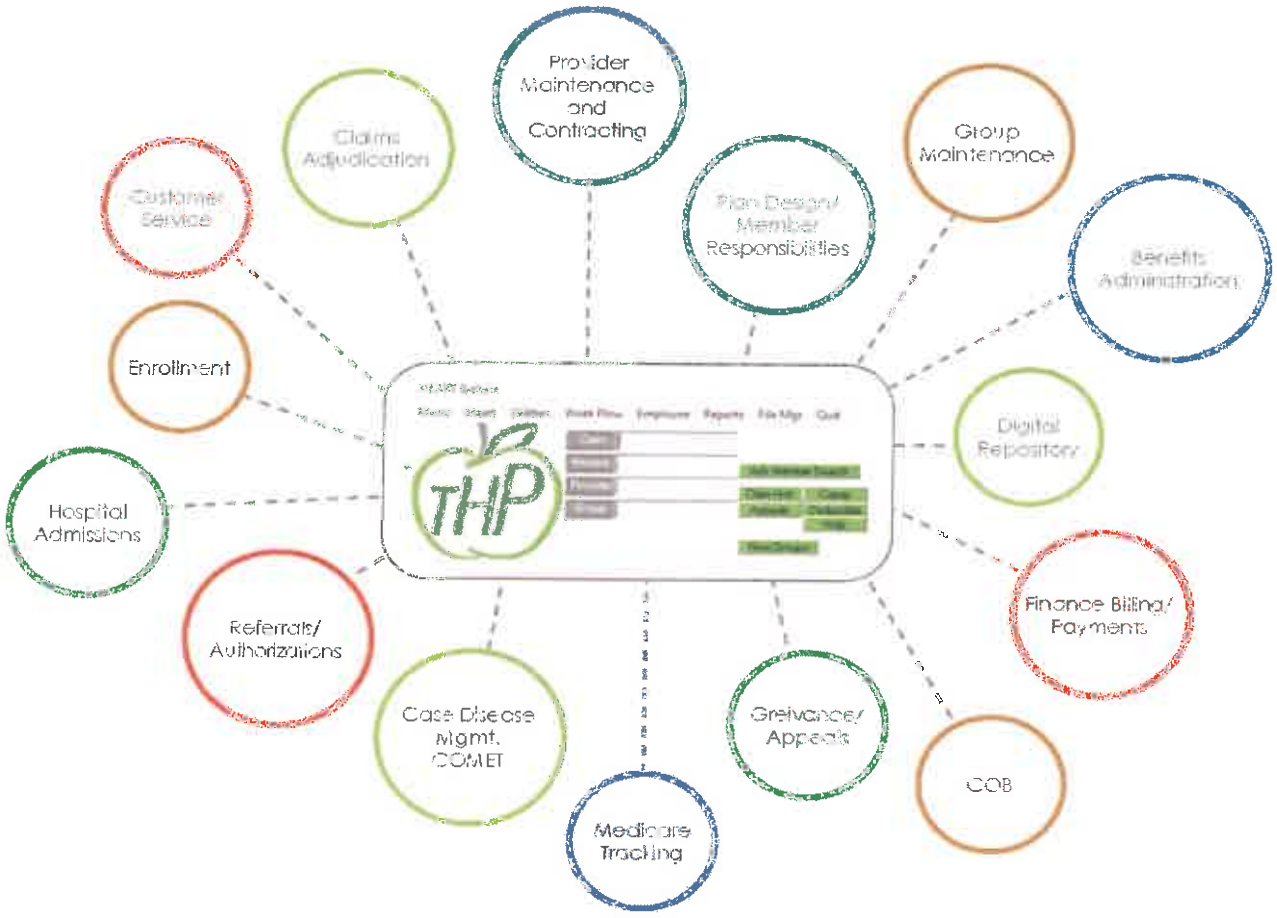


Figure 7: HEART System. Our HEART system is centralized information management that includes enrollment, claims adjudication, customer service, plan design/member responsibilities and other key modules to help us provide integrated care to our members.

Fiscal Agent MMIS Website

THP accesses the MMIS website to support transitions of care to enhance the member's continuity of care, e.g., pharmacy or prior authorizations from the fiscal agent. We also access the MMIS system for eligibility inquiries, MCO assignment, risk stratification with information review of past claims and prescriptions.

MS003: 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.

MS004: The Vendor should describe how they will develop protocols to notify members of Primary Care Provider (PCP) assignment.

MS005: The Vendor should describe how they will educate members of the right to change Primary Care Providers (PCPs).

PCP Assignment, Member Notification, Right to Change

A strong member and PCP relationship is key to meeting the quadruple aim of healthcare, which is improving the quality of care, achieving lower costs, promoting better health outcomes and reducing provider burnout. Moreover, appropriate attribution of members is essential to value-based payment arrangements (VBP's), both for financial performance and quality measurement. Our defined process for assigning members to PCPs, defined below, will apply to WVCHIP members. In 2019, we assigned PCPs within five calendar days of enrollment, greatly exceeding the requirement to assign PCPs within 10 calendar days of enrollment (Sections 2.2.3, 3.2.2 of the Service Provider Agreement).

Methodology for Assigning Members to PCPs (MS003)

During the enrollment process, WVCHIP and Medicaid members who do not select a PCP through the enrollment broker are auto-assigned a PCP. Our auto-assignment process for PCPs allows us to quickly assign PCPs to members. On average, we assign members to a PCP in our HEART system, then send a welcome packet and ID card to new members within five calendar days of enrollment notification. The welcome packet and ID card, in separate mailings, each include a letter that explains the PCP assignment and how to easily change the PCP. Additionally, our member advocates educate members about PCP assignments during the welcome call. At any time, members may change their PCP either online or by calling customer service.

Monthly, we receive an enrollment file from the fiscal agent that lists all THP Medicaid members. This file identifies members who either selected an ineligible PCP or did not select any PCP upon enrollment. For these members, we auto-assign the member to an eligible PCP. It is important to note that we understand that members with a disability, chronic illness or who are eligible for SSI must have a choice of specialist to serve as their PCP. The specialist must agree to perform all PCP duties required in the contract, as well as the duties within the scope of the specialist's license and board certification(s).

Our system auto-selects a PCP based upon the member's age (pediatrician or general practitioner), gender, claims history, proximity and previous PCP history. All members upon enrollment will be assigned a PCP either by choice or auto-assignment. If the member is a re-enrollee and does not select a PCP, we auto-assign the same PCP he/she previously had if that PCP remains effective to promote continuity of care.

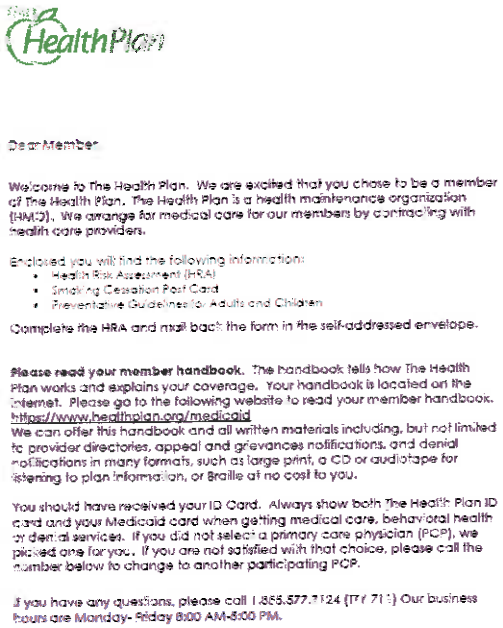
All Medicaid members must have a PCP listed to generate an ID card. The ID card lists the PCP's name and office phone number.

As a matter of protocol, THP does not assign more than 2,000 members per PCP to ensure member access.

Protocols for Notifying Members of PCP Assignments (MS004)

It is important for members to know their PCP. We notify them each time there is a change in their PCP assignment. We also provide members with PCP notification and education through various media:

- ***Welcome packet*** includes information about the ID card and the PCP assignment. Members are encouraged to call customer service if they want to change their PCP. In addition, our welcome packets include:
  - Initial HRA
  - Preventive guidelines for adults and children
  - How to access the Member Handbook
  - Brochures describing tobacco cessation assistance, non-emergency medical transportation (NEMT), WIC, Children with Special Health Care Needs (CSHCN) program, Birth to Three program, Right from the Start program and a free cell phone
- ***Welcome letter*** includes the member ID cards with PCP assignment on them. This information is distributed within five calendar days of enrollment.
- ***Welcome phone calls that are completed on average*** within 30 days of enrollment, exceeding the 90-day requirement. During the calls, our member advocates educate the member about their health coverage and answer questions, including any around PCP assignment.



The HealthPlan

Dear Member

Welcome to The Health Plan. We are excited that you chose to be a member of The Health Plan. The Health Plan is a health maintenance organization (HMO). We arrange for medical care for our members by contracting with health care providers.

Enclosed you will find the following information:
- Health Risk Assessment (HRA)
- Smoking Cessation Post Card
- Preventative Guidelines for Adults and Children

Complete the HRA and mail back the form in the self-addressed envelope.

Please read your member handbook. The handbook tells how The Health Plan works and explains your coverage. Your handbook is located on the internet. Please go to the following website to read your member handbook. https://www.healthplan.org/medicaid
We can offer this handbook and all written materials including, but not limited to provider directories, appeal and grievances notifications, and denial notifications in many formats, such as large print, a CD or audiotape for listening to plan information, or Braille at no cost to you.

You should have received your ID Card. Always show both The Health Plan ID card and your Medicaid card when getting medical care, behavioral health or dental services. If you did not select a primary care physician (PCP), we picked one for you. If you are not satisfied with that choice, please call the number below to change to another participating PCP.

If you have any questions, please call 1.855.577.7124 (TTY 711). Our business hours are Monday- Friday 8:00 AM-5:00 PM.

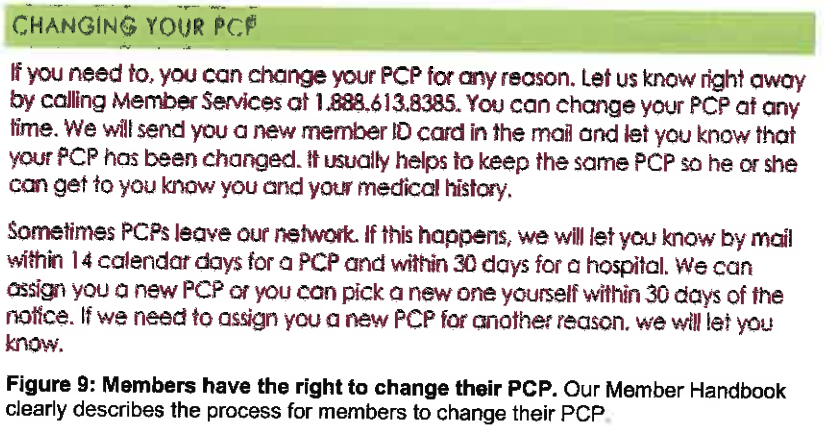
Figure 8: Educational welcome packet. Our welcome packet contains important information about available benefits, including how to change their PCP and how to access services.

It is important to note that members can view and change their PCP assignment on our website, healthplan.org, and by calling our customer service center.

Educating Members of the Right to Change PCPs (MS005)

Members may initiate a PCP change at any time and for any reason. We accept the request in writing or over the phone, per Section 2.2.6 PCP Transfers in the Service Provider Agreement.

It is important for members to know that they have a choice in their PCP. We clearly communicate the member's ability to change their PCP in several ways:



CHANGING YOUR PCP

If you need to, you can change your PCP for any reason. Let us know right away by calling Member Services at 1.888.613.8385. You can change your PCP at any time. We will send you a new member ID card in the mail and let you know that your PCP has been changed. It usually helps to keep the same PCP so he or she can get to you know you and your medical history.

Sometimes PCPs leave our network. If this happens, we will let you know by mail within 14 calendar days for a PCP and within 30 days for a hospital. We can assign you a new PCP or you can pick a new one yourself within 30 days of the notice. If we need to assign you a new PCP for another reason, we will let you know.

Figure 9: Members have the right to change their PCP. Our Member Handbook clearly describes the process for members to change their PCP.

- Letter in the welcome packet
- Welcome telephone calls
- Member Handbook, both the website and printed versions (see figure for an excerpt from the Member Handbook on how to change PCPs)
- Website
- Conversations with CSR
- Member newsletter

Annual Attribution Reconciliation

Prior to the new contract, we will implement an attribution reconciliation of Medicaid members to PCPs, exceeding contract requirements for verifying PCP assignments for members. This annual reconciliation process will occur around March 1 of each year. It ensures the strong relationship between members and PCPs, more effectively closes gaps in care and reduces provider abrasion regarding patient panels and confusion regarding assigned members. In developing this annual attribution policy, we consulted with key provider groups to determine the best time to conduct the attribution and minimize disruption to both the provider and member.

As stated above, we assign members to a PCP based upon several criteria such as member age, gender, claims history, proximity, PCP panel size, if a PCP is accepting new patients and utilization history. Claims history is the basis for our attribution reconciliation logic. When we initiate the attribution reconciliation process, we run a

report based upon an 18-month claims lookback to determine the preponderance of claims in a PCP setting. The report generates three possible attribution outcomes:

- ***No change required*** indicates one of the following: the member saw their PCP the most (or the same amount as another PCP), notified THP of their PCP selection or had no PCP claims. For members who had no PCP claims, our member advocates on the outreach team will initiate a phone call to the member to engage them with a PCP.
- ***Other PCP within tax IDs*** indicates the member saw another provider within the same provider practice the most but is still seen in that practice/healthcare system.
- ***Other PCP not within tax IDs*** indicates the member saw another provider the most and should be attributed to that provider.

For those members whose records indicate "other PCP not within tax IDs," we assign a new PCP (the provider the member saw the most), update our records accordingly and issue new ID cards with the updated PCP and PCP phone number reflected on them. We also send a PCP Change list to our customer service and population health teams.

For those members whose records indicate "no change required" or "other PCP within tax ID," we will not change the PCP. Additionally, we will not change the PCP if one was member-selected, nor will we change the PCP if the member had no PCP visits for the review period.

MS006: 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: Methods utilized to complete assessments, and variances by risk level

MS008: Timeline to complete assessments, and variances by risk level

MS009: Identification of the trigger(s) for completion of a comprehensive assessment

MS010: How assessments will be used to develop and update treatment plans and confirm the risk stratification level for each member

MS011: 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: 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: How assessment data will be stored and made available to members of the care team in order to coordinate care

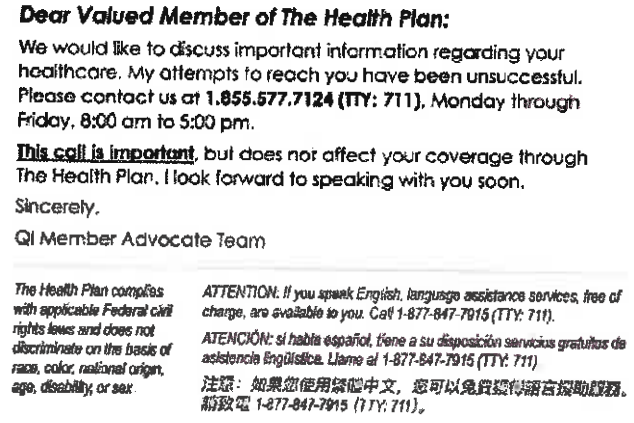
MS014: How assessment data will be shared with a member's other payer(s), as applicable, in order to prevent duplication of efforts

Process for Conducting the Initial Assessment (MS006, MS007, MS008)

Completing the new member welcome call and HRA are critical to identifying members who may benefit from care management or other specialized programs (e.g., disease management) and connecting them to resources that can address their needs as soon as possible. The welcome call is often our first live contact with a member, and the HRA is our opportunity to understand our members in a personal way. We recognize that we are asking members to share deeply personal information through the HRA, so we train our member advocates to implement evidence-based engagement strategies, such as motivational interviewing, to help us build trust with every member.

Attempting to Reach the Member to Complete the Screening

We complete the initial HRA within 90 days of enrollment in accordance with the Service Provider Agreement, Article III, Section 5.3.1 Initial Health Assessment. We attempt all initial assessments via our welcome calls within the first 30 days of member enrollment, far exceeding the BMS and NCQA 90-calendar day completion requirement and, most importantly, getting members the care they need quickly. When a new member is assigned to us, we begin outreach to the member as follows:



Dear Valued Member of The Health Plan:

We would like to discuss important information regarding your healthcare. My attempts to reach you have been unsuccessful. Please contact us at **1.855.577.7124 (TTY: 711)**, Monday through Friday, 8:00 am to 5:00 pm.

This call is important, but does not affect your coverage through The Health Plan. I look forward to speaking with you soon.

Sincerely,

QI Member Advocate Team

The Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-847-7915 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-847-7915 (TTY: 711)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-847-7915 (TTY: 711)。

Figure 10: Postcards to members we are unable to reach. We send this postcard to members with outstanding initial HRAs to encourage HRA completion.

- Send the member a welcome packet that introduces the member to THP. The packet includes an HRA the member can complete and return to us using a self-

addressed, stamped envelope. If the member returns a completed HRA to us, we document the HRA in our care management system and determine if the member may benefit from care management as described later in this section.

- Send the member's ID card to them. This engagement is separate from the information sent in the welcome packet and requests the member call us to complete an HRA.
- A member advocate from our outreach team attempts multiple times to reach each member telephonically in the first 30 days of their enrollment. If attempts to engage the member in the first 30 calendar days are unsuccessful, we send a postcard with every failed attempt.

The member advocate from our outreach team attempts to complete the new member welcome call and HRA, calling at different times of the day and on different days of the week to maximize success. We leave messages, when possible, for the member to return our call. Member advocates document each attempt to complete the HRA in our care management system. To increase the number of members who have completed an HRA, we send a postcard that explains we are trying to reach them and asks them to call us to complete the HRA.

Initial Screening Using Our Health Risk Assessment

Once a member advocate reaches the member, they complete the HRA, confirm the member has received their welcome packet, confirm the member has their ID card, confirm the member has a PCP or help them select a PCP and educate the member about what their plan covers and how to reach us. The member advocates use evidence-based pediatric and adult HRAs to evaluate the member's overall health and wellness and identify critical information, such as:

We use age-appropriate assessments to understand the needs of our members. Our adult HRA and comprehensive assessment is for members 18 years or older and our pediatric assessments are for members under 18 years.

- Social determinants of health (SDOH), such as caregiver support, housing, food security, awareness of available community resources or health literacy.
- Current PCP and provider relationships, active treatment plans and services.

- Barriers to accessing care, such as transportation.
- Chronic physical or behavioral health conditions or members who are pregnant.
- Members who have specialized needs, such as children with special healthcare needs (CSHCN).

Process for Conducting the Initial Comprehensive Assessment (MS006, MS007, MS008, MS009)

We identify newly enrolled member for engagement in care management programs based upon four core factors, including: 1) member risk as indicated by a risk score over 3.75 or risk factors, such as high cost (e.g., more than $20,000 in behavioral health expenses in one year); 2) inappropriate or unnecessary utilization, such as four or more admissions in prior 12 months; 3) gaps in care, such as a member who has diabetes and an A1c over eight; 3) specific conditions (e.g., SUD); and 4) the intensity of intervention required (short or longer term).

For members who may benefit from care management, our care management team assigns a care manager to collaborate with the member to coordinate their care and deliver care management services in accordance with Service Provider Agreement, Article III, Section 5.3.2 Coordination of Care. We assign a care manager to work with the member, their providers and their chosen planning team to assess their needs and goals, develop a treatment plan, implement services and supports and monitor the member's health status and progress toward the completion of their goals.

The member's care manager engages the member to begin to conduct a comprehensive assessment of their needs, goals and preferences for care within 30 days of the completion of the HRA. The comprehensive assessment must be completed within 60 days. The care manager collaborates with the member and their planning team to complete the development of their initial treatment plan with 60 days of

engagement of the member in care management. The care manager then coordinates the delivery of the services identified in the member's treatment plan and begins to monitor the member's health status and their progress toward achieving their goals.

Process for Conducting Ongoing Assessments (MS006, MS007, MS008, MS009)

For members enrolled in care management, we conduct an assessment of the member's needs at least annually. This assessment confirms the member's risk stratification level and provides inputs into any treatment plan updates that may be required. We also conduct an assessment for any member we identify as experiencing a change in health status, circumstances or condition. For members in care management, the care manager and ICT monitor these changes through ongoing touchpoints with the member and their family, discussions with ICT participants, admission, discharge and transfer (ADT) alerts and referrals from the member, their family, providers or THP departments, such as our utilization management team.

We conduct an annual HRA for Supplemental Security Income (SSI) members.

For all members, we use daily reports to identify members in various settings who require outreach, such as infants who have NAS, members in substance use treatment settings or members admitted to a hospital. We conduct a monthly predictive modeling analysis to identify changes to each member's level of health risk, which may indicate a need for care management. Once we identify members experiencing a change in health status, circumstances or condition, members in various settings or members experiencing a change in their health risk, a care manager

We conduct a 72-hour post-hospital assessment for members who have been discharged from an inpatient setting.

outreaches to the member and conducts a comprehensive assessment of their needs, as we discussed in the previous section.

Process for Conducting for Condition-specific Assessments (MS006, MS007, MS008, MS009)

We supplement our HRA and comprehensive assessment with evidence-based condition-specific assessments (e.g., diabetes or substance use disorder), based upon the member's specific conditions. For example, a member's positive response to questions regarding behavioral health needs (e.g., depression, anxiety, alcohol use) triggers specific behavioral health assessments (e.g., PHQ9, GAD7 and AUDIT-C). For children, we may apply the CSHCN Screener or the Child Stress Disorders Checklist – Short Form (CSDC-SF).

Using Assessments to Develop and Update Treatment Plans (MS010)

The care manager collaborates with the member and their chosen planning team to develop the member's treatment plan that includes goals, milestones and accountability. Our care management system supports the creation of the member's treatment plan by using the findings from the comprehensive assessment to recommend a list of suggested opportunities, goals and interventions (OGIs) that can be reviewed by the member and their planning team for inclusion in the treatment plan.

For example, a member who reports cigarette smoking may receive a suggestion of tobacco cessation as an intervention, with a goal to quit smoking in six months and discuss tobacco cessation options with their PCP as an intervention. We use evidence-based care management practices, such as motivational interviewing, to help the member restate and prioritize their own identified OGIs.

- ***Opportunities*** are based upon the member's needs identified through the comprehensive assessment process.
- ***Goals*** include the desired or anticipated results based upon identified opportunities. Goals are measurable, achievable and time-bound. Member participation in goal setting is a foundational component of the treatment plan.
- ***Interventions*** include specific steps to achieve a goal. They have defined time frames for completion and are assigned to a specific person (e.g., the member, their PCP) for completion.

Because each intervention includes specific steps with defined due dates that are assigned to a specific person for completion, the member, care manager, PCP and the member's ICT can monitor progress toward completion of each OGI intervention.

Using Data from a Member's PCP to Prevent Duplication and Help Identify the Member's Priorities (MS011)

We identify the member's PCP in a variety of ways, including information in the State's enrollment file, during the new member welcome call and HRA, during the comprehensive assessment process and through an analysis of claims. The care manager includes the PCP in the development of the member's treatment plan by working with the PCP to obtain any information the PCP has about the member and scheduling the planning meetings and arranging for the PCP to attend them.

The care manager shares the treatment plan with the member's PCP and other providers as applicable, with the member's agreement. Our care management system's provider portal gives all authorized providers a variety of capabilities to participate in the member's assessments and in development of the member's treatment plan, including:

- Securely sharing the information in the member's care management record.
- Allowing the PCP to review, acknowledge, sign and contribute to member assessments and the member's treatment plan.

Additionally, through grand rounds, our ICT of medical directors, pharmacists and nurses reviews the member's case. Each of these ICT members brings a unique viewpoint on the member's needs, such as a deep understanding of pharmacy issues and available behavioral health services or approaches. The ICT discusses chronic

conditions, developmental challenges, emotional and behavioral issues, pharmacy utilization and any special considerations unique to the member. The ICT also discusses care opportunities, goals and interventions for inclusion on the member's treatment plan. We include the PCP in the process through peer-to-peer discussions with our medical directors and pharmacist to discuss treatment options presented during grand rounds.

Handling a Member who Cannot be Reached or who Refuses to Complete the Initial Assessment (MS012)

As described in response to **MS006**, **MS007** and **MS008**, we use several methods to initially reach a new member to complete the initial HRA. We mail a welcome packet and an ID card in two separate mailings and make outbound telephone calls to the member.

The member advocate from our outreach team attempts to complete the new member welcome call and HRA, calling at different times of the day and on different days of the week to maximize success. We leave messages, when possible, for the member to return our call. Member advocates document each attempt to complete the HRA in our system. To increase the number of members who have completed an HRA, we send a postcard that explains we are trying to reach them and asks them to call us to complete the HRA.

Additionally, we take advantage of every member interaction to complete the HRA. For instance:

- A member can complete their HRA through our member portal.
- When a member calls customer service, our care management system identifies that the member needs an HRA, so our CSR can connect the member to our outreach team to complete the HRA.

- For a new member, analyzing the State's historical claims data, if available, to identify the member's PCP and other recent providers. If we are unable to reach the member, a member advocate engages the member's providers to help us locate or conduct outreach to engage the member.
- Our care management system identifies members when they engage with the healthcare system, such as a member who is experiencing an inpatient admission. Our member advocates attempt to engage the member where they are accessing services.
- We analyze pharmacy data to identify refill dates and service locations. Our member advocates engage the member's pharmacy to help us locate or conduct outreach to engage the member.

Handling a Member who Meets the Criteria for Care Management and who Cannot be Reached or who Refuses to Complete the Comprehensive Assessment (MS012)

Once we identify a member who may benefit from care management, we make three attempts over a three-week period to engage the member, making one call per week for three weeks. After the first call, we send a letter to the member that explains that we are attempting to reach them and the benefit of care management to them. After the second and third calls, we send the member a postcard explaining we are trying to reach them.

For members we are unable to reach, we flag them in our care management systems at a "following" level and work with their primary or specialty care provider to help engage them in care. We set reminders for services they may need and attempt to engage these members at those intervals. We monitor when their level of care changes or when they access healthcare services, such as an inpatient admission, to outreach to them and see if they have changed their minds about participating in care management.

Partnership with Episource. We are partnering with Episource to help us locate and engage members who are high risk and may benefit from care management. We currently partner with Episource in our Medicare line of business. Episource will leverage technology to build comprehensive member profiles, tailor our message based

upon their needs and engage members via multiple channels (e.g., telephone, direct mail, email or text message). Episource clinicians will perform a face-to-face visit with these members to comprehensively understand their needs and connect them to care, including reviewing their social environment and other risks that can be difficult to capture during office visits.

Implementing a community-based health navigator. In March 2020, we will implement a pilot with the Prestera Center that includes a community-based health navigator—paid for 100% by a THP care coordination fee. The navigator will be employed by Prestera Center. The navigator will supplement the Prestera Center chronic care management team in Cabell, Kanawha and Putnam Counties. They will locate and engage members who are difficult to reach and support THP members who need extra support in managing their healthcare challenges, such as coordinating a PCP or specialist appointment, completing laboratory testing, dietary needs/food insecurity or non-emergent transportation.

The community-based health navigator will have access to Prestera Center's electronic medical record system and THP's care management systems to see a complete picture of the member's healthcare utilization and unmet needs. Should this approach to coordinating care prove successful, THP will enlist other comprehensive behavioral health centers as partners in the model—especially those located in counties with disproportionate utilization of behavioral health services.

Storing and Making Assessment Data Available to Members of the Care Team (MS013)

The member's care manager shares assessment data with members of the care team in a variety of ways, such as through discussions with providers or including the planning team in the assessment and treatment planning process. Additionally, our care management system enhances coordination of care, improves communication, reduces fragmentation and offers seamless continuity of care. It does this by providing a mechanism to share the member data needed to coordinate member care and providing tools that promote collaboration among the care manager, member, their providers and others involved in the member's care. We provide these capabilities to providers through our care management system's provider portal. Our care management system allows the care team to:

- ***View or update the member's treatment plan.*** Our care management system's care planning capability facilitates the development of a treatment plan that includes evidence-based OGIs. The care manager works with the member and their planning team to identify OGIs that help each member achieve their goals and desired outcomes and verifies we provide services and supports that meet each member's needs.
- ***Monitor the member's progress toward achieving the goals they have identified in their treatment plan.*** Because each intervention includes specific steps with defined due dates that are assigned to the member or an ICT participant, the member, care manager and ICT can monitor progress toward completion of each OGI.
- ***Respond to actionable data*** that alerts the care manager about changes in the member's health status by continuously integrating claims/utilization data and lab and predictive modeling results, such as an HbA1c test that indicate poorly controlled blood sugar levels or a first fill of insulin identifying a member with newly diagnosed diabetes.
- ***Monitor the member's adherence to their treatment plan***, such as a member with asthma not filling prescriptions for a rescue inhaler.
- ***Identify a member experience a care setting transition*** by integrating admission, discharge and transfer (ADT) alerts from the WVHIN and provider systems, such as Epic. Our care management system provides tools to manage care setting transitions, such as discharge planning for a member in an inpatient setting, including providing workflows that prompt for follow-up PCP

appointments, perform member reminders via phone, text or email and track event completion post-discharge.

- ***Identify members who have gaps in care*** by integrating HEDIS and EPSDT measures and predictive modeling results that indicate a care gap, such as a member with a chronic condition who has not visited a PCP in the previous 12 months. Our care management system provides tools for the care manager to close the member's care gaps.

Sharing Data and Promoting Collaboration with Providers through Our Provider Portal

Our care management system provider portal gives authorized providers a variety of capabilities to access member data and collaborate to coordinate member care, including:

- ***Data sharing***. Securely shares the information in the member's care management record with the ICT.
- ***Assessment.*** Allows providers to review, acknowledge, sign and contribute to member assessments using our care management system's assessment suite.
- ***Care planning.*** Allows providers to review, acknowledge, sign and contribute to a member's treatment plan.
- ***Communication.*** Provides a mechanism for providers to securely communicate with care team members and email external users.
- ***Monitoring member care.*** Integrates data analyses and provides this information to the ICT in an actionable way. For instance, the portal helps:
  - Monitor the member's progress toward achieving their goals.
  - Monitor the member's adherence to their treatment plan, such as a member not filling a prescription.
  - Respond to data analyses indicating that members that are risk, such as an individual under the age of 25 who is experiencing their first psychiatric episode and who has a history of SUD. This member could be at-risk for future unnecessary utilization or a deterioration of their condition.
  - Respond to ADT alerts from the WVHIN, such as a member who has visited the ER.
- ***Managing care setting transitions.*** The portal provides workflows that help manage care setting transitions, such as prompting for follow-up PCP appointments, performing patient reminders and tracking the completion of a post-hospital assessment.
- ***Identifying members with gaps in care using*** a customizable Quality Measure Dashboard that allows providers to view their members with care gaps using HEDIS quality measure data, refreshed twice monthly.
- ***Identifying each member's risk level***, allowing providers to engage their members with the highest risk.

The figure presents the provider portal Population Dashboard. The dashboard is the screen providers see when they log in to the provider portal.

Figure 11: Population Dashboard. This dashboard is the screen providers see when they log in to the provider portal. It provides quick application access to tools, such as the care planning tool, and provides tiles with summary statistics of the members in the provider's panel.

Engaging Members in Their Care through Our Member Portal

Our care management system's member portal engages members in their healthcare by providing a variety of tools to communicate with their THP care team and ICT, view and track the completion of goals in their treatment plan, keep track of appointments in their calendar and complete assessments.

Sharing Assessment Data with a Member's other Payers (MS014)

For members in care management, the member's care manager facilitates the exchange of all data needed to coordinate a member's care with other payers. Depending upon the size of the file, we provide the requested information to the appropriate contact person at the other payer via secure email or through a secure file transfer protocol (FTP) site. We have also established data-sharing methods with other MCOs. For instance, we already share data with Aetna through the BMS-approved portal.

MS015: 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: Updates to the member handbook

MS017: Handbooks requested ad hoc by a member

MS031: Distributing member handbooks

Distribution and Notification of Member Handbooks

We group **MS031** with **MS015**, **MS016** and **MS017** as they are similar and to avoid duplication within this Member Services section.

Updates to the Member Handbook (MS016)

We review and update the Member Handbook annually at a minimum (and maintain documentation of such as required), when BMS revises the program or when THP revises our policies. Updated Member Handbooks are posted on our website, healthplan.org, for online member access.

Beginning this year, we send a postcard to members that notify them of Member Handbook updates to their benefits. In addition to providing information about changes, this postcard increases member awareness of their health benefits and may drive increased member engagement in their healthcare.

Ad Hoc Requests for Member Handbooks (MS017)

On an ad hoc basis, members may request a copy of the Member Handbook by calling customer service. Alternatively, the Member Handbook is available online at healthplan.org, accessible 24/7.

THP has a 100% timeliness rate in mailing member handbooks per BMS contract standards within five calendar days of request. We track material distribution in our customized system, HEART, to ensure timeliness. Using a local Morgantown company to produce and mail the materials allows us to closely monitor their ability to meet turnaround times and quickly address any concerns. In further support of monitoring timeliness, we complete daily quality control checks for ad hoc requests.

Distributing Member Handbooks (MS031)

After each update, and annually, at a minimum, we send a postcard to members that notify them of an update or change in benefits. With this notification, we educate members on where to access the Member Handbook, either online at healthplan.org or by calling customer service and requesting a copy be mailed to them.

Members may access an updated copy of our Member Handbook 24/7 via our website.

MS018: The Vendor should describe its warm transfer protocols for its member services, other internal departments, other entities, and subcontractors, as applicable.

Warm Transfer Protocols

Our warm transfer protocols require CSRs and care managers to warm transfer telephone calls to other internal departments so that members do not have to repeat the information with other departments. With subcontractors, CSRs and care managers may warm transfer, directly transfer or simply provide the member with the appropriate contact information.

CSRs receive notifications of issues or questions, e.g., member gaps in care, and advise callers of the need for a warm transfer to speak with a different internal department. With member approval, the CSR transfers the member to the appropriate department, staying on the line to make sure that the member is appropriately transitioned.

We effectively triage member needs in the call center to resolve issues and address member calls quickly. Including warm transfers, our 2019 first-call resolution rate was 85 percent.

MS019: The Vendor should describe how they will train member services representatives.

Customer Service Center Training

Training of newly hired CSRs encompasses a six-week period. Per industry standards, training encompasses classroom work prior to graduation to phones. Trainees must receive a passing score of 80 percent before moving to phone work; there they are shadowed by a senior representative before and after going "live" until the customer service manager feels the trainee is capable to answer calls and conduct warm transfers. Silent monitoring is performed frequently at first, then gradually tapering down to a minimum of five calls per month once the trainee is performing well. Senior representatives and the customer service manager continue to offer coaching and monitoring to the trainee throughout.

Our initial CSR training agenda is summarized in the following table.

New Customer Service Representative (CSR) Training
Week 1 Training
▪ Life of a claim, Outlook introduction, training terms, review THP departments ▪ CITRIX, intranet, NPI, provider, member FEIN ▪ HEART navigation, including reporting, searching, provider view and member view; HEART navigation test; provider module test; member module test ▪ Pay class, pay driver, system denial codes ▪ Fee schedule, RBRVS and UCR Training ▪ Provider, member and claims worksheets ▪ Acronym list and review, medical coding training, medical terminology training, medical terminology quiz #1 ▪ Member Handbook, Medicaid contract, THP Medicaid Processing Manual ▪ Claims view training, claim form training, claims module test ▪ BMS website training ▪ All online training required (HIPAA; Fraud Waste, Abuse; compliance) **Documentation:** Life of a Claim Visio, THP Org Chart, Outlook TR manual, Terms Document, CITRIX manual, Intranet TR manual, Navigation TR manual, Provider Manual, Member Manual, Claims Manual, Training Manual, FS, BRRVS & UCR Training Manual, Acronym Document, In Office Proc Training Manual, Medical Coding Manual, Medical Terminology Training Manual, Referral Training Manual, Census Training Manual, Duplicates Training Manual, Medicaid Contract, THP Medicaid Processing Manual, BMS Website Training Manual, Claim Form Training Manual, Member Handbook
Week 2 Training
▪ Medical terminology training, medical terminology quiz #2, quiz #3, quiz #4, quiz #5

New Customer Service Representative (CSR) Training
▪ Provider, member and claims worksheets, determining claims payment ▪ Action item training, medical coding training, pended claims training, claims payment ▪ THP Processing Manual spreadsheet ▪ Medicaid coverage test ▪ Review all materials, Member Handbook, contract, THP Processing Manual spreadsheet **Documentation:** Medical Terminology Training Manual, Provider, Member & Claims Trailing Manual, Action Item Training Manual, Medical Coding Manual, Pended Claims Training Manual, Claims Processing Screen and Step Out Manual, THP Processing Manual Spreadsheet, Member Handbook, Medicaid Contract
Week 3 Training
▪ Claim XTEN training ▪ Office claims ▪ Claims payment – Inpatient/Outpatient 1500 Claims ▪ Claims processing test, training class final **Documentation:** CXT Training Manual, THP Processing Manual spreadsheet, Member Handbook, Medicaid Contract, THP Medicaid Processing Manual
Week 4 Training
▪ Pay claims – all claims audited (review errors with class) **Documentation:** Not applicable
Week 5 Training
▪ CSR training ▪ Encounter system training ▪ Mock calls ▪ Determining claims payment ▪ Begin referral training **Documentation:** CSR Etiquette Training Manual, CSR Encounter Training Manual, System and Training Manual
Week 6 Training
▪ Mock calls and job shadowing **Documentation:** Not applicable

Ongoing Customer Service Training

We provide monthly CSR-wide training to review any changes or updates to the program, systems or to share BMS updates. Additionally, the manager completes monthly meetings with each CSR. During these 1:1 meetings, they review the CSR's

performance, including quality of calls and statistics. The manager provides individualized coaching or training during these meetings, as needed.

Additional Initial and Ongoing Compliance-related Training

THP's comprehensive employee training covers federal, State and contract requirements and are mandatory for all new employees. Selected compliance-related training programs are summarized in the following table.

Compliance Related Training		
Name	**Description**	**Frequency and Target Audience**
Medicaid Service Provider Agreement Training	Summarizes the Service Provider Agreement provisions. Updated annually. Ensures CEO/COO, CFO, senior management and employees are trained on contract provisions. Training is documented by the successful completion of a post-training quiz (at least 80%).	Conducted at hire and every July thereafter. Mandatory for all employees of THP.
Medicaid University	Serves as a resource for all things Medicaid. The presentation is posted on THP's intranet (available to all employees) and includes general contract provisions, Medicaid operations, quality, medical management and member outreach.	All employees who work on the Medicaid line of business.
Compliance & FWA Prevention Training	Covers the seven elements of a compliance program and how to prevent, detect and correct potential non-compliance and FWA. Includes information on relevant healthcare laws such as the Anti-Kickback Statute and the federal False Claims Act (including its qui tam provisions). Training on the federal False Claims Act complies with the requirements of the Deficit Reduction Act of 2005.	Conducted at hire and every November thereafter. Mandatory for all employees of THP and THP board members.
HIPAA Privacy & Security Training	Covers HIPAA requirements, uses and disclosures of PHI and member rights under HIPAA. Training documented by the successful completion of a post-training quiz (at least 80%).	Conducted at hire and every April thereafter. Mandatory for all employees of THP.
Cultural Competency Training	Reviews access for individuals with limited English proficiency (LEP), individuals with disabilities or limited literacy and cultural competency. Training documented by the successful completion of a post-training quiz (at least 80%).	Conducted at hire and every January thereafter Mandatory for all employees of THP.

MS020: 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: Member-to-representative ratios

MS022: Call answering time, with a minimum of 83% of calls answered in thirty (30) seconds

MS023: Call abandonment rate not to exceed five percent (5%)

MS024: Single contact resolution

MS025: Turnaround time for member requests

MS026: Remediation strategies for performance issues

Customer Service Center Standards

THP staffs our in-state call center during normal business hours from 8 am to 5 pm EST Monday-Friday from our Charleston, WV, office. We meet or exceed BMS performance standards for customer service by monitoring performance, staffing appropriately and providing many other supports to assure members and BMS we sustain high-quality support.

THP's Call Center Exceeds BMS Standards for Customer Service	
Measure	**2019 Results**
MS022: Call Answer Time	85.35% live in 30 seconds vs the 83% BMS standard
MS023: Abandonment Rate	1.27% vs the 5% BMS standard
MS024: Single Contact Resolution	85%
MS025: Member Request Turnaround Time	48 hours

Ensuring That We Meet Customer Use

We ensure we are meeting or exceeding standards through ongoing performance monitoring. Every day, we review key customer service results, including the number of calls, average wait time, number of CSRs, abandonment rate and number/percentage of calls answered within 30 seconds. We compare each day's performance to recent historical performance to identify and investigate any irregularities.

Best practices and standards that we apply to support our CSRs and ensure that we continue to meet or exceed customer use and performance requirements include:

CSRs with the Right Data and Knowledge Help Members

"A member's sister handled her brother's care. She was financially burdened from paying for her brother's Depends and other needs. I informed her that his insurance covered the product, advised her to have his PCP write a prescription for such, and gave her contacts to where she could access the products (e.g., different DMEs).

Within a week, she called back and asked for me with tears of joy because she could now focus on her brother's more significant needs."

– CSR story

- Offer 24/7 access to members via nurse line, staffed by THP nurses and Teladoc.
- Per **MS021**, maintain a member:representative ratio at 7,000:1. This ratio is based upon historical call data to make sure that we consistently meet or exceed performance standards. We continuously analyze call volume data and forecast seasonal and other trends (e.g., peak hours, new-contract spikes, especially with the WVCHIP addition) to meet THP and BMS contractual performance requirements. Backup staff to handle call volume increases include West Virginia-based CSRs who currently serve our Medicare and Commercial members.
- Enable CSRs to address calls quickly via two levels of call center staffing – CSRs who take provider calls and CSRs who take member calls. All CSRs are cross-trained to take either type of call.
- Conduct intensive training per above and ongoing silent monitoring of at least five calls/month per CSR to ensure BMS quantitative metrics and internal quality standards are met.
- Monitor member turnaround time for requests by internal key performance standards.

Reporting Customer Service Results to BMS

We submit quarterly customer service results to BMS. These results are reported by member and provider, and by medical, behavioral health and dental.

As part of our compliance program, we track these metrics monthly in Gorman's Online Monitoring Tool (OMT). These performance metrics are built into OMT as "indicators." Indicators are set up to repeat on a periodic basis (e.g., monthly, quarterly) and include the responsible submitter and reviewer, thus incorporating clear assignments, timelines and measurements.

Remediation Strategies for Performance Issues (MS026)

Individual CSR performance is monitored through daily reports. If we identify a performance issue with a specific CSR, we initiate retraining, intensified silent monitoring and, as needed, a formal corrective action plan.

For broader call center issues, our remediation strategies include root cause analysis identification, then corrective action to resolve the issue. If we identify a significant issue that needs addressing, we create an internal remediation plan to formally track and monitor issue resolution.

Additionally, our multi-level staffing model includes built-in remediation strategies for performance issues such as spikes in call volume. With such spikes in volume, we engage other CSRs who are cross-trained to handle overflow calls.

MS027: 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: Member contact, including welcome calls, welcome letters, and/or home visits

MS029: Outreach to members who are difficult to contact, including disabled members and members without telephones

MS030: Processing and issuing identification cards

MS032: 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).

MS044: The Vendor should describe its policies and procedures related to issuance of member identification cards within contractually defined timeframes.

New Member Enrollment and Education

THP's new member enrollment and education process per **MS027** was introduced thoroughly in the Initial and Ongoing assessment subsection **(MS006-MS014)**, which provided details about the timing for welcome letters with ID cards with PCP assignments on them, welcome packets and welcome calls to attempt to initiate and

complete initial HRA assessments and treatment plans within the NCQA-required 90 days–all per **MS028**. We do not repeat that here for brevity.

Summarily, once enrollment file data has been verified as accurate, we develop the member's welcome packet for dissemination. Welcome packets include (tailored to member cultural preferences as indicated on the enrollment file or per previous member data if the member is re-enrolled based upon redetermination):

Welcome Timeliness

- 100% timeliness rate in dissemination of ID cards with PCP assignments on them within 5 calendar days
- PCP assignments in 5 calendar days, exceeding the contractually required 10 calendar days per 3.2.2 Assignment of Primary Care Providers in the Service Provider Agreement

- Benefit information, including value-added services.
- Websites, secure member portal information.
- How to access the Member Handbook online per **MS031** and how to request the Member Handbook or any other information in print for free and per member cultural needs. We grouped **MS031** with **MS015-MS017** given their similarities, and described them in detail earlier in this section. We do not repeat here for brevity. THP sends requested materials within five calendar days of the request per **MS031** and **MS040. See MS041-MS042** for our response to cultural competency translation for member materials.
- Information related to other programs that may be appropriate for members, including Women, Infants and Children (WIC); Birth to Three; Children with Special Healthcare Needs (CSHCN); Non-Emergency Medical Transportation (NEMT).
- Contact information per all BMS enrollment material standards per Section 3.4.1 Enrollee Information in the Service Provider Agreement,

Packets are disseminated within five calendar days of verification of accurate enrollment information. Daily quality control checks support our 100 percent timeliness rate.

ID Card Process, Timeliness Assurance. The welcome letter, including the ID card with PCP assignment (imprinted with either the member-selected PCP on the ID card or the auto-assigned PCP (as per the process defined in the PCP Assignment Section

earlier per **MS005**), is sent separately to the member. Per **MS030** and **MS044**, THP maximizes reachability and timeliness of ID card distribution through:

- Address verification methods, including verification of valid city and ZIP codes
- Daily quality control checks for accuracy and timeliness of card issuance per contract standards
- Use of electronic information transfer to the ID card print vendor to support the tight timeframe from notification to distribution

Every call, email and web request, including those for replacement ID cards, is documented in our HEART system.

Welcome Calls. Per **MS028,** THP supplements the initial welcome packet mailing with new member outreach and education through welcome calls, including initial HRA completion. As cited earlier, we complete welcome calls at various times of the day and week to maximize outreach within the first 30 days. In 2019, we completed 13,185 initial HRAs either via phone or paper. In addition to the health assessment, member advocates use the telephone call to reiterate the welcome packet information (e.g., benefits, value-added services, how to access information, how to access and request the Member Handbook), and to educate the member about:

- Appropriate ER use
- Importance of being established with PCP
- How to obtain a referral to certain specialists or other care
- Transportation for non-emergent care

The member advocate logs the call in HEART, including member contact preference or other updated member information so other staff are aware of special communication needs.

Outreach to Members Who Are Difficult to Contact (MS029)

Our response to **MS012**, above, details our approach to outreach to members who are difficult to contact. Specific to those members with disabilities or without a telephone, we are going out into the community to locate and engage these members. This community engagement is through a partnership with Episource and through the implementation of a community-based health navigator with Prestera Center.

Partnership with Episource. For our MHT members, Episource will leverage technology to build comprehensive member profiles, tailor our message based upon their needs and engage members via multiple channels (e.g., telephone, direct mail, email or text message). Episource clinicians will perform a face-to-face visit with these members to comprehensively understand their needs and connect them to care, including reviewing their social environment and other risks that can be difficult to capture during office visits.

Implementing a community-based health navigator. In March 2020, we will implement a pilot with the Prestera Center that includes a community-based health navigator—paid for 100% by a THP care coordination fee. The navigator will be employed by Prestera Center. The navigator will supplement the Prestera Center chronic care management team in Cabell, Kanawha and Putnam Counties. They will locate and engage members who are difficult to reach and support THP members who need extra support in managing their healthcare challenges, such as coordinating a PCP or specialist appointment, completing laboratory testing, dietary needs/food insecurity or non-emergent transportation.

The community-based health navigator will have access to Prestera Center's electronic medical record system and THP's care management systems to see a complete picture of the member's healthcare utilization and unmet needs. Should this approach to coordinating care prove successful, THP will enlist other comprehensive behavioral health centers as partners in the model—especially those located in counties with disproportionate utilization of behavioral health services.

Additional services for people with a disability. Our solution for people with a disability includes offering the requisite TTY/TDD phone line. For those with limited English proficiency, we provide interpretive services through Cyracom. We also engage vendors to produce materials to support the unique member needs, including information in other languages, Braille, large print and audio. This is the same solution for those who have limited English proficiency and reading skills per **MS032**. We verify our materials are 6th grade reading level by running tests via Flesch-Kincaid Readability Scale.

Assisting people without a telephone. As a value-added service, we provide members with a free cell phone with free minutes for text and voice, unlimited calls to customer service, and free wellness and appointment reminder text messages. This cell phone allows providers and our outreach staff and care managers to reach members to address health issues and schedule provider appointments.

MS033: 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: Medical records

MS035: Authorization status

MS036: Cost sharing information

MS037: Temporary identification (ID) cards

MS038: Confirmation of Primary Care Provider (PCP)

MS039: Provision of access to guardians

Members access their secure member portal by logging in from our home page at healthplan.org. Members simply click on the dark green Secure Login button at the top of the page, as illustrated in the figure.

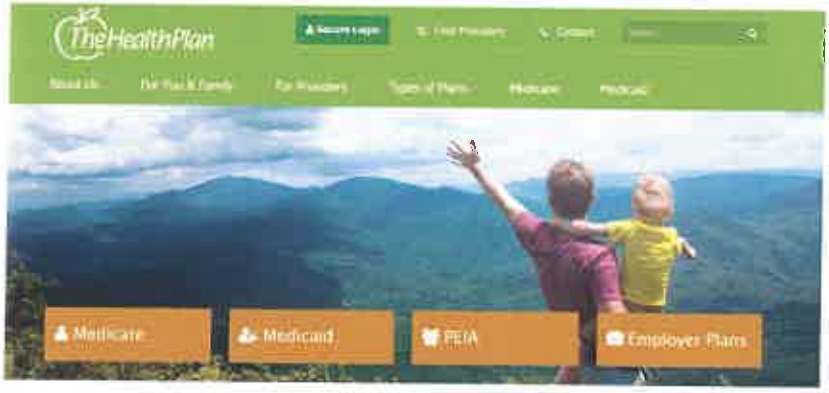


Figure 12. Easy website navigation. THP's home page, healthplan.org, easily directs members to their area of interest. Members who wish to log in to the secure portal simply click on the dark green Secure Login button at the top of the page.

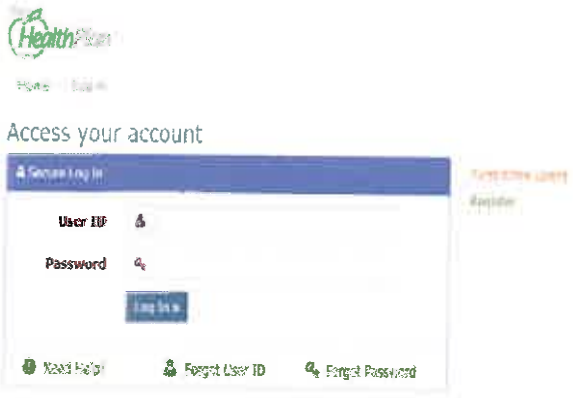


Figure 13: Secure log-in page. Our page easily directs members to either register (for first-time users) or log in, offering assistance as needed.

Once they click on this button, a popup appears, requiring the user to enter a user ID and password. For first-time users or those needing assistance with logging on, this popup provides easy-to-follow instructions and access to assistance as needed. See the figure to view the information provided on our secure logon popup.

Our secure member portal allows members to log in and access benefit information, including but not limited to:

- ***Medical records:*** Our care management system maintains all information about the member's care and services in their care management electronic health record (EHR), providing a comprehensive view of their needs and goals and the services and supports being delivered to meet their needs and help them achieve their goals. For example, members in a care management program can access their treatment plan, including:
  - Review the plan
  - Track goals and interventions
  - Send and receive messages from providers and care team
  - Change care team/add members
- ***Authorization status:*** View information on authorization, including status updates
- ***Claims data including cost-sharing information:*** Search and review claims and EOB details, including member's cost-sharing information
- ***Temporary ID cards:*** View, print or download their ID card
- ***Confirmation of PCP:*** View their PCP assignment, find a provider or change their PCP
- ***Provision of access to guardians:*** For members under the age of 18, the guardian listed in the state enrollment information is eligible to sign into the secure portal. Within our care management system, we provide access to guardians to receive information on family members covered under the plan if permitted by HIPAA.

Other information available to members within the secure member portal includes:

- Track current enrollment status, benefit information, coverage start date
- View prescriptions processed
- View other coverage, dental and vision, value-added services
- Conduct self-assessments, health risk assessments
- Track medications
- Track appointments against a calendar
- Look up providers based upon name, specialty, distance from a specific ZIP code; additional search fields include gender, language spoken, if accepting new patients, board certification, hospital affiliation(s) and medical group affiliation
- Look up dental and vision providers

Easy to Navigate

Our THP website is ADA Section 508-compliant, HIPAA-compliant and WCAG (Web Content Accessibility Guidelines)-compliant for easy navigation. We will continue to

build upon our knowledge of local demographic and cultural needs to engage members with web content and features that increase member empowerment and knowledge.

Additional details about our website and our mobile app are provided in response to **MS002**, earlier in this section.

MS040: 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.

MS041: 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.

MS042: 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.

MS043: 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.

Information Available In Paper, Other Languages and Formats

THP's comprehensive plan for providing materials in a way that all members can access based on their access preference, supports member satisfaction, program integrity and member engagement. In our entire Medicaid history, we have never had a complaint about communicating with members in a culturally competent manner.

Our 10-step process ensures Medicaid-specific materials are readable, comprehensible and actionable to members. The process is:

- Provide cultural competency training for all staff at onboarding and annually for a baseline orientation to the population.
- Through our Community Engagement Director, work with local community partners to localize and otherwise customize materials to the West Virginia Medicaid population (per **MS001**) reflecting demographics and local language preferences.
- Verify all materials are 6th grade reading level by running tests via Flesch-Kincaid Readability Scale.

- Engage vendors to translate materials into 80 other-than-English languages, including the top 15 cited in the RFP; in Braille and large print; and produce materials in an audio format. For those with limited English proficiency, we provide oral interpretive services through Cyracom. We also make auxiliary aids and services, including TTY/TDD, available. (**MS032, MS041**) For those accessing telehealth, Teladoc also provides translation services.
- Use a checklist to conduct quality control reviews of all materials, including those in the prevalent non-English languages, originally developed or adapted from national or state organizations per the above requirements; to ensure that they adhere to BMS marketing guidelines; that they include taglines in 18-point font explaining availability of written translation or oral interpretation and include the toll-free and TTY/TDD numbers **(MS043).**
- Conduct a visual quality control inspection during routine on-site provider visits and for formal visits per credentialing to ensure provider materials are culturally appropriate and follow above guidelines.
- Notification to members of availability of all information in culturally appropriate formats, including oral interpretation services in any language and that written information is available in prevalent languages and Braille, and in paper form without charge upon request within five business days is completed: **(MS040, MS042)**
  - At enrollment in welcome packet and during the welcome call
  - Via information contained on our website at healthplan.org, on mobile app, on all materials and upon receipt of ad hoc requests
  - During membership contacts via routine outreach calls; when members contact customer service, their care manager or another THP employee or department
  - Annually via annual provider directory and member manual communications
- Provide a website that is ADA Section 508, WCAG and HIPAA-compliant.
- Distribute materials in a targeted manner via care managers for those with care management needs (e.g., if a care manager is working with a member who is deaf or English as a second language (ESL), materials always will be delivered using available services, e.g., TTY/TDD, Cyracom and through translated materials).
- Monitor complaints for cultural competency in member communications for both THP and our subcontractors (to date in THP Medicaid history: None).

Finally, we monitor our dental and vision subcontractors to ensure cultural competency through our formal and comprehensive Subcontractor Monitoring Plan, required in Section 8.5 of the Service Provider Agreement. Using the Subcontractor Monitoring Plan, we oversee each subcontractor to ensure they are following the required guidelines.

MS045: The Vendor should describe how they will administer a health education program for disease and injury prevention and identification.

MS046: The Vendor should describe its tobacco-cessation program.

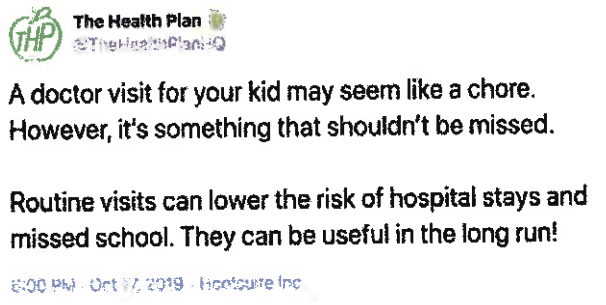
Administering Health Education, Tobacco-Cessation Programs

Initial welcome calls help engage members in their healthcare. As part of these welcome calls, we complete the initial health assessment and provide members with education about their health benefits. During these welcome calls and in the Member Handbook and on our website at healthplan.org, we educate members about how to access our health education program, including health and wellness information. Resources are available online at healthplan.org or through a direct connection between the member and a THP representative, e.g., a care manager or CSR.

Online Health and Wellness Resources

Our website offers 24/7 access to health and wellness, disease and injury prevention through the Health and Wellness page. The site contains more than 180 articles, quizzes, blogs, and newsletters on a range of topics from "Growing Your Own Indoor Herb Garden" to autism support, and is updated quarterly. Members also have access to our CoreWellness program, available online at healthplan.org, for information on tobacco cessation and alcohol screening.

To help meet members where they are and to maximize reach and engagement, THP uses social media to promote health and wellness per the Facebook and Twitter examples here.



Directly Connecting Members to Additional Health and Wellness Resources

Some of the health and wellness programs are available through a direct connection between a member and a THP representative. For example, a care manager or member advocate may identify and recommend a health and wellness program while talking with a member during a welcome call or through care coordination. Alternatively, a member may initiate contact and call customer service and obtain information about accessing a health and wellness program.

Our health and wellness programs are available to all members and include a variety of initiatives as summarized in the following table.

Health and Wellness Programs for All Members	
Encouraging Annual Well-Visits	Members age 13-21 who have not had a well-visit in the previous 12 months, The goal is to increase the rate of members receiving well visit appointments by 10% through social media, outreach calls to members who have no claims for a well-visit within the past 12 months, notifying PCPs of their patients who have not had a well visit within the past 12 months and delivering targeted coordinated care through value-based agreements.
Improving Glycemic Control	Members age 18 and over who have diabetes. The goal is to lower or maintain the population with an HbA1c control by <8.0% by 5% through outreach and care navigation calls to members with an HbA1c >8.0% or a missing HbA1c, providing a list to the provider of patients who have an elevated or missing HbA1c, engaging members in diabetes disease management programs and delivering targeted coordinated care through value-based agreements.
Improving Diabetic Eye Exams	Members age 18 and over who have diabetes. The goal is to increase the target population who receive diabetic eye exams within the past 12 months by 10% through outreach calls to members who have no claims for a diabetic eye exam within the past 12 months, notifying PCPs of patients who have a missing diabetic eye exam, engaging members in diabetes disease management programs and delivering targeted coordinated care through value-based arrangements.
Women's Health Initiative 2020	This initiative is designed to support and improve evidence-based breast cancer, cervical cancer and chlamydia screening rates in women enrolled in the MHT program.
Performance Improvement Projects (PIPs)	We have implemented two PIPs to address to improve performance for the following measures: ▪ Adolescent Well-Care Visits ▪ Annual Dental Visits for 2-3 Year Olds

Incentive Programs	We offer members a variety of incentives to connect them to care, such as:
	▪ $50 gift card for a diabetes screening
	▪ $25 gift card for a pediatric dental visit
	▪ Maternity outreach programs:
	  ▪ $50 gift card for two visits in 1st trimester
	  ▪ $50 gift card for four visits in 3rd trimester
	  ▪ $50 gift card for post-partum visit between 7-84 days after delivery
	▪ $25 gift card for yearly well visit for ages 3-6 and 12-21
	▪ $25 gift card for women ages 21-64 for Pap smear every three years

Gap in Care Closure	Member advocates on our member outreach team engage members who have gaps in care identified by HEDIS and EPSDT measures. During outreach calls, member advocates work with members to identify barriers to accessing these services, including social determinants of health, and connect members with resources that can resolve these barriers.
Other Wellness Programs	▪ Tobacco cessation packets, managed internally by our certified smoking cessation coordinators, for all members ages 12 and older, with workbook, relaxation exercises CD, and quit smoking survival kit. ▪ Access to our CoreWellness online tool that helps members learn ways to get and stay healthy. ▪ Connect members to SafeLink wireless that provides members with a free cell phone with free minutes for text and voice, unlimited calls to THP Customer Service and free wellness and appointment reminder texts.
Disease	Members with diabetes, a chronic cardiac condition, COPD and members who

Management Programs for members low risk	smoke, including members who are pregnant.
Perinatal Care	Member advocates on our member outreach team engage pregnant women who have low-risk pregnancies in a variety of activities to connect them to care throughout their pregnancy.

Tobacco Cessation Program (MS046)

THP offers two tobacco cessation programs: "Freedom from Smoking" and "Not-on-Tobacco" targeted to adults and adolescents, respectively. Staff who administer the program have been trained as American Lung Association Facilitators. In 2019, 1,695 members completed the program.

Figure 14: Smoking and Tobacco Cessation. We encourage members to take control of their health through initiatives like our smoking and tobacco cessation program. This postcard is included in our welcome packet, sent to all new members upon enrollment.

MS047: The Vendor should describe how they will leverage community events/resources to help improve the health of its member population.

Leveraging Community Events/Resources to Improve Member Health

THP takes its commitment to invest in the community where it is serves seriously, especially for population health and wellness improvement. We do this through sponsorships and participation in local community events throughout West Virginia. We also collaborate with community-based organizations to expand existing programs and create innovative solutions to population health needs.

An example of an innovative solution is through our recent work with the Healthy Grandfamilies program at West Virginia State University. We helped launch several Healthy Grandfamilies coalitions, in collaboration with the Ohio County FRN, by hosting a training for representatives of community-based organizations, as well as educational and legal representatives, that routinely support Medicaid populations. This is in direct response to the foster care and kinship care crisis in the state.

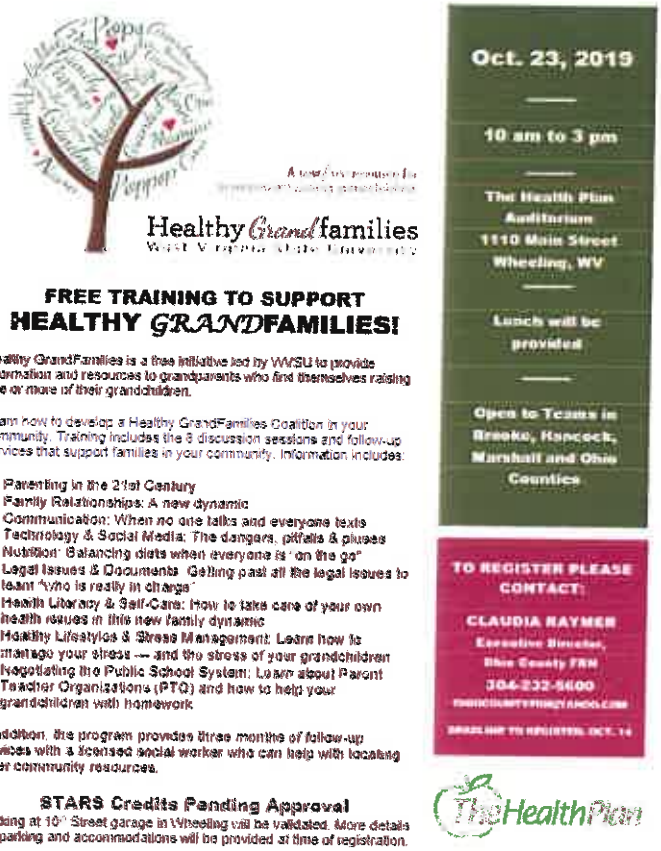


Figure 15: Healthy Grandfamilies. To help address the prevalence of children being raised by their grandparents in West Virginia, we helped expand the Healthy Grandfamilies program and hosted a training in for the Northern Panhandle counties of West Virginia.

According to the West Virginia KIDS Count 2019 databook, West Virginia is number two in the country for the rate of children being raised by their grandparents/kinship care.

Unique Community Sponsorships

The following table highlights some of our signature and unique sponsorships.

THP Invests in Population Health and Wellness		
Sponsorships	**Demonstrating**	**Details**
Camp Kno Koma	Demonstrates early childhood education and active lifestyles	A week-long summer camp for children ages 7-15 with a diagnosis of diabetes. The camp is held at the Greenbrier Youth Camp in the Monongahela National Forest and allows campers to experience adventure, education and friendship. Campers are introduced to

THP Invests in Population Health and Wellness		
Sponsorships	**Demonstrating**	**Details**
		new diabetes management skills during a week of canoeing, swimming, biking and more.
Tough As Nails Challenge	Ties to community wellness weekend to promote health and wellness in a community setting	The Tough As Nails Challenge is the first of its kind in the Wheeling area. As part of the Ogden Wellness Weekend, the race gives participates a unique perspective of Wheeling during the 6-mile, 20 obstacle race.
Wheeling Community Bike Share	Healthy communities	Wheeling is the home to the state's first community bike share program. THP has partnered to provide 10 bike stations in downtown Wheeling for users to explore the city and enjoy the local trail system.
Marshall University Joan C. Edwards School of Medicine and Marshall Health Project Hope for Women & Children	Supports two-generational approach to good health	Project Hope provides a stable and supportive environment for women and their children so they can work toward long-term recovery (from substances), developing healthy parenting skills and building safe family relationships.
Oglebay Institute's Art of Healing Exhibition	Demonstrates holistic health support	The Art of Healing exhibition explores the therapeutic power of the creative process to address the physical, emotional and spiritual needs of cancer patients and their loved ones.
SMART5.29K Run and Walk	Demonstrates economic advancement to good health	The SMART5.29K raises money to establish SMART529 College Savings Plans for children recently adopted out of the foster care system in West Virginia. All proceeds from the 5.29K registration will be deposited into SMART529 College Savings Accounts.
Clay Center for the Arts and Sciences	Demonstrates how the creative arts support well-rounded, good health	The Clay Center's mission is to inspire creativity, learning and wonder through experiences in the Arts and Sciences for all people of West Virginia and the region. THP sponsored the *Da Vinci – Inventions* exhibit and the Disney Junior Dance Party.
King's Daughters Dragon Boat Race	Demonstrates early childhood education with good health	The King's Daughters Dragon Boat Race is an annual fundraiser for the King's Daughters Child Care Center. The organization provides care for children in a nurturing, safe environment encouraging educational experiences, which promote social, emotional, physical and cognitive development.

Participation in Community Events Across West Virginia

THP leverages community events/resources to help improve population health by considerable attendance at these local events to distribute materials, answer questions and collaborate with complimentary services. THP reached individuals, both members and non-members, across community events for pregnant women and newborns, children, seniors and the general public statewide.

The following table highlights the 23 community events representing 1,607 attendees that we attended in 2019, including enrollment and health fairs throughout West Virginia.

Fairs and Community 2019 Events: 1,607 attendees	County	Attendance
PEIA Enrollment Fair - Martinsburg	Berkeley	50
Berkeley Heights Community Block Party	Berkeley	200
PEIA Enrollment Fair - Huntington	Cabell	20
Calhoun FRN & Community Brunch	Calhoun	35
Minnie Hamilton Women's Health Fair	Calhoun	50
Top of West Virginia Resource Fair	Hancock	100
EA Hawse Health Center Health Fair	Hardy	100
Grandparents & Kinship Caregiver Resource Fair	Harrison	19
PEIA Enrollment Fair - Charleston	Kanawha	25
Kanawha Community that Cares	Kanawha	23
Kanawha-Charleston Health Dept Health Fair	Kanawha	40
Children's Safety Fair	Lewis	125
Lincoln Co Health Fair	Lincoln	150
Fairmont Arbors Health & Wellness Fair	Marion	15
PEIA Enrollment Fair - Morgantown	Monongalia	60
BB&T/Community Resource Fair	Morgan	75
Northern Community College PEIA	Ohio	30
Ohio County DHHR Resource Fair	Ohio	55
Senior Sunset Health Fair	Ohio	100
PEIA Enrollment Fair - Wheeling	Ohio / Marshall	40
PEIA Enrollment Fair - Beckley	Raleigh	20
Summers Co Brothers and Sisters Health Fair	Summers	100

Fairs and Community 2019 Events: 1,607 attendees	County	Attendance
PEIA Enrollment Fair - Parkersburg	Wood	25

In the above table, we included our PEIA enrollment fairs in recognition of the addition of WVCHIP to managed care. State and county employee children qualify for WVCHIP coverage if the family meets the financial guidelines. Under the new contract and with the addition of WVCHIP, we will continue to participate in these PEIA enrollment fairs and promote the value of enrolling children in WVCHIP, if eligible.

In further demonstration of our community connections as it relates to pregnant women and children, the following table highlights our participation in 17 baby showers and 26 children's events, including back-to-school events.

Pregnant Women and Babies; Children 2019 Events	County	Attendance
Pregnant Women and Babies		**1,264**
Pregnancy, Baby & Child Expo	Berkeley	35
Cabell County. Baby Shower	Cabell	200
Gilmer County Community Baby Shower Minnie Hamilton Children's Event	Gilmer	80
Grant County Baby Shower	Grant	18
Baby & Me	Harrison	300
Harrison County Community Baby Shower	Harrison	23
Harrison Library Baby Shower	Harrison	15
McDowell County Baby Shower	McDowell	75
Monongalia County Community Baby Shower	Monongalia	25
Baby Shower	Monongalia	35
Morgan County Baby Shower	Morgan	32
Paw Paw Baby Shower	Morgan	32
Pleasants County Baby Shower	Pleasants	50
Raleigh County Community Baby Shower	Raleigh	150
Ritchie County Baby Shower	Ritchie	60
Upshur County Baby Shower	Upshur	59
Wayne County Community Baby Shower	Wayne	75
Children		**3,857**

Pregnant Women and Babies; Children 2019 Events	County	Attendance
Barbour Pre K / K Registration	Barbour	62
Barbour County Back to School Bash	Barbour	170
Berkeley Head Start Health Advisory Meeting	Berkeley	14
Berkeley County Early Head Start Community Resource Fair	Berkeley	62
Berkeley County Head Start End of Year Picnic	Berkeley	250
Project Hope for Women and Children	Cabell	45
West Virginia Child Welfare Collaborative	Kanawha	35
West Virginia Kids Health Roundtable (Huntington)	Cabell	45
Calhoun County Back to School Bash	Calhoun	200
Region 3 Children's Summit	Harrison	19
Pals PreSchool Screening	Harrison	40
Head Start End of Year Picnic	Jefferson	150
Our Children, Our Future Kids & Family Day	Kanawha	100
Kids Strong	Kanawha	565
Children's Safety Fair	Lewis	125
Marshall County Back to School Fun Fair	Marshall	300
Region 3 Children's Summit	Mineral	17
Children & Leadership Council (2x)	Monongalia	40
West Virginia Kids Health Roundtable (Morgantown)	Monongalia	50
Head Start End of Year Picnic	Morgan	100
Morgan County Back to School Bash	Morgan	275
Pleasants County Back to School Bash	Pleasants	75
Putnam County Back to School Bash	Putnam	200
Ritchie County Back to School	Ritchie	68
Tyler County Back to School Fair	Tyler	350
West Virginia University Medicine Children's Kids Fair	Monongalia	500+

The last table illustrates our participation in three senior events reaching 580 individuals in 2019.

Seniors 2019 Events Reaching 580 individuals	County	Attendance
Senior Expo 2019	Monongalia	50
Senior Sunset Health Fair	Ohio	100
Senior Day - Randolph County Fair	Randolph	150

As evidenced by the above tables, we are invested heavily in our local communities and are actively engaged in working with local community organizations to enhance population health. We will continue this engagement and are looking forward to ongoing participation in the various community sponsorships and events.

MS048. The Vendor should describe how they will foster cultural competency among staff.

Fostering Cultural Competency Among Staff

Our West Virginia-based staff, including our CSRs and member advocates on our outreach team, reflect the community; in essence, they offer an intimate understanding of the West Virginia-specific issues that members might face and locally nuanced responses to best engage members. THP fosters cultural competency in many ways. Indeed, every THP employee is required to complete annual cultural competency training, requiring an 80 percent passing score. This training reinforces that cultural competency requires effort. As individuals, we must keep an open mind and ask questions. Our cultural competency training is web-based and covers several important topics, including:

- ***Cultural Competence:*** Defines BMS, CMS and NCQA expectations, culture and how culture influences care
- ***Language Competence:*** Explains the value of communicating effectively with diverse audiences, including persons with limited to no English proficiency, persons who are not literate or those with low literacy skills, individuals with disabilities and individuals who are deaf or hard of hearing
- ***Social Determinants:*** Defines social determinants of health and explains why they are important and how they can impact a member's care
- ***Ageism:*** Defines ageism as the specific use of negative or derogatory images to discriminate a certain population group, and why it is important to treat people as individuals
- ***Learning Cultural Competence:*** Includes the national standards for Culturally and Linguistically Appropriate Services (CLAS) in healthcare, and provides information on how to conduct a cultural assessment
- ***Resources:*** Additional cultural competency reference materials that were used to develop the training

Additional Ways We Foster Cultural Competency

Other ways we foster cultural competency are demonstrated through the services we provide to members, including:

- Our language-translation vendor, Cyracom, translates to 80 languages for individuals with limited to no English skills; other vendors translate materials to Braille and in large-print and produce audiotapes for those who need additional assistance.
- Members receive person-centered care with an enhanced SDOH solution for complimentary member service and holistic care coordination. For example, our care management system integrates with Aunt Bertha, a database of social care resources. This integration allows the staff, including member advocates and care managers, to use Aunt Bertha to identify resources to meet the member's social care needs.
- Members' digital experience supports interaction with members in the way they interact elsewhere in their lives: via the web, mobile app and social media. Our website is ADA Section 508 and HIPAA-compliant. It is also WCAG (Web Content Accessibility Guidelines)-compliant.
- Members can newly access telehealth medical services via Teladoc (that also provides translation services as needed)

Cultural Competency and SDOH Training for Providers

It is important for providers to consistently exhibit cultural competency, especially regarding their patient demographics. We offered cultural competency and SDOH training to network providers via webinar in 2018 in response to CMS requirements. Attestation of training completion is required. In addition we host annual cultural competency training for providers. Our director of provider education and training generates a list of providers who have not submitted attestation to cultural competency training to date. These providers are invited to attend the annual webinar training provided by THP. The director coordinates with our provider engagement managers and provider engagement representatives to contact PCPs, OB/GYN providers and behavioral health providers identified as not completing the training to schedule training dates. The provider engagement representatives schedule training with high-volume

providers in other specialties. Reminders to complete cultural competency training will be addressed at each opportunity, including workshops, conferences and professional organization meetings throughout 2020 and beyond.

TheHealthPlan

Attachment 6
Enrollment and Disenrollment

6. Enrollment and Disenrollment

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

Effective enrollment and disenrollment processes are essential to maximize member continuity of care. Our enrollment and disenrollment approach has built-in processes to consistently meet or exceed contractual requirements, especially in key areas that impact the member's care or the State's fiscal responsibility. The four measures on which we focus are turnaround time for identification (ID) cards, our ability to outreach and engage members shortly after enrollment, our ability to quickly reconcile 820 capitation files and our ability to quickly enroll newborns. We successfully meet or exceed these measures, in part, because of our process to efficiently accept the twice monthly 834 enrollment file. We already accept daily 834 enrollment files from other clients and are prepared to accept daily WVCHIP 834 enrollment files to accommodate member enrollment/termination. A summary of the Bureau for Medical Services (BMS) requirements and our ability to exceed them follows.

Measurement	BMS Requirement	The Health Plan (THP) Actual Performance
Issue ID cards	100% within 5 business days of enrollment	100% within 5 business days of enrollment throughout the past 5 years as an existing West Virginia Medicaid managed care organization (MCO)
Initial health risk assessment screening	Best effort to conduct an initial screening within 90 calendar days of enrollment	We initiated contact with 100% of members within 30 calendar days of enrollment, far exceeding the 90 calendar day requirement (2019)
Newborn enrollment	Process newborn enrollment within 30 calendar days	We enroll newborns within an average of 7 calendar days
820 capitation file reconciliation process	Reconcile capitation files within 45 calendar days	We reconcile 90% of the 820 capitation files within 30 calendar days; 100% within 45 calendar days

ED001: The Vendor should describe its policies and procedures regarding enrollment of members, including the processing of 834 enrollment files.

Processing enrollment promptly and accurately is important to members, as it initiates processes such as primary care provider (PCP) assignments, welcome calls and receiving a member welcome packet and THP ID card. We have 24 years of experience receiving eligibility and enrollment information from BMS and its fiscal agent.

Our seasoned employees use proven technologies and established policies and procedures to receive and process 834 eligibility files and manage the enrollment of assigned members according to BMS requirements. Jason Landers, Contract Liaison/MHT Administrator, is responsible for coordinating with the enrollment broker. Mr. Landers works closely with Christy Donohue, VP Medicaid, to provide the enrollment broker with information for eligible members about THP and PCP selection (e.g., value-added services and the provider directory so members can select a PCP during enrollment).

Within HEART, our enrollment module is the system of record for all member enrollment and eligibility data, which enables us to support key business functions, such as reporting, claims processing, PCP assignment, utilization management, care coordination and, if required, premium collection for the WVCHIP population.

Processing Enrollment Files

We follow existing policies and procedures when processing the 834 enrollment files.

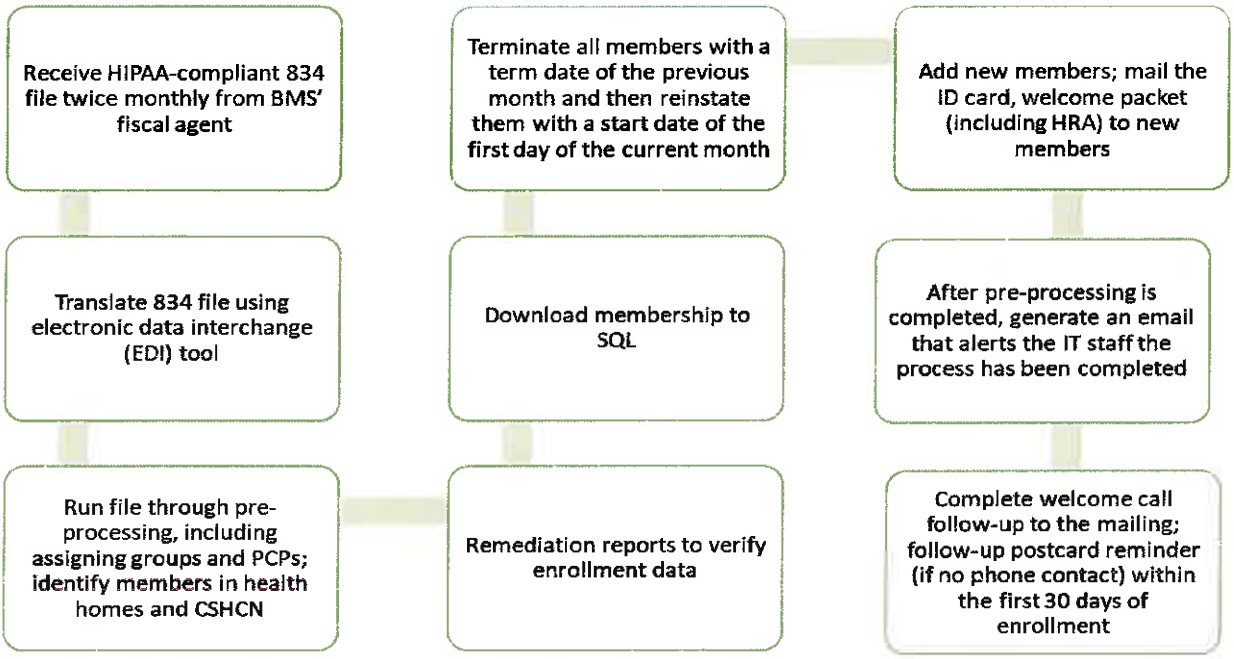
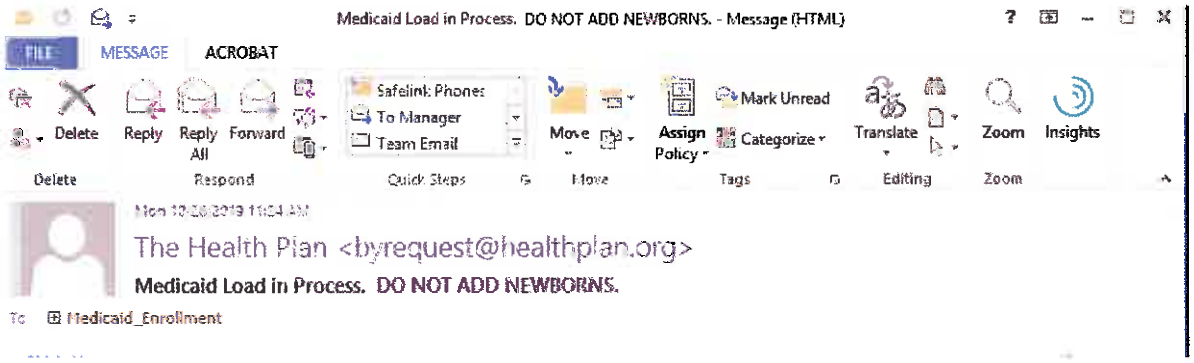


Figure 1: Our 834 enrollment process. Our process for uploading and processing the 834 enrollment files is consistent, quick and accurate in loading enrollment information.

Our enrollment process is represented in the figure and described in the following paragraphs.

Twice monthly, BMS' fiscal agent sends a Medicaid membership file to THP via secure FTP. This is a HIPAA-compliant 834 file. The first file received is considered a "full-file." This file includes the majority of the membership assigned to THP. The second file received is a "supplemental file." The supplemental file includes members who missed their renewal appointment with Department of Health and Human Resources (DHHR) and missed the deadline to be included in the full file and newborns whose birthday was after the managed care enrollment cut-off date. An email, illustrated in the figure, is sent

alerting our enrollment specialist that no changes can made while the file is being loaded.



Once we receive the 834 file, the file is translated using our electronic data interchange (EDI) tool that can parse and convert data from one format to another (such as XML, AS2 or X12). After translation, the file runs through pre-processing. Pre-processing includes assigning group numbers associated with the applicable rate codes and PCPs. Pre-processing also identifies members in Health Homes, pregnant members and members who are in the Children with Special Health Care Needs (CSHCN) program. The membership is then downloaded to SQL. All members are terminated with a term date of the previous month and then reinstated with a start date of the first day of the current month. New members are also added during this process. After the pre-processing is completed, an email is generated that alerts Information Technology (IT) staff the process has been completed. IT staff begins the manual back-end run process.

Monitoring for Accuracy

Our system automatically performs accuracy verifications on several enrollment file fields:

- Invalid state/ZIP code
- Medicaid ID switches

- Missing Medicaid ID
- Name check
- Newborn status

If the system flags any potential issues, reports are generated and are investigated by our Medicaid team.

Additional Remediation Reports to Verify Accuracy

Outside of the standard 834 verification of fields above, additional reports are developed and reviewed by our MHT member advocate to verify the accuracy of the information and to perform the appropriate remediation to correct inaccuracies. Some examples of the monthly remediation reports are:

- Members with out-of-state addresses
  - This report is sent to BMS for client services to investigate to determine if member should still be receiving West Virginia Medicaid benefits.
- Members who are over the age of 65
  - This report is sent to BMS for client services to work with the member in obtaining the appropriate Medicare services.
- Members whose MAID number changed from previous enrollment files
  - Our MHT member advocate works with BMS to determine the appropriate ID number for the member. Once the investigation is complete, our enrollment specialist updates the member record with the correct information.
- Newborns outside of 90-day eligibility that did not show on enrollment file
  - Our MHT member advocate investigates the MMIS system to determine if the newborn has been enrolled with another MCO, fee-for-service or Foster Care. Once determined, our enrollment specialist makes the appropriate changes within HEART.
- Retroactive Terminations/Additions
  - Our MHT member advocate works with our eligibility specialist to make the appropriate effective or termination dates in the system.

Producing and Mailing ID Cards

Once processed, we send ID cards to new or re-enrolled members. As part of our workflow, we send an electronic file to our print vendor to produce and mail ID cards and/or welcome packets, depending upon if the member is new or re-enrolled. If the

member is re-enrolled, they receive only the ID card along with information on how to obtain their Member Handbook—either by contacting THP customer service to request a printed copy or via download at THP's website.

Tracking Member Preferences

The ability to identify and track member preferences facilitates a member's transition to managed Medicaid. We understand and fully support BMS' requirements for the tracking of member preferences on the enrollment record. We monitor and act on important indicators such as member PCP preference, member language and other cultural competency needs, as well as member preferences for communication. For example, we use the State's TTY service for members who are deaf, and Cyracom, a telephonic interpretive service, to provide welcome calls for non-English speaking members. We also offer packets in alternate forms per member needs (e.g., Braille, large print, audio, other languages).

If a member does not select a PCP during enrollment, we auto-assign a PCP in accordance with Section 3.2.2 Assignment of Primary Care Provider in the Service Provider Agreement and based upon the member's prior PCP relationship, member location, age, gender and claims history, in that order.

Immediate Member Care via Stratification

In addition to the enrollment file, we receive a comment file that includes codes that allow members to immediately move into care management or complex case management (e.g., CSHCN, pregnancy, diabetes). Members with these codes are directly assigned to a care navigator for care management or other referrals.

Monthly, we also receive from the enrollment broker completed hard copy enrollment forms from our members. Our customer service representatives (CSRs) review these forms for identifiers such as pregnancy, transplants, being treated for particular medical conditions, asthma, etc. If the member answers "yes" to an identifier, a referral from our CSR to the applicable department is initiated. Besides medical identifiers on the enrollment form, we review if the member has other insurance. If the member answers "yes," the information is sent to our coordination of benefits department for verification.

Within the welcome packet that is mailed to all new members, we include a health risk assessment (HRA). The HRA screens members for medical, functional and social needs. We also complete a welcome call follow-up to the mailing and follow-up postcard reminders (if no phone contact) after each attempt within the first 30 calendar days of enrollment, per NCQA requirements. We make four separate attempts—through telephonic (at different days and times) and then postal means (welcome packet and postcards)—to complete the HRA.

Completed HRAs guide initial risk stratification and determine any further action regarding the member. For example, we may ask a clinician to outreach to a member to complete a more detailed, comprehensive HRA. Depending upon the results of this comprehensive HRA, we may recommend a member for care management or engage the member in a discussion of disease management programs, wellness/prevention and applicable value-added services. Lastly, we engage in discussions with members regarding chronic illnesses, use of out-of-network providers or recommendations to close gaps in care.

We track member engagement in various programs or as they are part of other initiatives. For example, in the figure, the red font indicates that the member is in a care coordination program via our value-based payment agreement with WVU Medicine.

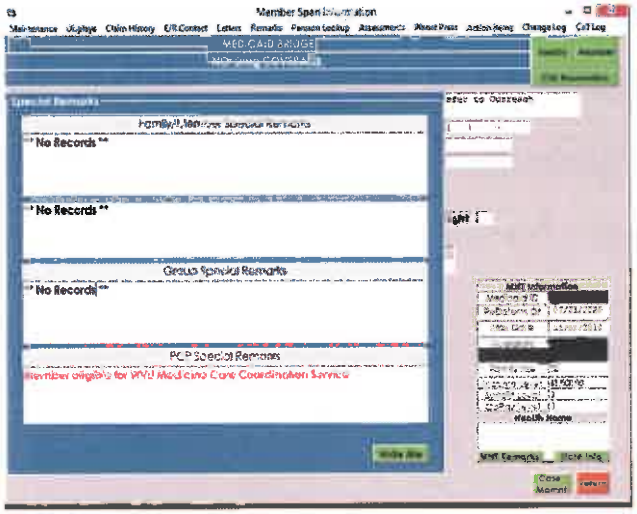


Figure 2: Tracking Member Engagement. We track our member engagement in various programs or other initiatives. This screen shot indicates the member is eligible for WVU Medicine's care coordination program via our value-based payment agreement with WVU Medicine.

Engaging Welcome Calls

Welcome calls are important to help members transition to Medicaid and to reduce the stress involved with changing health insurance. These welcome calls will be especially important for WVCHIP members as they transition from fee-for-service to MHT. Our welcome calls are designed to be informative and to help members understand their available benefits and how to access them. Welcome calls are an opportunity to educate the member about the importance of a PCP, appropriate use of the emergency room (ER), the importance of Early and Periodic Screening, Diagnostic and Treatment (EPSDT)/Well Child Visits and enrollment in programs such as WIC, Right from the Start, tobacco cessation, working with a dietician, disability outreach and other community resources that enhance member welfare.

ED002: The Vendor should describe its policies and procedures regarding disenrollment of members, including processes for reconciliation of members against the monthly 820 capitation file.

Low Member-Initiated Disenrollment
As a testament to our member engagement, less than 1% of THP members request disenrollment (churn rate, measured as members who moved to another MCO).

To reduce the fragmentation of healthcare delivery and member care, it is important to provide members with uninterrupted care. We understand that members who are satisfied with our services are less likely to seek disenrollment. We consistently demonstrate our abilities to resolve issues so that requested member disenrollment is an unlikely event. Our personnel, including the MHT member advocate, CSRs, care managers and outreach member advocates, work with members to identify any barriers and quickly resolve issues to ensure they can access the care they need.

However, we understand that disenrollment occurs and have established policies and procedures to effectively manage disenrollment and to maximize continuity of care for our Medicaid and WVCHIP members.

Disenrollment Policies and Procedures

We inform members of their disenrollment rights as part of the new member orientation process, in the Member Handbook and on our website. A member may request disenrollment at any time, per Section 3.2.4.3 Enrollee-Initiated Disenrollment in the Service Provider Agreement, by contacting the enrollment broker directly.

Member-initiated Disenrollment

When we receive notification that a member wishes to disenroll outside of the monthly enrollment file, we work directly with the enrollment broker to facilitate this request. The

enrollment broker documents the disenrollment information on the 834 file. We document the disenrollment date and the reason in our HEART system.

MCO-initiated Disenrollment

We understand that BMS allows MCO-initiated disenrollment for a limited number of reasons, as specified in the Service Provider Agreement, Article III, Section 3.2.4 Disenrollments, including:

- Loss of eligibility for Medicaid or for participation in Medicaid managed care or WVCHIP.
- The beneficiary's permanent residence changes to a location outside the MCO's Medicaid service area. However, if the resident moves to a location serviced by other MCOs, the resident must reenroll into a new MCO as soon as administratively possible.
- Continuous placement in a nursing facility or intermediate care facility for more than 30 calendar days.
- Error in enrollment. This may occur if the beneficiary was inaccurately classified as eligible for enrollment in an MCO, if the beneficiary does not meet the eligibility requirements for eligibility groups permitted to enroll in an MCO, or after a request for exemption is approved if the enrollment broker enrolled the beneficiary while their exemption request was being considered.
- Beneficiary death.

When we initiate a disenrollment request with BMS, we cite one of the above reasons. Note that for the 30-plus day stays in nursing facility, or intermediate care facility, we will notify BMS within 5 business days following the end of the 30-day stay.

Based upon our request, BMS will approve or deny disenrollment. BMS notifies the fiscal agent of the loss of eligibility.

Once we receive the disenrollment information from the fiscal agent, we document the disenrollment date in our HEART system.

820 Capitation File Reconciliation Process

Jeanette Williams, MHT Member Advocate, works with our finance team to review and investigate any discrepancies with the 820 file. Once she has completed the investigation, she works with BMS and the fiscal agent to correct future 820 payments paid by the fiscal agent to THP after a member has been disenrolled. We greatly exceed BMS' 820 capitation resolution requirements of 45 calendar days. We protect Medicaid funds by addressing recoupments within 30 calendar days, an average of 90% of the time.

Preventing Member Coverage Breaks During Redetermination

Our policies and procedures also minimize member breaks in coverage due to the member's failure to reenroll during the redetermination period. We enhance member continuity of care through various processes:

- ***Postcard Reminder:*** Thirty days prior to the member's redetermination date, we send a postcard to the member reminding them to take action.
- ***Regional Review of Disenrollment:*** Monthly, we look at counties with a high disenrollment percentage and investigate the reason for the high disenrollment. For example, we want to know if a provider leaving the area led to high disenrollment. This process helps us identify trends that may not be otherwise easily found.
- ***Customer Service Reminders:*** CSRs remind members of their redetermination date. The CSR also explains the value of

Figure 3: Timely Postcard Reminder. We send a postcard to members approximately 30 days prior to their redetermination date, reminding them to take action.

maintaining their eligibility and continuity of care.

- ***Provider Office Posters:*** Our disenrollment postcard is now a poster that we offer to providers. Providers may hang the poster in their offices as a reminder for MHT enrollees to stay enrolled.
- ***Disenrollment Survey:*** With the new MHT contract, we will pilot a disenrollment survey to members. As part of this survey, we will request member feedback on the reasons for disenrollment. We will analyze this feedback to determine if there are trends and, if so, take appropriate steps to reduce disenrollment.

ED003: 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.

THP's dedicated newborn enrollment specialist enables us to greatly exceed contract requirements by enrolling newborns three weeks sooner than contract requirements so newborns can get the care they need to be as healthy as possible, as quickly as possible.

Newborn Enrollment Results
We enroll newborns within an average of 7 calendar days, versus the BMS-contracted requirements of processing newborn enrollment completion within 30 calendar days.

To manage the additional WVCHIP membership, we will hire an enrollment specialist who also will quickly enroll newborns to ensure that we continue to exceed this requirement.

Policies, Procedures and Protocols for Enrollment Newborns

It is important to note that we do not rely on a birth before we engage our Medicaid or WVCHIP pregnant members. When we find out that a member is pregnant, either through claims data or another source (e.g., identified during the outbound welcome call with a new member or reviewing the paper enrollment form from the enrollment broker), we outreach to her to educate her about available benefits, programs and value-added services, including our Pregnancy Care Program. As part of this outreach, we educate the member on how to enroll the newborn.

Once the baby is born, we receive notification of the admission/delivery from our medical management department. This notification triggers our newborn enrollment process, and we assign a dedicated Enrollment Specialist to complete the enrollment. The Enrollment Specialist outreaches to the mother and to the hospital to obtain needed enrollment information, including verifying the mailing address for both the newborn and the mother. The Enrollment Specialist enters this information into our HEART system, including the anticipated termination date of either 60 or 90 days, as defined by BMS coverage rules.

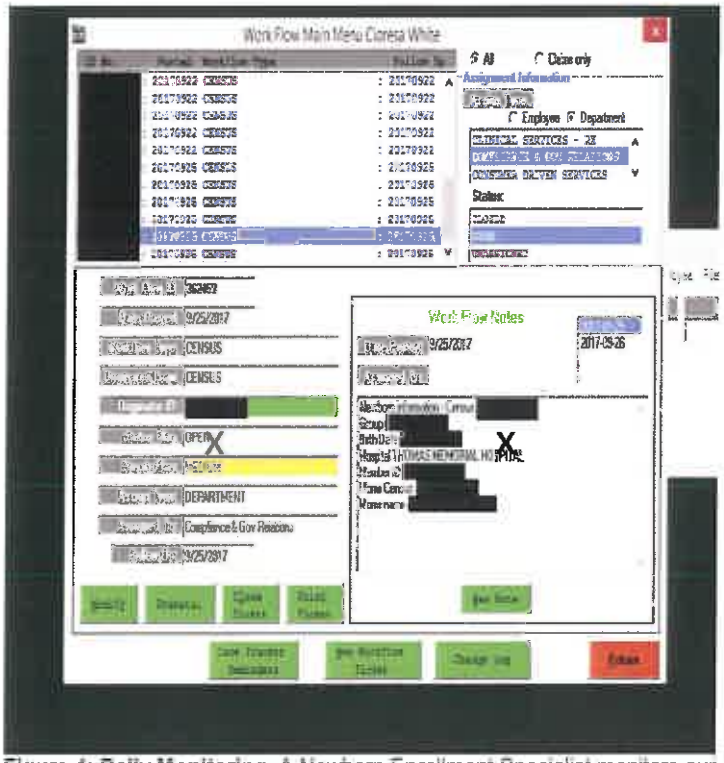


Figure 4: Daily Monitoring. A Newborn Enrollment Specialist monitors our our Work Flow module within HEART every day. Work Flow notifies us when a baby is born, allowing us to quickly outreach and enroll the newborn.

One of the unique steps in our newborn enrollment process is that our Enrollment Specialist sends a second copy of the newborn enrollment form to our utilization review support staff so the new THP Medicaid number can be entered in HEART on the newborn census/authorization.

Once the newborn is enrolled in our HEART system, we send:

- Enrollment information to the enrollment broker. We send this information daily to generate the eligibility file.
- Welcome letter to the member. This letter includes the member ID cards with PCP assignment on them. This information is distributed within 5 calendar days of enrollment and meets BMS contractual requirements.

- A welcome packet to the member. Our welcome packets include:
  - Initial health risk assessment (HRA)
  - Preventive guidelines for adults and children
  - How to access the Member Handbook and information about NEMT, WIC, CSHCN program, the Right from the Start program and a free cell phone.

ED004: The Vendor should describe its protocols to cover newborns even if the mother does not remain enrolled after the newborn's date of birth.

Newborn Coverage with a Disenrolled Mother After Birth

When a mother is disenrolled after birth, our processes verify that we continue to cover the newborn per BMS coverage rules. We enroll each newborn as a new, individual member and assign him/her a THP Medicaid ID number. As a result, we continue to cover the newborn even if the mother is disenrolled.

Regardless of the mother's enrollment status, we enroll the newborn through our newborn enrollment process, described above.

If the newborn needs care management (e.g., NICU, NAS), we engage our nurse navigator. The nurse navigator oversees the process and, if needed, makes sure that the newborn is directed to the correct program (e.g., CSHCN, foster care).

We continue to cover the newborn for either 60 or 90 days, as defined by BMS coverage rules or until notified by BMS.

ED005: 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.

Member Information Transfer to Another MCO or FFS

When a member transfers to another MCO or fee-for-service, the receiving MCO/fee-for-service vendor has the ability to send a request for the member record and treatment plan. Depending upon the size of the file, we provide the requested

information to the appropriate contact person at the MCO via secure email or through a secure FTP site.

Successfully transitioning members to THP

When an MCO left the MHT program in 2019, we successfully transitioned 16,000 members to THP. We accomplished this through data transfers between our two organizations and weekly calls with the other MCO's care managers to discuss member transitions. Also, the other MCO produced a report of members who were in the hospital on their termination date to cleanly transition the members to us.

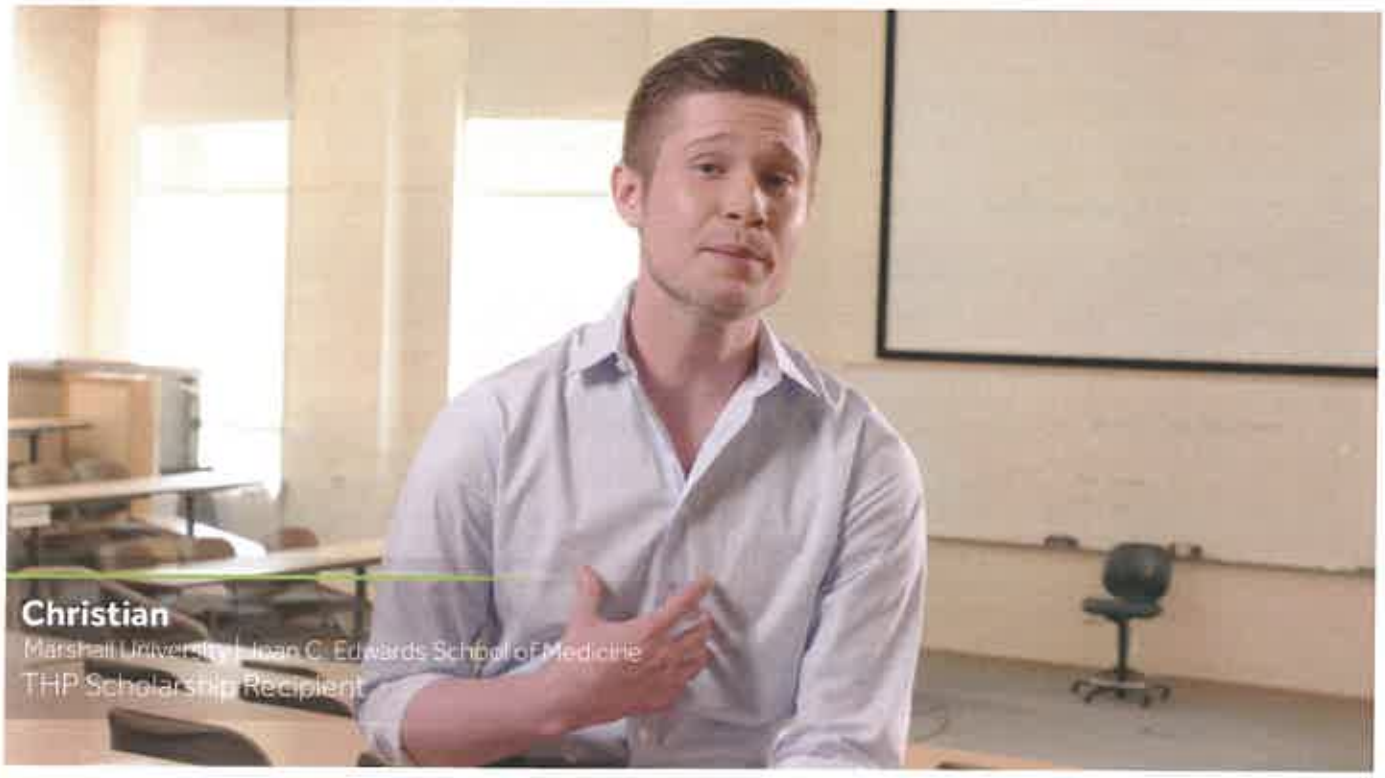
In addition to the 2019 transition, we successfully transitioned large groups of members to THP:

- 2015 Medicaid expansion and behavioral health (35,000 members)
- 2017 SSI expansion (10,000 members)

As such, we are prepared to accept WVCHIP membership and, as appropriate, additional MHT membership.

WVCHIP Transition

We anticipate using our established enrollment process to successfully transition WVCHIP members to THP with the new contract. Our process is scalable, and we will easily accommodate the change to daily 834 files for WVCHIP.



Attachment 6
Network Development

7. Network Development

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Network Development (ND) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

The Health Plan (THP) provides a robust, geographically accessible provider network to our members. We operate an established Medicaid provider network and have been privileged to serve West Virginia Medicaid members for 24 years. THP initially established our Medicaid provider network in 1996 when we first received a state award to serve West Virginia Medicaid members. We became certified in all 55 West Virginia counties in 2013 and our network has supported Medicaid Expansion members since 2015. Since that time, we have continued to develop, expand and refine our network to provide improved access and convenience to our members.

ND001: 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.

Established Medicaid Network

In compliance with **MD004**, our existing Medicaid network includes geographically accessible providers in all 55 West Virginia counties and across all provider specialty types, including physical and behavioral health, for both adult and pediatric populations. In addition, THP completed an analysis of providers who currently only contract to provide services to WVCHIP members. To further develop our network to better serve the WVCHIP population, THP will complete outreach to those WVCHIP providers with invitations to join the THP network to ensure those members experience uninterrupted care with their established providers. THP routinely monitors our compliance with geographic network adequacy standards as defined in Attachment J of the Service Provider Agreement. If geographic network deficiencies are identified, we develop and

implement a plan for improvement. THP leverages a variety of resources to identify additional providers to mitigate network deficiencies, including our Commercial and Medicare Advantage provider networks, published network data from other West Virginia health plans, the West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine. The table provides a summary of our THP network by key provider categories.

THP Network Summary by Provider Category	
Provider Type	**Network Summary and Status**
Hospitals	THP has a comprehensive hospital network and holds existing Medicaid contracts with all West Virginia hospitals and many additional hospitals in contiguous states, which includes facilities in bordering counties and major referral hospitals for pediatric members. These contracts include, but are not limited to, Akron Children's Hospital, Children's Hospital of Cincinnati, Nationwide Children's Hospital in Columbus, UPMC Children's Hospital in Pittsburgh and Winchester Medical Center.
Primary Care	THP maintains a complete primary care network that maximizes geographic network coverage. Our network includes 2,891 contracted primary care providers (PCPs) who serve Medicaid members in practice locations across West Virginia and contiguous counties in Ohio, Pennsylvania, Maryland, Virginia and Kentucky. THP recently assessed our network against the primary care network standards defined in Attachment J of the Service Provider Agreement. Our current network affords 100% of our Mountain Health Trust (MHT) members with access to two or more adult and/or pediatric PCPs within the 20-mile geographic access standard. Additional WVCHIP providers will be added as noted above.
Specialty Care	THP has an established specialty care network for Medicaid members. We evaluate and monitor the adequacy of our network for all BMS-defined provider specialty types to ensure we deliver a comprehensive specialty care network. Additional WVCHIP providers will be added as noted above to further enhance our THP specialty provider network to better serve the WVCHIP population.
Dental	For our adult members over the age of 21, THP contracts with a dental provider network across the state to provide covered emergency dental services, such as emergent extractions, as defined in the MHT member benefit plan. THP also provides payment to non-contracted dental providers who provide care to members. For our pediatric population under the age of 21, THP contracts with SKYGEN USA, LLC as our dental network vendor. SKYGEN provides THP with a monthly provider file that is used to assess geographic network access. THP recently assessed our dental network against the Pediatric Dental Network Access standards defined in Appendix J of the Service Provider Agreement for dentists, oral surgeons and orthodontists. Based upon our current pediatric membership, we confirmed our network affords 100% of our MHT pediatric members with access to at least 2 dentists within 25 miles, and 99.7% of our members with access to an oral surgeon and an orthodontist within 45 miles. With the addition of the WVCHIP membership, THP will continue to assess our compliance with the dental geographic access standards. In the event any network gaps are identified in the future, we will work collaboratively with SKYGEN to establish a plan to identify

THP Network Summary by Provider Category	
Provider Type	**Network Summary and Status**
	additional available providers and remediate the identified network gaps.
Behavioral Health / SUD	THP has developed an extensive network for behavioral health and substance use disorder services. THP is the only Medicaid managed care organization (MCO) that contracts with all Comprehensive Behavioral Health Centers in West Virginia. THP is the only MCO that maintains a Medicaid contract with Northwood Health System. In addition, our network includes all Psychiatric Residential Treatment Facilities and all outpatient and residential Substance Use Disorder (SUD) providers in West Virginia.
Other Required Provider Types / Specialties	THP's existing network includes other required provider types, such as Essential Community Providers. Our network includes all West Virginia Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), as well as additional FQHC and RHC locations in bordering states including Maryland, Virginia, Ohio and Pennsylvania. In the event BMS identifies additional required provider types when it promotes the objectives of the Medicaid program as determined by CMS, THP will contract with a sufficient number of providers, where providers are available, who are accepting new patients and will meet the standard of at least one provider within 20 miles or 30 minutes travel time for both adult and pediatric populations.

Our commitment to West Virginia goes far beyond our development and management of a comprehensive provider network. We care about the people in our community. Our provider engagement representatives collaborate with community organizations throughout the year and across the state to support local health and wellness initiatives, to educate regarding accessibility and cultural competency, and to advance programs to address social determinants of health (SDOH). THP is deeply committed to improving our communities and the health and wellness of the vulnerable populations of West Virginia.

THP Community Support
"As a Family Resource Network, we host and participate in a variety of community meetings both countywide and region wide. Representatives from THP are typically present and engaged in discussions relating to disabilities, health and wellness, substance use prevention, child abuse prevention, and community needs in general. The Health Plan is willing to share ideas and move forward with implementing those ideas to better West Virginia."

- *Claudia Raymer*
Executive Director, Ohio FRN
12/12/19 letter

In addition to our comprehensive provider network and expansive community engagement, THP will offer Teladoc as a value-added service to help enhance

members' access to care. Teladoc is our 24/7 telehealth service for members to access medical, behavioral health and dermatology care via phone, video or app. Teladoc is the first telehealth provider to receive NCQA certification for its physician credentialing process and is the only telehealth provider to receive NCQA certification twice and pass both certifications with a perfect score of 100%. Teladoc physicians are board-certified and state-licensed with an average of 25 years of practice experience.

Expanding Access to Care

THP is offering Teladoc as part of this RFP response in part to help address our members' access to care barriers. Our members sometimes encounter difficultly scheduling or attending appointments to secure a diagnosis or refills for needed medication to treat their behavioral health conditions. Any delay in diagnosis or gaps in receiving prescriptions has a major impact on the member's overall health and quality of life.

THP recognizes that Teladoc's psychiatric and psychological capabilities are no substitute for face-to-face care with a primary care and/or specialist provider. Therefore, THP will promote Teladoc as an interim step to stabilize and transition a member to a new or existing primary care provider and/or specialist. THP also will monitor utilization of the service by reviewing submitted claims and filled prescriptions to assure appropriateness of the care rendered.

THP takes a comprehensive, data-driven yet personal approach to network development that includes the following advantages and processes:

- ***Multiple Lines of Business:*** THP has the unique advantage of operating and managing an in-state MCO that offers Commercial HMO/PPO, D-SNP, and Medicare Advantage lines of business. This allows THP to leverage the provider contracts, market knowledge and relationships gained through our other lines of business to build our Medicaid provider network. It also allows us to continually evaluate and enhance our Medicaid network. As we identify and credential new providers to enhance our Commercial, D-SNP and Medicare Advantage networks as a part of the ongoing network monitoring processes, we can add those providers to our Medicaid network.
- ***Provider Engagement Representatives:*** Our seasoned, in-state provider engagement representatives live and work in the communities they serve and possess a deep knowledge of the West Virginia provider community. They also bring a collective 150 years of healthcare and provider network experience and understand the geographic areas with the greatest access concerns and the natural referral patterns across the state. Provider engagement representatives interact with community providers on a personal and continual basis to quickly identify new provider entries into the communities they serve. The regularly scheduled and ad hoc provider meetings hosted by our provider engagement representatives allow them to collect the information needed to immediately

connect with new community providers. This process helps us establish and maintain a comprehensive provider network for Medicaid members.

- ***Claims Analysis:*** We generate and analyze a quarterly non-participating provider claims report to identify any non-contracted providers who submitted claims on behalf of our MHT members. THP's network development team then reaches out to those providers to encourage them to join our Medicaid network.
- ***Member Referral:*** THP maintains a public website, healthplan.org, that promotes member engagement in our network development efforts by encouraging members to nominate their established providers for contracting outreach. That information is reviewed by our internal provider relations team and is then forwarded to our network development department for recruitment.

Network Maintenance

THP is focused on maintaining the geographic accessibility of our Medicaid network. We deploy strategies to ensure our contracted providers maintain a high level of satisfaction with our health plan that drives provider satisfaction and retention. We also have established processes to monitor and maintain the geographic network adequacy and consistency of our provider network:

Outstanding Provider Service
"We hold monthly provider engagement meetings with our provider representative, Hanna Taylor. In these meetings we discuss any claim issues that need resolution. Hanna is a pleasure to work with and provides prompt responses and claim resolutions."

– Jessica Adams,
RMC Physician Billing Manager
Wheeling Hospital
1/8/20 letter

"The assistance of our Provider Engagement Representative, Marjorie Burdick, has been very valuable to us and has benefited our patients. Having access to a local face-to-face representative has had a positive impact on patient interaction."

– Sarah Chouinard, MD
Chief Medical Officer
Community Care of West Virginia
12/20/19 letter

- ***Provider Service and Support:*** THP is committed to affording our network providers the highest level of provider service. Our provider support model includes three separate teams of provider support personnel who all work collaboratively and cohesively to drive provider satisfaction and retention:
  - ***Customer Service Representatives*** (CSRs) in our Charleston, West Virginia customer service call center manage incoming provider inquiries and assist providers with the majority of their routine questions and concerns.
  - ***Provider Relations Representatives*** provide internal telephonic support for more complex provider issues such as electronic claim rejections, issues with provider electronic data interchange (EDI) submissions, administrative issues

relative to the secure provider portal, management of provider demographic data changes and resolution of complex claim projects.

- ***Provider Engagement Representatives*** work directly in the field with providers and their staff to validate provider roster and demographic data to ensure provider directory accuracy, complete provider training and education, provide cultural competency training, attend professional organization meetings and conferences to provide payer updates, collaborate with THP's quality management team for retrieval of medical records for HEDIS audits, provide education on SDOH, and assist with issue resolution to drive provider engagement and satisfaction.

- ***Ongoing Network Validation:*** Provider engagement representatives request validation of provider roster information and provider demographic data during provider site visits on an ongoing basis. The collection of this information assists THP in maintaining accurate information regarding providers joining and leaving participating practices and helps to drive the accuracy of our provider directory.
- ***Annual Member Experience Analysis:*** Annually, THP completes an analysis of our members' experience with our provider network. The analysis includes:
  - A review of member complaints and appeals relative to network adequacy
  - Analysis of Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results
  - Analysis of out-of-network utilization and requests
  - The provider network department then assesses the results of the Member Experience Analysis by geographic area and practitioner type to identify potential network gaps, identifies areas for network enhancement and prioritizes network recruitment efforts based on importance and risk related to member access. The provider network department measures the effectiveness of interventions and recruitment efforts and reports the results to the Clinical Quality Improvement Workgroup for review.
- ***Geographic Network Adequacy Monitoring:*** Annually, THP assesses the geographic network adequacy of our provider network against the Provider Network Standards defined in Appendix J of the Service Provider Agreement. In the event network deficiencies are identified, they are documented and we create and implement a plan for improvement based upon identified available providers. Detailed information regarding our Geographic Network Adequacy Monitoring process can be found in our response to **ND011**.

As a result, THP maintains a highly stable and reliable provider network. The table provides key data regarding our network turnover rates for 2019.

THP Network Turnover Summary		
Turnover Rate	**Turnover Type**	**Definition**
5%	Voluntary Turnover	Includes providers who are no longer practicing due to death, retirement, relocation out of state, etc.
1%	THP Terminations	Includes providers with loss of license, adverse actions, etc.
1%	Involuntary Turnover	Includes providers who elect to terminate their contract with THP.

ND002: 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.

THP has an established, accessible provider network that has provided care and services to MHT members since 1996 when we first received a state award to serve West Virginia Medicaid members. We maintain and monitor our network to ensure we provide a network of appropriate, credentialed providers, supported by signed contracts that is sufficient to provide adequate access to all covered services to meet the needs of our members. We use a variety of processes to validate that we have established and maintain a high-quality provider network for MHT members. Our network is:

- ***Accessible:*** THP assesses member access to all covered services through our network monitoring and geographic network evaluation processes as further defined in our response to **ND003-ND008** and **ND011**. We deploy multiple network assessment and monitoring procedures that allow us to continuously monitor our network to ensure we maximize access to our members. Those processes include: analysis of geographic network adequacy, evaluation of provider-to-member ratios, assessment of member experience data to evaluate our members' experience and satisfaction with their network access, review of non-participating provider claim reports to identify opportunities to expand our network, assessment of timely access to appointments, and utilization of our member referral process that allows our members recommend providers to our network. THP also collects data regarding accessibility and ADA compliance during our initial credentialing processes and through our site surveys completed with primary care, OB/GYN and behavioral health providers. We publish provider accessibility status in our provider directories to assist members with disabilities to select accessible providers for their care.
- ***Contracted:*** All THP network providers have executed a signed provider agreement that they are compliant with all federal regulations. THP's provider agreements and addenda are consistent with provider contract requirements defined in the Service Provider Agreement, Section 2.6.3 Provider Contract. Our

provider agreement templates were previously submitted to and approved by BMS. We will continue to provide these templates and addenda for BMS approval per **MD005**. THP maintains copies of our fully executed provider agreements.

- ***Credentialed:*** All THP network providers have completed our initial provider credentialing process. The credentialing/re-credentialing process assures we maintain a high-quality provider network and is validated through external entities who perform periodic audits of our processes through file review. Those entities include NCQA at the time of our accreditation audit and the External Quality Review Organization (EQRO) audit. Our provider engagement representatives complete site visit surveys as a component of our initial credentialing process for certain provider types including PCPs, OB/GYN providers and high volume/high impact specialists as defined in the Service Provider Agreement, Section 2.1.6 Additional Credentialing and Recredentialing Criteria for Certain Providers (and as further detailed in **ND018**). THP validates the ongoing credentials of our network providers by re-credentialing all network providers every three years, and through our ongoing provider monitoring processes. Our ongoing monitoring processes include a monthly review of actions by state licensing boards and other regulatory agencies as well as a review of other Medicare Sanction actions as defined in Medicare sanction and reinstatement reports, the Office of Inspector General (OIG), Medicare Opt-Out reports, System for Award Management (SAM) and the CMS Preclusion List (as further defined in **ND015**).

ND003: 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: The anticipated MHT enrollment and the appropriate PCP provider-to-member ratios for adult and pediatric members

ND005: The expected utilization of services for the anticipated MHT populations assigned to the Vendor for care

ND006: The number of providers not accepting new patients

ND007: The geographic location of providers and members, considering time and distance, and transportation needs

ND008: 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)

THP has mature network development and monitoring processes that assist us in ensuring that our Medicaid provider network is and remains sufficient to provide MHT members with access to covered services that meet their needs. The table provides a summary of the key processes we use when monitoring our Medicaid network and to stay in compliance with **MD010**.

THP Network Development and Monitoring Considerations and Processes	
Monitoring Process Consideration	**Process Summary**
The anticipated MHT enrollment and the appropriate PCP provider-to-member ratios for adult and pediatric members (ND004)	Per BMS contract requirements, THP annually assesses our provider-to-member ratios as compared to BMS standards. THP receives a spreadsheet from BMS that defines the number of PCPs and OB/GYN providers required, on a county by county basis, to meet the BMS provider-to-member ratio standard based upon THP membership estimates. THP completes the spreadsheet with the number of contracted PCPs and OB/GYN providers in each county, and the number of providers required is compared to the number of contracted providers to identify any deficiencies. In the 2018 report, THP exceeded the number of required providers for all provider types and counties. As BMS implements pediatric-specific standards in 2020, THP will begin to assess provider-to-member ratios for our pediatric members. With the abundance of contracted providers, we do not anticipate any concerns with meeting and exceeding the adult and pediatric standards as defined in Attachment J of the Service Provider Agreement.
The expected utilization of services for the anticipated MHT population (ND005)	We monitor and trend rates of preventive care services, including cancer screenings, immunizations and well visits, to ensure individuals are receiving the appropriate evidence-based care. We also monitor evidence-based services related to disease specific care, such as statin therapy for cardiovascular disease and diabetes, medication management for people with asthma, and adherence to effectiveness of care in people with severe and persistent mental illness (SPMI). Utilization reports are generated and analyzed on all-cause readmissions, low back imaging and prenatal and post-partum care. The data is reported to the Medicaid Oversight Workgroup to follow trends across the state and determine if further drill down, investigation or corrective action is needed based on patterns of care. Additionally, through our Provider Analytics Program, trends of practice pattern variations with peer-to-peer comparison are identified and reviewed with both Medicaid Oversight Workgroup and Medical Directors Oversight Committee. To ensure network adequacy, the provider network department annually completes an analysis by evaluating member experience with the THP network. The analysis includes: ▪ Evaluation of member complaints and appeals relative to access and network adequacy ▪ Review of CAHPS survey results ▪ Evaluation of out-of-network pre-authorization service requests to identify potential geographic or provider specialty type deficiencies ▪ Analysis of a report of both paid and denied claims for professional and facility out-of-network providers to identify potential network deficiencies or opportunities to add to our contracted network of providers Results are analyzed by geographic area and provider type to identify potential network gaps. The provider network department summarizes opportunities and prioritizes interventions based upon member need and risk related to member access. Identified interventions to address network deficiencies are implemented, and the provider network department measures the effectiveness. Results

THP Network Development and Monitoring Considerations and Processes	
Monitoring Process Consideration	**Process Summary**
	are reported to the Clinical Quality Improvement Workgroup by the quality management department.
The number of providers not accepting new patients (ND006)	THP collects information regarding primary care and OB/GYN provider panel status (open versus accepting established patients only) at the time of initial credentialing and annually during provider directory accuracy audits. When a PCP is identified as not accepting new patients, THP flags their provider screen as such to prevent new members from being added to the provider's panel through customer service requests or through the auto-assignment process. The provider's panel status is updated in the provider directory. THP does require providers who request a closed panel status to maintain that same status with other plans to ensure parity. Monthly, THP reviews a report that defines the number of Medicaid members assigned to primary care and OB/GYN providers. In the event an individual provider's assigned members reaches the 2,000 member limit, THP flags the provider screen to designate the provider is either accepting established patients only or that the provider is not accepting new patients, and the provider directory is updated with the provider's panel status. Providers are notified in writing of the panel status change. THP's provider directory also designates other provider practice restrictions, including age, gender and other practice restrictions. When assessing geographic network adequacy, THP removes all providers without an open panel status to ensure that providers with a closed panel status are not being counted toward geographic network adequacy. THP does allow certified nurse practitioners and physician assistants to serve as PCPs.
The geographic location of providers and members, considering time and distance, and transportation needs (ND007)	Annually, THP completes a geographic network adequacy monitoring analysis to assess the geographic network adequacy of our provider network against the Provider Network Standards defined in Appendix J of the Service Provider Agreement. In the event network deficiencies are identified, we create and implement a plan for improvement based upon identified available providers. Additional detail regarding our geographic network adequacy monitoring can be found in the response for ND011. Our goal is to meet or exceed the geographic network access standards, where providers are available, to minimize transportation burdens on our MHT members. THP does provide information regarding member transportation benefits and how to access services in our Member Handbook, website at healthplan.org, provider manual, newsletters and other communications.
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) (ND008)	THP collects and documents data regarding accessibility and ADA compliance during our initial credentialing processes and through site review surveys conducted by provider engagement representatives. Site review surveys are conducted on all new PCPs, OB/GYNs and high volume/high impact providers (which includes behavioral health providers). Our site visit survey tool includes validation that provider locations have wheelchair accessibility and ADA compliance relative to exam tables, scales and other equipment for diagnosis and treatment. We publish provider accessibility status in our provider

THP Network Development and Monitoring Considerations and Processes	
Monitoring Process Consideration	**Process Summary**
	directories to assist members with disabilities in selecting accessible providers for their care. THP also completes an analysis to ensure the needs of members with limited English proficiency are being met. Those processes are defined in more detail in the response to ND009.

ND009: The Vendor should describe how they ensure its provider network will provide culturally competent care to members.

THP is committed to ensuring our members receive services in a culturally competent manner. Members are educated regarding how to request assistance with language interpretation needs in our Member Handbook. We evaluate the network's cultural and linguistic needs on an annual basis. Membership-specific data reveals that in West Virginia, 97.6% of our members speak only English, 1.0% Spanish, 0.9 % Indo-European languages, 0.4% Asian or Pacific Island languages and 0.2% speak languages other than those listed above.

During 2018, THP received only 25 language translation requests via customer service. These requests represent .0057% of all customer service calls received during 2018. Of these translation requests, 19 were for Spanish translation services, 5 were for Chinese/Mandarin language services and 1 caller requested Arabic language services. Although the current prevalence of linguistic and cultural diversity in West Virginia does not require publication of member materials in other languages, THP continues to evaluate the cultural diversity of our Medicaid membership to ensure our network composition and cultural training curriculum are appropriate to serve our members' needs. We leverage a variety of tools and processes to evaluate the cultural needs of our members and to assist our network providers in delivering culturally competent care. The table provides a summary of the key processes we use for this purpose.

THP Processes to Ensure Delivery of Culturally Competent Care to Members	
Process/Resource	**Process Summary**
Network Composition / Monitoring Plan	THP conducts an annual analysis to identify unmet member needs through evaluation of: ▪ Member complaint data ▪ Member survey data including CAHPS data ▪ U.S. Census data for the THP service area ▪ Member enrollment data ▪ Network practitioner languages spoken An analysis is completed to identify unmet member cultural/linguistic needs and to identify if provider recruitment is required to better address member linguistic or cultural/ethnic requirements. Data regarding providers who speak languages other than English is collected at the time of credentialing and re-credentialing. Our CSRs have access to this information when they are assisting members telephonically, and the information is published in our provider directories to assist members in selecting providers who best meet their cultural and linguistic needs.
Translation Vendor	THP contracts with Cyracom as our translation vendor, who provides translation services in 80 different languages.
ADA Accessibility Information	ADA accessibility information is collected from providers during the initial credentialing process for all provider types, and detailed accessibility information is collected and validated during provider site visits for PCPs, OB/GYN providers and high volume/high impact specialists (including behavioral health). Our site visit survey tool includes validation that provider locations have wheelchair accessibility and ADA compliance relative to exam tables, scales and other equipment for diagnosis and treatment. We publish provider accessibility status in our provider directories to assist members with disabilities in selecting accessible providers.
Cultural Competency Provider Curriculum	THP has developed a cultural competency, health equity and SDOH training curriculum that meets industry standards and includes: ▪ Definitions of cultural competency ▪ Provider network expectations relative to cultural competence ▪ How cultural differences can influence medical care ▪ Introduction to National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) ▪ Berlin and Fowkes' LEARN for conducting cultural assessments ▪ What providers can do to improve cultural competency ▪ Information on SDOH assessment, coding and referral resources ▪ Links to additional resources
Required Provider Training	THP initially implemented our provider cultural competency training program via webinar in 2018 in response to federal regulations. Since that time we have continued to expand and evolve the program and to complete outreach to additional providers. Providers submit a training completion attestation. THP's director of provider training and education works with our IT department to monitor a list of providers who have not submitted attestation of cultural competency training. Reminders to complete the training are addressed at each opportunity, including workshops, newsletters, conferences and professional organization meetings throughout the year. Providers will be invited to future webinars to receive training. In addition, THP's provider engagement representatives continue to contact PCPs, OB/GYN providers and behavioral health providers who have not submitted an attestation to schedule training dates. The provider engagement representatives also will begin scheduling training with high volume providers in other specialties. THP's provider directories indicate if contracted providers have

THP Processes to Ensure Delivery of Culturally Competent Care to Members	
Process/Resource	**Process Summary**
	completed cultural competency training to assist members with the selection of providers to better meet their needs.
Social Determinants of Health	THP integrated SDOH information into our current cultural competency provider education and training. During the first quarter of 2019, we published an article regarding SDOH in the ProviderFocus quarterly provider newsletter to introduce the topic to network providers. Our updated training demonstrates how cultural competency and SDOH are related. The enhanced training materials are available on THP's provider portal for provider review and attestation and will be included in our 2020 training. A second article in THP's ProviderFocus first quarter 2020 newsletter reminded providers that cultural competency/SDOH training is available for completion and attestation.
Training at Initial Credentialing	THP requires new providers to attest to completion of cultural competency/SDOH training as a provision of their initial credentialing.
On-Site Training	Our provider engagement representatives offer cultural competency/SDOH training to providers and their staff during on-site reviews and meetings, at conferences and workshops and at various professional organization meetings throughout the year.
Provider Newsletters	THP publishes reminders, information and articles about cultural competency and SDOH in our provider newsletters. Provider newsletters are also published on our provider portal.
Provider Resources	THP houses our cultural competency/SDOH training presentation on our provider portal along with the training attestation form.

Based upon analysis of the available data, THP believes our network currently meets our members' ethnic, racial, cultural, linguistic and other needs. We will continue to educate our provider network and to monitor and assess the needs of our membership through these processes to ensure members receive culturally competent care.

ND010. 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.

Developed Directory

THP recognizes that members rely upon our provider directory to help them find practitioners. Our fully developed provider directory for our statewide Medicaid network is available in both paper and electronic forms. Our paper provider directory is updated at least monthly, while our electronic provider directory is updated no later than 30 calendar days after our receipt or identification of updated provider information. A current version of our searchable provider directory is available on our website,

healthplan.org. THP's electronic provider directory can be searched by line of business and includes information on all contracted providers including PCPs, specialty providers, general pediatric dentists, behavioral health providers, hospitals, facilities, community clinics and ancillary providers.

The provider data elements in THP's directory include the following:

- Provider/facility name
- Specialty
- Telephone number, address and website (if applicable)
- Confirmation of accommodations for members with disabilities or special needs
- Completion of cultural competency/social determinants of health training (as applicable) indicated with a Y or N
- Languages spoken other than English
- Gender (individual practitioners only)
- If the provider/practice/facility is accepting new patients
- Board certification (as applicable)
- Accreditation and accreditation expiration date (hospitals only)
- Hospital affiliations
- THP lines of business the provider participates in
- Provider type (PCP, Facility, etc.)
- Practice restrictions (professional practitioners only)
- Medical group affiliation (as applicable)
- Date the provider information was last updated

THP provides members with updates to any changes in provider directory data at least 30 calendar days before the intended effective date of the change. We notify members on an annual basis of their right to obtain a provider directory and provide them with information on how a copy of the provider directory can be requested. This information can also be found in our Member Handbook. In compliance with the Service Provider Agreement, we provide existing and potential members with a hard copy of the provider directory within five business days of request.

Maintain Accurate Directory

THP invests significant efforts into maintaining the accuracy of provider data and our provider directory. Every three years, at the time of provider re-credentialing, provider directory information is reviewed for accuracy and verified with the provider to drive provider data accuracy. But beyond that, THP verifies directory data during incoming and outgoing telephonic provider contacts through our CSRs, network team and care navigators. Our provider engagement representatives conduct regular, statewide outreach to provider offices and validation of provider directory data is a key element completed during those field visits. THP, through our provider engagement team, takes a "high touch" approach to working with our providers. We are in their communities every day, collecting information about practice and demographic changes that is immediately and efficiently leveraged to update our directories to ensure our MHT members have accurate, reliable information about their care provider options. Providers can also independently update their provider directory data via THP's provider portal. The figure shows the link where providers can update their provider directory data through THP's website.

Figure 1: Easy to update. Our provider portal, available at healthplan.org, is easy to use and allows providers to quickly and easily update their practice information.

We maintain network provider information in our HEART system, THP's database that houses all member, provider and facility information. We continually update provider contact information in HEART; the changes are reflected the next business day on THP's electronic provider directory. Paper directories are updated within 30 days.

THP also conducts an annual audit of the provider directory data to assess the accuracy of THP's provider data and to identify opportunities for improvement. The annual provider directory audit process includes three key steps as outlined below:

- **Generation of the provider sample:** THP selects a random sample of provider directory practitioners for audit using the sample size calculator provided by Creative Research Systems. To determine our sample size, we use a confidence level of 95% and a confidence interval of 5. In 2019, the required sample size was calculated to be 376 and an over sample of 92 was used to assure an adequate response rate. The annual review sample includes selection from all PCP specialties which include General or Family Practice, Internal Medicine, Pediatrics and Obstetrics and Gynecology, as well as high volume/high impact specialty types that includes Behavioral Health providers, Oncologists, Ophthalmologists, Obstetrics and Gynecology, and Cardiologists. Other High-volume/High-impact providers may be added during the retrieval process.
- **Directory data validation:** Directory data validation is completed using a telephonic survey, conducted by internal plan staff. The survey validates accuracy of data currently found in THP's electronic provider directory. The provider offices are asked to verify the data and provide updated and additional information when applicable. The survey tool collects the following data:
  - Office locations
  - Office telephone numbers
  - Hospital affiliations
  - Whether the provider is accepting new patients
  - The awareness of the provider office staff of the practitioner's participation in THP's network and the applicable lines of business
- **Analysis and report:** In 2019, of the 468 practitioners surveyed, the response rate was 84%. THP sets an internal performance goal of 90% accuracy for each component evaluated in the annual provider directory audit. Our 2019 audit provided the following results:
  - Office locations – 83% accuracy
  - Office telephone numbers – 91% accuracy
  - Hospital affiliations – 90% accuracy
  - Accepting new patients – 96% accuracy
  - Awareness of participation in THP lines of business – 87% accuracy

To identify opportunities for improvement, THP conducts a barrier analysis following review of the annual survey results. Internal participants include representatives from network, provider relations, provider data management, contracting and quality

management. For each barrier identified, THP staff identifies interventions for implementation that afford opportunities for improvement. The analysis and report is submitted to the director of provider operations for review and initiation of action plans to implement identified improvements. The complete report is presented to the Quality Improvement Committee.

Our efforts to maintain accurate provider directories not only benefit our THP members, but the state and other Medicaid members are benefited as well. Through our investigations to ensure the accuracy of our own provider directories, we often identify outdated or inaccurate provider data in the directories of other West Virginia Medicaid MCOs. THP is conscientious about reporting those discrepancies to the State to advance the accuracy of provider directory data for all West Virginia Medicaid members.

ND011. The Vendor should describe its process to ensure its provider network adheres to geographical access standards for all adult and pediatric members.

THP deploys several processes to validate and ensure our provider network adheres to the geographical access standards for adult and pediatric members.

Geographic Network Access Reporting

Because we maintain a mature, well-established Medicaid provider network, THP completes an annual assessment of our geographic access based on the Provider Network Standards defined in Attachment J of the Service Provider Agreement and in accordance with **MD011**. Geographic network access reporting compares the location of members to the location of providers within the geographic access (travel time and distance) standards as defined in the Service Provider Agreement. THP configures our geographic access reporting software with the required geographic network access standards by provider specialty for both adult and pediatric members and then imports

enrolled member and provider data to complete an analysis of the geographic location of members as compared to our network providers. This analysis is conducted on a provider specialty basis.

Adult and pediatric members are evaluated separately and in accordance with their appropriate geographic network access standard. Results are reported by county and include a count of the number of members and providers of each specialty per county, as well as a calculation of the percentage of members who have compliant geographic access as defined by the BMS standard for the given provider specialty. Report results provide both a graphical representation of the network accessibility and any network gaps as well as the written report that defines the percentage of members with the required access by adult and pediatric population, then by provider specialty and then by county. The figure represents a geographic analysis report for PCP coverage in West Virginia and contiguous states.

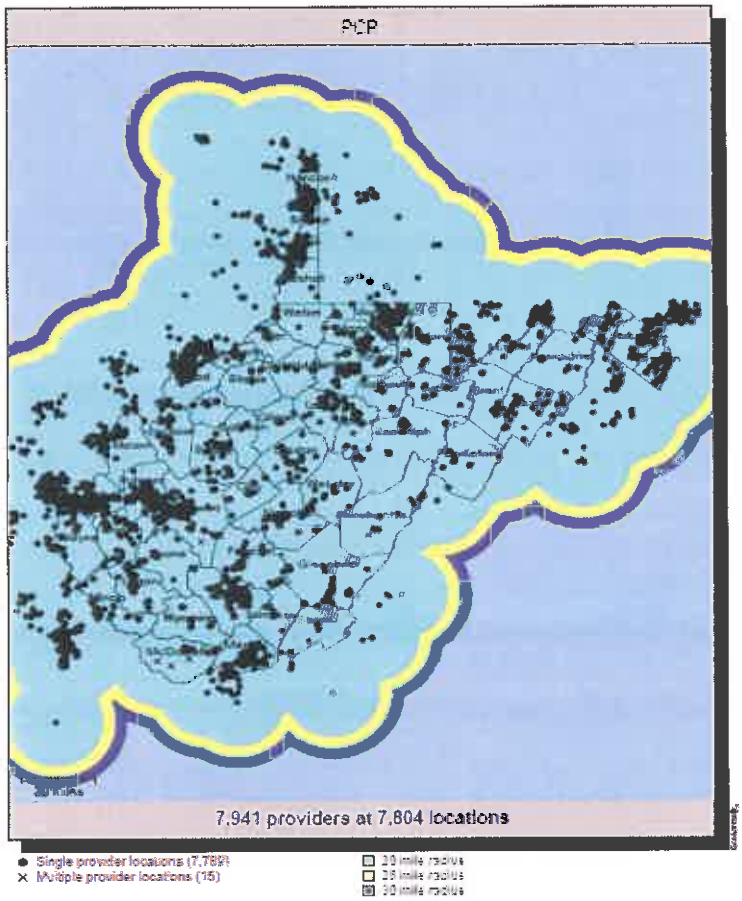


Figure 2: Complete Primary Care Coverage: The practice locations of contracted PCPs are plotted on the state map. We used the geographic distance standard for primary care of at least two providers in 20 miles. A teal circle representing a 20 mile radius is plotted for every PCP location. The fact that the entire state of West Virginia is covered in teal validates the geographic coverage of contracted PCPs.

County access standard detail information

Medicaid Adult Population						
			Employees access to 2 providers			
County	Total number of employees	Total number of providers	Average distance	Pct of employees with 2 providers within x miles		
				20	25	30
BARBOUR - WV	736	29	1.3	100.0	100.0	100.0
BERKELEY - WV	1,502	109	1.5	100.0	100.0	100.0
BOONE - WV	1,005	72	5.4	100.0	100.0	100.0
BRAXTON - WV	430	47	2.4	100.0	100.0	100.0
BROOKE - WV	696	18	1.1	100.0	100.0	100.0
CABELL - WV	1,914	336	0.9	100.0	100.0	100.0
CALHOUN - WV	234	16	4.4	100.0	100.0	100.0
CLAY - WV	435	25	4.3	100.0	100.0	100.0
DODDRIDGE - WV	555	18	0.9	100.0	100.0	100.0
FAYETTE - WV	1,459	148	1.5	100.0	100.0	100.0
GILMER - WV	395	11	4.1	100.0	100.0	100.0
GRANT - WV	560	57	0.6	100.0	100.0	100.0
GREENBRIER - WV	791	158	2.8	100.0	100.0	100.0
HAMPSHIRE - WV	378	43	5.0	100.0	100.0	100.0

Figure 3: Detailed geographical access reporting. A supplemental report is generated for each provider specialty and separately for adult and pediatric members. The report shows the number of members and providers by county and the percent of members with the required geographic access.

Following THP's completion of the geographic network access report, we analyze the data to identify any areas of deficiency by provider specialty and county (e.g. member access below 100% of the defined geographic access standard). The figure outlines the supportive processes THP leverages to identify additional providers, if available, to mitigate the identified network gaps. THP then develops a plan for improvement, based on available providers.

Supportive Processes to Ensure Compliance with Access Standards

THP Supportive Processes to Ensure Compliance with Geographic Access Standards	
Process	**Process Details**
Provider Engagement Representative Review	Our seasoned, in-state provider engagement representatives possess a deep knowledge of the West Virginia provider community; they understand the geographic areas with the greatest access concerns as well as the natural referral patterns across the state. The provider engagement representatives interact with community providers on a personal and continual basis to quickly identify new provider entries into the communities they serve. The regularly scheduled and ad hoc provider meetings scheduled by our provider engagement representatives allow them to collect the information needed to immediately identify and connect with new community providers. Information on the new provider is passed on to the network development team to initiate contract discussions to expand our Medicaid network. This process helps us establish and maintain a comprehensive provider network for our members and resulted in the addition of 745 new network providers last year.
Competitor Networks	As network deficiencies are identified, we research competitor and other health plan published provider network data and compare their network providers to those contracted with THP to identify additional providers we can target for recruitment outreach.
Medical Boards	We work with the West Virginia Board of Medicine and the West Virginia Board of Osteopathic Medicine to identify newly licensed practitioners for targeted network

THP Supportive Processes to Ensure Compliance with Geographic Access Standards	
Process	**Process Details**
	contracting outreach to fill identified network gaps.
Claims Analysis	We generate and analyze a quarterly non-participating provider claims report to identify non-contracted providers who may have submitted claims on behalf of our MHT members. Recruiting non-participating providers could mitigate potential network deficiencies. Our network development team then contacts the providers to encourage them to join our Medicaid network.
Member Referral	THP maintains a public website that promotes member engagement in our network development efforts by encouraging members to nominate their established providers for contracting outreach. That information is forwarded to our network development team for recruitment. Providers identified through the member referral process may also fill identified network deficiencies.
Teladoc	Our new Teladoc value-added service can be leveraged to provide members in rural areas with an absence of providers with easy, fast access to medical services. Teladoc provides 24/7 telehealth services for members to access medical, behavioral health and dermatology care via phone, video or app. (See ND001 response for additional detail regarding Teladoc.)

ND012: 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.

THP has developed a comprehensive network of behavioral health and SUD providers. THP is in full compliance with the state's direction to contract with all Comprehensive Behavioral Health Centers (CBHCs) and is the only Medicaid MCO that currently contracts with all CBHCs and maintains a positive working relationships with Northwood Health Systems. Our network includes all PRTFs and all outpatient and residential SUD providers practicing in West Virginia. In the event new providers or facilities begin practicing in the state, we will immediately initiate network recruitment efforts to add them to our network. With the addition of the WVCHIP population, THP will analyze the WVCHIP

Comprehensive Behavioral Health Center Support

"I am writing this letter in support of The Health Plan's reapplication to manage WV Medicaid's Mountain Health Trust program.

Northwood Health Systems has been a participating provider in The Health Plan's network, working collaboratively and successfully to serve the behavioral health needs of Medicaid recipients throughout the Northern Panhandle since 2015."

– Mark A. Games
President and CEO
Northwood Health Systems
1/23/2020 letter

provider enrollment file and identify any providers who participate only in the WVCHIP program who may not already contract with THP. We will document those recruitment opportunities and use our dedicated behavioral health provider engagement representative to complete the recruitment and contracting activities to bring those additional providers into our network. Our behavioral health provider engagement representative is very active across the state and will continue to identify and capitalize on new provider recruitment opportunities through his understanding of West Virginia and emerging referral patterns.

ND013: 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.

To support network access and availability, and to drive member convenience, THP has defined requirements for network providers relative to hours of operation and parity.

Hours of Operation/Availability

As a part of our network development process, THP requires contracted providers to maintain certain standards relative to hours of operation and availability to support network accessibility and member convenience. PCPs are required to meet the following hours of operation and availability standards:

- Must have 24-hour availability, seven days a week, with backup coverage
- Must list one to two participating practitioners as backups
- Must provide a minimum of 20 hours per week of patient care availability in a county to be considered a PCP in that county. In the instance of practitioners with multiple sites, the alternate location(s) must be within 30 miles or 60 minutes driving time of the primary location and the alternate location(s) must meet all the necessary requirements, as determined appropriate by THP's Credentials Committee or the Executive Management Team
- Must provide coverage 24 hours a day, seven days per week and have privileges at a contracted facility or have arranged with a contracting provider/hospitalist group to handle all inpatient care for patients
- Must maintain at least a 50% primary care practice

Specialty care practitioners are required to meet the following hours of operation and availability standards:

- Must have 24-hour availability, seven days a week, with backup coverage
- Must list one to two participating practitioners as backups
- Must provide a minimum of 20 hours per week of patient care availability in a THP county
- Specialist practitioners who provide patient care access fewer than 20 hours per week in a THP county shall be considered as a practitioner in that region only if the specialty service of the practitioner is not otherwise available through sufficient plan practitioners residing in that region

Providers must acknowledge their understanding and willingness to comply with these standards when requesting to join the network on the THP website. These requirements are also found in the provider contracts, provider manual and provider newsletters. THP validates provider compliance with the hours of operation/availability requirements through several processes, including:

- ***During the initial provider credentialing processes:*** Hours of operation are collected from the credentialing application and are validated.
- ***During re-credentialing:*** We review the Provider Occurrence Screen in THP's HEART system, which is THP's database that houses all member, provider and facility information and is where THP documents issues, complaints and access concerns regarding providers. We review the Provider Occurrence Screen to determine if members have reported quality or access concerns during the time period since the provider's last credentialing. In cases where members have reported quality or access concerns or other complaints, the Provider Occurrence Screen is printed and is included in the documents that are provided to the Credentials Committee for review as part of the re-credentialing consideration.
- During ***provider directory accuracy audits*** via completion of the provider directory accuracy worksheet.
- During provider engagement representative ***site visits.***
- During ***annual after-hours survey audits***. Beginning in 2020, an External Quality Review Organization (EQRO) will be conducting periodic after-hours provider audits. However, THP will continue its after-hours monitoring processes as further defined in **ND014**.

Parity

To support member access to services that are consistent with the access afforded to commercial and other health plans, our network development process requires providers to execute a contract that includes the following verbiage that establishes the requirement for parity relative to hours of operation, appointment availability, in-office wait times and service quality:

"Physician shall not discriminate in the treatment of Members and, except as otherwise required by this Agreement, shall make its services available to Members in the same manner as to its other patients. Furthermore, Physician agrees not to differentiate or discriminate in the treatment of or in the quality of services delivered to Members on the basis of race, national origin, sex, age, religion, ancestry, marital status, sexual orientation, genetic information, place of residence, health status, handicap or by reason of their status as Members."

The parity requirement is also included in our provider manual and provider newsletters and providers are reminded of the requirement during THP provider trainings and during on-site visits by THP's provider engagement representatives.

Member Convenience/Impact

THP monitors the impact to member convenience through our performance on annual CAHPS surveys. THP CAHPS survey data validates that our MHT member report a high degree of satisfaction with their ability to access care in a timely manner. With 5.0 being a perfect score, THP scored a 5.0 for the past two years, and has an average score of 4.9 over the past five years.

ND014: The Vendor should describe its guidelines and monitoring processes that ensure members have timely access to care per contractual requirements.

THP has established guidelines for, and monitors provider compliance with, timely access to care. Our guidelines are:

- ***Emergency Cases:*** Must be seen immediately or referred to an emergency facility
- ***Urgent Cases:*** Must be seen within 48 hours
- ***Routine Cases (other than clinical preventive services):*** Must be seen within 21 calendar days (exceptions are permitted at specific times when PCP capacity is temporarily limited)
- ***Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services:*** Must be scheduled in accordance with EPSDT guidelines and the EPSDT Periodicity Schedule
- ***Initial Prenatal Care Visit:*** Must be scheduled within 14 calendar days of the date on which the member is confirmed to be pregnant
- ***Members with Supplemental Security Income (SSI):*** THP encourages members to schedule an appointment with a PCP or specialist who manages the member's care within 45 calendar days of initial enrollment. If requested by the member or provider, THP schedules or facilitates an appointment with the member's PCP.

Monitoring Timely Access to Care

THP monitors compliance with timely access to care guidelines through multiple processes as defined in the table.

THP Timely Access to Care Monitoring	
Monitoring Process	**Monitoring Process Summary**
Timely Access Compliance Audits	THP's Quality Management department conducts annual compliance audits of PCPs, behavioral health providers and high volume/high impact specialty providers to assess provider performance against our timely access standards. We measure appointment access through a survey of practitioner offices. Data is collected by a telephone survey supplemented by other contacts with the provider offices. Our sample size is determined by using the sample size calculator provided by Creative Research Systems. To determine our sample size, we use a confidence level of 95% and a confidence interval of 5. Providers who don't achieve a passing 90% score must submit a corrective action plan (CAP) to THP. Corrective action is based upon root cause analysis of the issue and may include provider re-education or revision of a practice workflow process. If a subsequent audit reveals sustained non-compliance, further remediation is implemented through THP's Continuous Quality Improvement Workgroup and other courses of action (e.g., termination) may occur. Credentials Committee minutes are submitted to THP's Quality Improvement Committee who can make additional recommendations relative to provider compliance. The case is then reviewed by THP's Executive

THP Timely Access to Care Monitoring	
Monitoring Process	**Monitoring Process Summary**
	Management Committee and the Board of Directors.
After Hours Surveys	THP conducts after-hours availability surveys to comply with BMS, CMS and NCQA. Practitioners are surveyed in a variety of ways to determine after hours availability and how quickly they can offer and schedule appointments. Practitioner data is obtained through after-hours calls. The requirements are designed to ensure our practitioners provide healthcare to our members in a timely manner based upon the nature of the member's condition that is consistent with prudent practice. To comply with after-hours accessibility, practitioners must use an answering service or answering machine to ensure services are available during evenings, weekends and holidays, with access to an on-call practitioner for urgent medical issues, or a directive to report to the nearest ER or to call 911. The data is analyzed in a qualitative and quantitative fashion to assist in barrier identification and opportunities for improvement. Those practitioners who do not meet the requirements are notified in writing of their office deficiencies. THP requires each noncompliant practitioner to submit a formal CAP to address their deficiencies. Practitioner after-hours accessibility is reported to the Credentials Committee and to the Quality Improvement Committee (QIC). The after-hours availability data analysis is placed in the Quality Management work plan. The work plan is shared at the Continuous Quality Improvement Workgroup to discuss overall barrier analysis and opportunities for improvement. The work plan and Continuous Quality Improvement Workgroup minutes are then reported to the QIC for further recommendations. QIC recommendations and committee minutes are shared with THP's Executive Management Team, who ultimately shares this information with the board of directors. All survey deficiencies are followed up throughout the year until resolution and compliance sustainability is evident. Those noncompliant practitioners are also re-evaluated as part of the survey sample for the following year.
Member Complaint Data	THP continually monitors member complaints for all practitioner sites. The quality management department submits ongoing reports to the provider engagement department of member complaints related to the following office site indicators: ▪ Accessibility equipment (in accordance with ADA standards) ▪ Physical accessibility (in accordance with ADA standards) ▪ Physical appearance ▪ Adequacy of waiting and examining room space ▪ Adequacy of medical/treatment record keeping Office surveys are conducted onsite within 60 days of receipt of any member complaint. Severity of the issue is considered. A standardized survey form is used for all onsite visits. Provider engagement with collaboration of the quality management department will complete the site survey. An exit interview with the practitioner office site is conducted to review the survey results. Practitioners scoring below 80% will be submitted to the Credentials Committee and QIC for further recommendations that include but are not limited to: ▪ Practitioner CAP submission ▪ Follow-up site survey within 6 months The effectiveness of the practitioner CAP is evaluated at least every 6 months

THP Timely Access to Care Monitoring	
Monitoring Process	**Monitoring Process Summary**
	until the office meets the standards and thresholds. Practitioner site survey follow up visits will be documented in the practitioner folder and will be reported to the Credentials Committee, Continuous Quality Improvement Workgroup, QIC and Executive Management Team.
Provider Engagement Representative Validation	Our field-based provider engagement representatives document and validate provider compliance with timely access to care standards. Data is captured on medical and behavioral health site surveys that provider engagement representatives complete for new primary care, OB/GYN and behavioral health providers.

ND015: The Vendor should describe its process for the selection, credentialing, retention, and maintaining of qualified providers.

Provider Selection

THP's provider selection and network development processes were established in full compliance with state and federal regulations and to facilitate member access to covered services through a network of quality practitioners and facilities that are geographically located to ensure member convenience and satisfaction. We maintain written, NCQA-accredited policies and procedures for provider selection, credentialing, re-credentialing and network retention.

THP's credentialing and re-credentialing processes ensure we maintain a high quality provider network and are validated through outside entities who perform periodic audits of our processes and conduct credentialing file reviews. Review entities include NCQA at the time our accreditation audit and during annual EQRO audits. Our written policies include our procedures for initial credentialing, re-credentialing, obtaining information from providers relative to their applications and credentialing data, and procedures for denying, suspending, or terminating providers and providers' right to appeal. The table outlines our provider participation standards.

THP Medicaid Network Physician Standards for Participation	
Service	**Timely Access Standards**

THP Medicaid Network Physician Standards for Participation	
Service	**Timely Access Standards**
Physicians must have the following credentials:	▪ Drug Enforcement Administration (DEA) registration number if the scope of practice would warrant the physician to have a DEA ▪ Professional liability - Minimum amount of $1 million, any amount below the minimum will be reviewed by the Credentials Committee ▪ Admitting privileges at a participating hospital. ▪ Clear report from the National Data Bank ▪ Board-certified or board-eligible. If not board-certified or board-eligible, the physician must demonstrate appropriate training for specialty listed ▪ Signed and dated agreement ▪ Office site survey for PCP, OB/GYN and those providers designated by the plan as high-volume specialist and who provide services to Medicaid members ▪ Proof of current medical license(s) ▪ Sufficient information concerning any malpractice actions ▪ NPI number and UPIN or PTAN number ▪ Completed application
Practitioners / providers eligible for participation with THP are:	▪ Medical doctor ▪ Doctor of osteopathy ▪ Doctor of podiatric medicine ▪ Doctor of dental surgery ▪ Doctor of chiropractic medicine ▪ Audiologist ▪ Certified nurse practitioner – Must submit a copy of their collaborative agreement and/or prescriptive authority (if applicable) with a physician who is a participating practitioner with THP ▪ Certified nurse midwife – Must have a collaborative agreement with a participating obstetrician ▪ Physician assistant – The collaborating physician must be participating with THP and submit a copy of the practice agreement ▪ Independent physical therapist ▪ Optometrist ▪ Fully-licensed psychologist ▪ Clinical licensed master social worker ▪ Ambulance provider ▪ Durable medical equipment – Must be accredited and possess a surety bond; if applicable ▪ Independent speech language pathologist ▪ Registered dietitian, diabetic educator and nutritionist
Providers / facilities eligible for affiliation in THP network are:	▪ Ambulatory surgical centers – Must be accredited ▪ End-stage renal disease facilities ▪ Federally qualified health centers ▪ Rural health clinics ▪ Home healthcare facilities ▪ Infusion therapy providers – Must be accredited ▪ Hospitals – Must be accredited ▪ Critical access hospitals

THP Medicaid Network Physician Standards for Participation	
Service	**Timely Access Standards**
	▪ Long-term acute care hospitals ▪ Outpatient physical therapy facilities ▪ Skilled nursing facilities ▪ Accredited behavioral health facilities
In addition to the above credentials, THP QIC has identified the following behaviors and expectations for THP practitioners who should: ▪ Have 24-hour availability, seven days a week, with backup coverage provided by participating providers. ▪ Accept members of any or all THP products, as required by THP. ▪ Admit THP patients to participating hospitals. ▪ Accept and support THP policies. ▪ Allow medical records and office to be reviewed as part of a collaborative quality program. ▪ Ensure records and office meet criteria established by THP and the participating physician. ▪ May not discriminate against THP patients or "de-market" THP. ▪ Admit under own service to participating hospitals if a patient's condition is within physician's range of expertise and scope of privileges. ▪ Meet the CME requirement that is required for state licensure.	

Provider Credentialing

THP recognizes the importance of ensuring that practitioners and providers who are contracted to serve THP members are credentialed in a manner that protects the health and welfare of our members. We established a set of procedures for credentialing providers to ensure compliance with our defined participation requirements and a mechanism to complete our evaluation prior to the provision of care to our members. THP validates and maintains compliance with state and federal regulations through both our NCQA accreditation and through our annual EQRO audit. The table outlines the key elements verified during initial credentialing.

THP Initial Credentialing Element	
Process	**Required Credential Verification**
Initial credentialing validation includes:	▪ State Licensure(s): All state(s) licensure(s) is/are verified. ▪ DEA certificate(s). ▪ Professional liability insurance. ▪ Board certification. ▪ Education and training. ▪ Malpractice history: includes last 10 years of acts or occurrences. ▪ Hospital privileges.

THP Initial Credentialing Element	
Process	**Required Credential Verification**
	▪ Personal health history. ▪ Work history: Application requires all work history and explanation for work gaps longer than three months. ▪ National Practitioner Data Bank Query: Actions are validated against the provider application and are reviewed by the medical director and Credentials Committee in determining whether to accept, accept with restrictions or deny credentialing. ▪ Medicare/Medicaid Sanctions: Restrictions/sanctions are reviewed by the medical director and Credentials Committee in determining whether to accept, accept with restriction or deny credentialing. ▪ Additional Sanction/Restriction Reviews: THP reviews the Medicare Opt-Out report, the System for Award Management (SAM) and the Social Security Death Master File. Any restrictions/sanctions are reviewed by the medical director and Credentials Committee in determining whether to accept, accept with restrictions or deny credentialing. ▪ Availability: At the time of initial credentialing, practitioners are required to have 24 hours a day/7 days per week availability and to list adequate coverage with at least one other practitioner on their application. ▪ Omissions or Inconsistencies. ▪ Site Survey: Conducted at the primary office of all PCPs, obstetric/gynecologists and high volume/high impact specialists. ▪ NPI: The National Practitioner Identifier (NPI) is verified through the NPI Registry (NPPES) for all practitioners at the initial and re-credentialing cycle.

Special requirements	▪ Additional credentialing criteria applies to certain provider types and is included in THP policies and processes that includes:
	  ▪ Dental providers
	  ▪ Behavioral health practitioners
	  ▪ Behavioral health agencies

Day-to-day direction and oversight of the credentialing process resides with the director of credentialing, who along with the credentialing team, is responsible for obtaining provider applications, verification of credentials and presenting credentialing/re-credentialing files to the medical director or Credentials Committee for review. Quarterly reports are presented to the QIC. Monthly reports are presented to THP's Executive Management Team regarding credentialing issues and actions. The final authority for credentialing decisions shall rest with the Executive Management Team who has been appointed by the board of directors to provide oversight. The actual date of the credentialing/re-credentialing will be the Credentials Committee review date. The

Credentials Committee submits quarterly updates and annual reports regarding credentialing activity, as well as reports of any adverse decisions that have been implemented to the quality management department for review by the QIC.

The Credentials Committee consists of at least five physician members who are actively practicing in West Virginia and who participate with THP, and will be nominated by the Executive Management Team, THP's medical director and the director of credentialing. The Committee is chaired by THP's local medical director who is also a voting member of the Committee. The Committee shall represent different specialties, and each member shall serve a two-year term. Members are permitted to serve consecutive terms as appointed by the Executive Management Team.

Provider Retention and Maintenance

THP re-credentialing is completed at least every 36 months. Each practitioner's re-credentialing cycle will be within a 36-month period following the original effective approval date and within 36 months thereafter. THP credentialing representatives receive automated reports of practitioners due for reappointment six months prior to the re-credentialing due date. If unable to access or obtain an application due to an expired attestation or missing documents, the practitioner will be notified via e-mail, or telephone to update the application. If the practitioner fails to respond within 30 days, the credentialing representative will follow up with another e-mail or telephone call. Any practitioner who fails to respond to the request will be sent a letter stating they will be removed from the provider directory and placed in an inactive status. If applicant exceeds the 36 months and wishes to continue as a participating practitioner, an initial application will need to be completed and the practitioner will need to be credentialed as

an initial applicant, with the exception of verification of education and training, unless the practitioner has obtained additional education or training. The table outlines the key elements verified during re-credentialing.

THP Re-Credentialing Element	
Process	**Required Credential Verification**
Re-credentialing validation includes:	▪ State Licensure(s): Applies to any new licensure not verified at the initial credentialing, as well as verification of licensure in the state(s) in which the practitioner is actively practicing. ▪ DEA certificate(s). ▪ Professional liability insurance. ▪ Board certification. ▪ Education and training: Applies to additional education or training to support being listed under another specialty. ▪ Malpractice history. ▪ Hospital privileges. ▪ Personal health history. ▪ Work history. ▪ National Practitioner Data Bank Query: Any new actions reported (that did not appear on the previous report) will be summarized and forwarded to the medical director or Credentials Committee for review and action. ▪ Medicare/Medicaid Sanctions: Any new actions reported (that did not appear on the previous report) will be summarized and forwarded to the medical director and/or Credentials Committee for review and action. ▪ Additional Sanction/Restriction Reviews: Any new actions reported (that did not appear on the previous report) will be summarized and forwarded to the medical director and/or Credentials Committee for review and action. ▪ Availability: The occurrence screen will be reviewed to determine if members have reported any QM issues, access concerns, or member complaints during the period since the last credentialing. In cases where QM issues, access concerns and member complaints have been addressed and logged into the system, the Provider Occurrence Screen is printed and included in the documents that are provided to the Credentials Committee for review. ▪ Omissions or inconsistencies.
Special requirements	Additional credentialing criteria applies to certain provider types and is included in THP policies and processes, which includes: ▪ Dental providers ▪ Behavioral health practitioners ▪ Behavioral health agencies

THP also holds multiple delegated credentialing agreements. THP conducts audits of delegated group credentialing/re-credentialing processes within one year prior to instituting a delegation agreement and on an annual basis thereafter. The audit consists of a review of a cross-section of the delegate's files and includes a 5% or 50 file sample,

whichever is less. The audits are compliant with NCQA guidelines and state and federal regulations. The delegated groups provide THP with monthly rosters of practitioner changes, and a THP credentialing representative updates the practitioner information. The delegated group rosters are managed and monitored on an ongoing basis by the director of credentialing and the credentialing representatives.

ND016: 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-medicaid-managed-care-chip-delivered).

BMS Enrollment Validation

THP ensures network providers have completed enrollment with BMS as required by CMS. We compare providers at initial credentialing and re-credentialing with the monthly Prov12 (mass enrollment eligibility file report) disseminated by the fiscal agent to validate BMS enrollment. In the event a provider has completed THP's credentialing process but the provider's BMS enrollment cannot be verified or is still in process, THP sets the provider up on our system so that claims cannot be processed until state enrollment is verified. THP will not load providers as effective in our Medicaid network until BMS enrollment is confirmed.

In addition to receiving reports from the fiscal agent to validate BMS enrollment, THP also can access the provider enrollment file on the West Virginia Medicaid Management Information System (MMIS) portal if there are questions or concerns regarding the BMS enrollment of a provider. THP reviews and evaluates enrollment reports received from the fiscal agent on a weekly and monthly basis. Report examples include:

- The number of newly enrolled/terminated providers
- Providers who are on or have been removed from pay hold
- Providers with inactivity

- Provider license renewal recertification
- Full file of all enrolled providers

THP reviews each report to determine if an action should be taken for each provider identified.

Pay Hold

THP receives eligibility files weekly (Prov98 report) that identify providers who are on pay hold through the fiscal agent. We have automated this process, so we do not have to manually process the Excel files. The Excel files from the fiscal agent are auto-loaded into our Pay Hold program. The NPI Pay Hold Information screen lives within the provider record. The screen shows the effective date of the provider within West Virginia Medicaid (Provider Effective). If the provider is no longer active, then it shows the exit date (Provider Exit). It also shows the Pay Hold Effective date to indicate that the provider is currently on pay hold. The figure illustrates our automated Pay Hold screen.

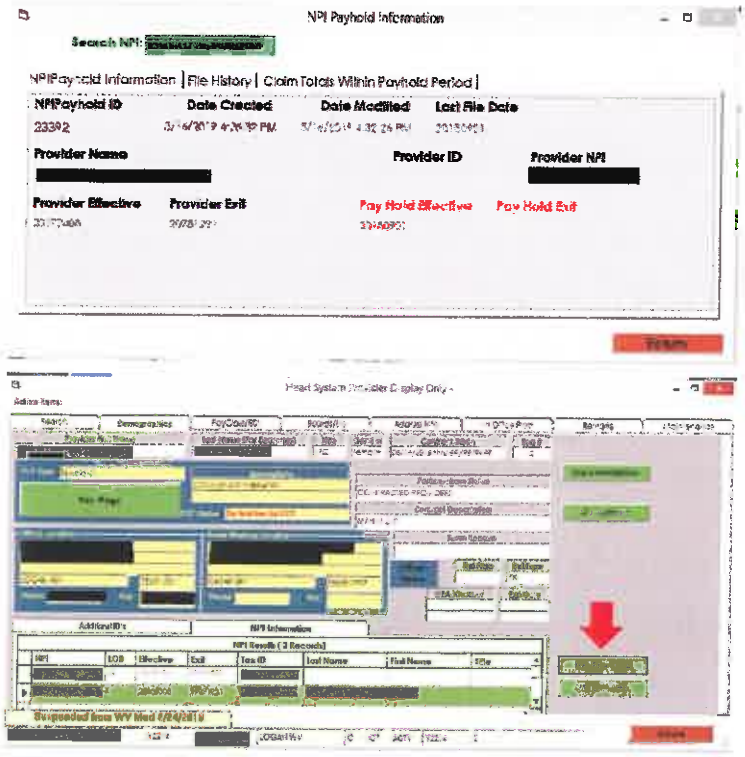


Figure 4: Automated Pay Hold Process. We load the Excel files from the fiscal agent into our provider record in the Pay Hold Information area.

ND017: 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).

THP has established credentialing and re-credentialing policies and processes that are fully compliant with state and federal regulations and in compliance with **MD012**. We initially established our Medicaid credentialing and re-credentialing processes in 1997 following our state award to serve West Virginia Medicaid members in 1996. At that time, we validated that our processes were fully compliant with state and federal regulations. Since that time, THP continually monitors changes to state and federal regulations and this audit process ensures our continued compliance. THP's credentialing department maintains our provider credentialing policies and procedures.

On an annual basis, the credentialing department reviews THP policy against NCQA, Medicare, Medicaid and state or regulatory agency requirements to ensure consistency and compliance. THP also validates our compliance with state and federal regulations through both our NCQA accreditation audits that are conducted on a three-year cycle and through our annual state EQRO audit that is conducted to validate our compliance. Both the NCQA and the EQRO audits include a comprehensive review of THP credentialing and re-credentialing policies and procedures as well as a periodic review of our provider credentialing/re-credentialing files. Any deficiencies or recommendations identified during NCQA and EQRO audits are immediately addressed in our policies and procedures. In our most recent EQRO audit, no deficiencies were identified relative to THP's compliance with West Virginia state and federal credentialing and re-credentialing regulations.

ND018: 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.

Our policy defines the processes for inclusion of provider site visits as part of our credentialing process. THP's policy requires site visits for PCPs, OB/GYN providers, DME and high volume/high impact specialists, which includes behavioral health providers, as defined in the Service Provider Agreement. THP requires Durable Medical Equipment (DME) providers be accredited or in the process of obtaining accreditation by one of the following organizations: The Joint Commission (TJC), Community Health Accreditation Program (CHAP), Healthcare Quality Association on Accreditation (HQAA), Accreditation Commission for Health Care (ACHC), American Board for Certification in Orthotics and Prosthetics (ABCOP), Board of Certification/Accreditation (BOC) or Exemplary Provider Accreditation Program (EPAP).

Provider site visits are performed to assess the quality of care and services provided by THP network providers. Our process includes the following components:

- An initial site review is required for all primary care, OB/GYN, DME and high volume/high impact specialist main offices prior to network approval or within 180 days of network acceptance for those providers who participate in the West Virginia Medicaid program and in accordance with BMS guidelines.
- THP provider engagement representatives collaborate with the provider practices to ensure the site visit is scheduled either prior to the provider's network approval or within the required 180 days of network acceptance.
- THP sends the provider a letter confirming the date/time of the site visit survey along with a copy of the site visit form to ensure the provider office understands the scope of the site visit assessment.
- If the provider office is unwilling to permit the survey, the office location is removed from the THP provider directory until the site visit is completed.

- Continued refusal to allow the site visit completion may result in network termination.
- When on-site, the provider engagement representative first meets with the office manager to discuss the site survey review form and to tour the facility.
- For the medical record audit, the provider engagement representative reviews a random sample of blinded medical records.
- If the medical records cannot be sufficiently blinded to ensure confidentiality and HIPAA compliance, the provider engagement representative will instead review a sample chart and charting procedures.
- Examples of the types of components assessed during the provider office site visit include:
  - ***Facility:*** Includes review of facility appearance and accessibility, equipment accessibility and ADA compliance (including review of scales, exam tables and equipment used for diagnosis and treatment), review of waiting room adequacy and lighting, adequate record-keeping and charting practices
  - ***Ancillary Services:*** Includes a review of laboratory certification, radiology state inspection or health physicist report, and review of licensure or certification of personnel performing the ancillary services
  - ***Medical Record Audit:*** Includes a review of confidentiality practices, documentation policies and processes, validation that provider notes are signed, initialed and dated, etc.
  - ***Safety:*** Includes a review of the facility fire exit plan and compliance with federal regulations regarding bio-hazardous waste management and disposal
  - ***Pharmaceutical and Stock Medications:*** Includes validation that controlled substances are stored in a double-locked cupboard/container and logged and that medicines are checked routinely for expired dates, etc.
- The provider engagement representative completes the site survey recommendation form and the provider receives a letter that defines recommendations if deficiencies were identified or confirmation that no deficiencies were noted.
- The provider engagement representative conducts an exit interview with the office manager to review the site survey results.
- Practitioners scoring below 80% on either the quality/safety/accessibility or the medical treatment/record-keeping practices will be presented to the Credentials Committee for recommendation that may include implementation of a CAP or follow-up reviews on the identified deficiencies every six months until the provider meets the 80% standard threshold.
- In the event providers remain non-compliant relative to implementation of recommendations to correct deficiencies, the Credentials Committee will be notified and may recommend additional action.

ND019: 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).

THP recognizes there are some services that are paid on a global basis rather than on a per visit basis. Our process for handling recoupments for mid-treatment transfers is founded on our commitment to protect our MHT members from treatment delays and balance-billing concerns. Our process is defined below:

- ***Medical Services:*** For medical services, if a member initiates treatment with one provider who receives the global payment, and then the member transfers mid-treatment to an alternative provider, THP investigates the circumstances on a case-by-case basis. If it is possible and appropriate to recoup the global payment from the initial provider and pay it to the subsequent provider, we will do so. However, in the event a recoupment is not possible or appropriate, THP will make a second global payment, in full, to the subsequent provider to ensure continuity of care and protect our MHT members from balance-billing concerns.
- ***Dental Services:*** In the case of orthodontia, as provided in the example, THP contracts with SKYGEN as our dental network vendor. When a member transfers to a new provider during orthodontia treatment, SKYGEN's orthodontist dental consultant for West Virginia works with both the original and the new provider to review the treatment records and determine if recoupment is appropriate. SKYGEN's dedicated MHT provider relations field representative and dental reimbursement analyst also keep both providers informed of the status throughout the process. In the event recoupment is not possible or appropriate, SKYGEN looks to THP for direction, and THP authorizes SKYGEN to make a second global payment, in full, to the new provider. Again, this preserves the integrity of the treatment and continuity of care and protects the member from inappropriate financial concerns.

ND020: The Vendor should describe how they will establish notification processes related to provider network terminations including, but not limited to, the following

ND021: 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: 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: Immediate notification of a hospital termination to the Department

THP has policies and procedures in place to ensure compliant notification to BMS, the state enrollment broker and MHT members of key changes to the composition of our provider network that may materially affect our members or the THP Medicaid network's

ability to deliver all covered services as required in the Service Provider Agreement, Section 2.1.8 Network Changes.

Written Notice to State/Enrollment Broker of PCP Network Terminations

THP notifies BMS and the enrollment broker of PCP network terminations within 14 days of becoming aware of the network change. Our processes for compliance with the notification requirement regarding PCP termination include the following scenarios:

- ***When THP Terminates a PCP for Cause:*** Immediately following THP's decision to terminate a PCP from the network, THP's manager of credentialing sends all documentation, including any letters to be sent to the practitioner, to the MHT contract liaison who then sends the required notification via email to BMS and the enrollment broker within the 14-day timeframe. The documents identify the reason for the termination and the effective date of the termination. The provider termination data is also included in the Quarterly PCP Report that is submitted to West Virginia Medicaid 45 days following the end of the quarter. In the event the PCP termination is immediate in nature, the manager of credentialing sends the notification to THP's program integrity lead in addition to the MHT contract liaison. THP's MHT contract liaison notifies BMS and the enrollment broker within the 14-day timeframe, and the data is also transmitted to the state via the monthly Credible Allegations of Fraud report.
- ***When THP receives a notice of termination from a PCP:*** When THP's provider network team receives advance notification of a PCP termination, THP immediately generates a report of the number of members impacted and sends notification to the MHT contract liaison. The notification includes the reason for the termination, number of members impacted and effective date. The MHT contract liaison then sends the required notification to BMS and the state enrollment broker within the 14 day timeframe. The information is also included in the quarterly report submitted to BMS 45 days following the end of the quarter.
- ***When THP identifies a PCP left the network without notice:*** In the event THP did not receive a PCP termination notice, but THP discovers a PCP has left the network, THP immediately generates a report of the number of members impacted and sends notification to the MHT contract liaison. The notification includes the reason for the termination, number of members impacted and effective date. The MHT contract liaison then sends the required notification to BMS and the state enrollment broker within 14 days of THP's becoming aware of the termination. The information is also included in the quarterly report submitted to BMS 45 days following the end of the quarter. THP may become aware of a termination through information collected during provider engagement representative on-site visits, newspaper or obituary notices or through THP's provider directory validation process.

Written Notice to Members Regarding PCP Network Terminations

To ensure members' continued access to care, it is THP's policy to notify members at least 30 calendar days prior to the effective termination date of a PCP, or within two weeks of THP's receipt of a PCP's intent to leave the THP network or in the event THP has identified the need to terminate a primary care practitioner from the THP network.

Our member notification process includes the following steps:

- ***Receipt of Termination Notification:*** THP's provider relations department is notified or becomes aware that a PCP is terminating, or being terminated from, the network.
- ***Generation of Member List and Member Communication:*** The provider relations department generates an appropriate member notification letter with information regarding the provider's termination date, and requests a report of members who are either assigned to the PCP or who have received care from the provider within the prior 12-month period.
- ***Member Notification:*** The letter is mailed to impacted members. The member letter includes the provider's termination effective date and instructions that the member will need to select or be assigned to a new PCP.
- ***PCP Reassignment:*** Members are provided information regarding how to find and select a new PCP. In the event the terminating PCP is a member of a primary care group practice, a provider service representative contacts the office to determine if an alternate physician in the practice will be assuming the terminating provider's members. If so, customer service reassigns the members accordingly. A notification letter is mailed to the member informing them of the group partner assignment and their option to select a different PCP by contacting customer service.
- ***Continuity of Care:*** Members are notified in the letter to contact THP's customer service with any concerns regarding continued access to care. The CSR will connect members to the appropriate care manager or case navigator who assist members with continued access to care concerns. A copy of the member letter is filed electronically to the member's folder.
- ***Member Non-Response:*** A new PCP is assigned to the member via THP's auto-assignment algorithm that selects a provider within the primary care geographic time and distance access standards. Members are notified of their new PCP assignment. Members are notified that they may contact customer service to select an alternative PCP at their discretion.

Immediate Notification to BMS of Hospital Termination (ND023)

In the event THP receives notification from a hospital of its intention to close or terminate from our network, or we become aware of a hospital termination, THP's MHT

contract liaison is immediately notified. The MHT contract liaison immediately contacts BMS to open discussions regarding member impact and strategies to preserve continuity of services to West Virginia Medicaid members. THP immediately generates a list of all members who received services from the hospital over the past 12 month period, and then generates and mails a member notification letter at least 30 days in advance of the planned termination date. The member letter includes information regarding the hospital termination or closure date and special instructions for members who may be ill, pregnant or who may have an urgent need to contact THP customer service immediately for connection to our care management team for assistance. The letter also includes information on how to request a THP provider directory or search online for alternative network hospitals.

THP works collaboratively with the terminating hospital to minimize member impact and ensure continuity of care. For example, in 2019 THP received a 90-day notification from a contracted hospital of its intent to terminate its THP contract. Although THP completed the member notification processes, we also continued to meet with the terminating hospital on an ongoing basis to attempt to re-negotiate terms. In addition, THP negotiated with the hospital to agree to enter into single case agreements beyond the termination date for members who required care from that facility that could not be provided by other contracted hospitals in the area. Through our negotiations, we were able to secure the hospital's agreement to extend its participation with several lines of business for an additional six months past the original termination date. Ultimately, our efforts resulted in the hospital's agreement to withdraw its termination and the service available to our THP members were uninterrupted.

TheHealthPlan

Attachment 6
Provider Services

8. Provider Services

The Vendor should refer to the relevant specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Provider Services (PS) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

The Health Plan (THP) is committed to ensuring our network providers receive exceptional service and customer support. We recognize that our engagement with our THP network providers directly contributes to their ability to more effectively provide care to our members. Our provider service model is distinguished by our high-touch approach, through our deployment of highly experienced, uniquely qualified provider engagement representatives throughout the state who live in the communities they serve. Our provider engagement representatives hold a collective 150 years of healthcare experience, and have developed a detailed understanding of how healthcare is delivered in their communities through on-site provider visits and participation in provider professional organization meetings and community-based organization events throughout the year. Each interaction of these field agents helps to enhance THP's relationship with and understanding of our network providers and their needs, and drives improved care and service to our West Virginia Medicaid members.

PS001: The Vendor should provide a description of its Provider Services operating model.

THP is committed to providing the highest level of customer service to our network providers through our provider service model. We recognize that our support of network providers strengthens their ability to care for our members. Our goal is to become a trusted advisor to West Virginia providers and to establish and maintain positive, productive relationships to provide stability to our network and the services we collectively offer to our West Virginia MHT members.

Provider Services Operating Model

THP maintains a three-tiered provider services model as the foundation of our provider support infrastructure. The table outlines the key components of our provider services model.

THP Provider Services Operating Model	
Service Model Function	**Description**
Customer Service Representatives (CSRs)/Call Center	THP current employs 12 in-state CSR. The THP CSRs staff our customer service call center based in Charleston, West Virginia, and manage incoming provider inquiries to assist providers with most of their routine questions and concerns. They function as the key intake point for our network providers and assist with inquiries regarding: ▪ Member eligibility ▪ Referrals and authorizations ▪ Operational policies and procedures ▪ Claim status and accuracy inquiries ▪ Claim reconsideration requests ▪ Provider complaints Our customer service call center operates a toll-free provider telephone line from 8 am to 5 pm EST, Monday through Friday excluding holidays. After hours, our toll-free telephone line is answered by an automated system that provides information regarding the hours of operation as well as information regarding resources available to assist providers when customer service is closed. THP's nurse line is answered by an on-call staff nurse who provides after-hours support and who can provide prior authorizations after hours in real-time. This after-hours support allows us to provide 24/7 access for providers and members in emergency situations per MD009. Our customer service team has deep experience supporting providers and members with West Virginia Medicaid coverage. Their existing level of expertise helps support first call resolution goals. THP's customer service call center maintains a high-performance level relative to the service level agreements (SLAs) defined in the Service Provider Agreement, Section 2.6.1.2 Performance Requirements of the Toll-Free Provider Phone Line. For 2019 our service level included: ▪ Percentage of calls answered live in 30 seconds: 85.3% (versus an 83% SLA) ▪ Call abandonment rate: 1.27% (versus a 5% SLA)
Provider Relations Representatives (Internal)	THP currently employs three in-state provider relations representatives. THP's provider relations representative are office-based roles that provide more focused, detailed support for provider issues. The provider relations representatives provide a second layer of telephonic and office-based support for providers beyond customer service. This team investigates and resolves more complex provider issues that require a more focused review or involved resolution. They accept assignments both from customer service and from our provider engagement representatives. Our provider relations representatives

THP Provider Services Operating Model	
Service Model Function	**Description**

	perform an integral function within our provider services model by taking on complex, time-consuming provider project that allows:
	▪ Our CSRs to staff the customer service call center and maintain our performance relative to our SLAs, including the average speed of answer and call abandonment rate
	▪ Our provider engagement representatives to spend more time in the community completing field visits with providers, attending community events and providing education and training
	▪ THP provider relations representatives provide resolution to a variety of issues and projects, including but not limited to:
	  ▪ Large or complex claims issues or claims projects
	  ▪ Process changes to provider demographic and participation information
	  ▪ Manage provider status checks relative to provider credentialing
	  ▪ Update W-9s and address changes
	  ▪ Facilitate provider directory audit processes
	  ▪ Assistance with provider electronic data interchange (EDI) submission issues
	  ▪ Assist providers and trading partners with questions relative to claim rejections
	  ▪ Set up electronic fund transfer (EFT) and electronic remittance advice (ERA) for providers
	  ▪ Resolve issues relative to missing ERA files or issues with data transmission
	  ▪ Educate providers on contract terms, administrative policies and procedures
	  ▪ Assistance to THP's special investigations unit (SIU) report validation with the requests for information received from Medicaid Fraud Control Unit (MFCU)

Provider Engagement Representatives (External)	THP's provider engagement team includes three provider engagement regional managers and 10 provider engagement representatives. Our field-based provider engagement team is all managed out of THP's West Virginia offices and work directly in the community with providers and their staff to develop and maintain the relationships that are critical to our success. The provider engagement representatives form the foundation of our provider relationships and fulfill a variety of key functions including: ▪ Identification of new providers to recruit into our network ▪ Supports credentialing/re-credentialing applications and the collection of required documents ▪ Completion of provider site reviews in compliance with Bureau for Medical Services (BMS) regulations and requirements ▪ Provider training and education regarding Mountain Health Trust (MHT) and Medicaid members, operational processes, provider tools and resources, etc. ▪ Education regarding fraud, waste and abuse; cultural competency and social determinants of health (SDOH); evidence-based care; and provider analytics program ▪ Provider issue resolution, including complex claims or authorization

THP Provider Services Operating Model	
Service Model Function	**Description**
	projects ▪ Validation of provider roster information and demographic data to ensure provider directory accuracy ▪ Presentations and/or attendance at professional provider organizations to provide THP updates and to maintain network relationships ▪ Participation in community events that support the health and wellness of our West Virginia members and communities ▪ Collaboration with THP's population health team for closing gaps in care related to External Quality Review Organization (EQRO), Healthcare Effectiveness Data and Information Set (HEDIS) and other evidence-based quality of care measures Our provider engagement representatives bring a collective 150 years' experience working in healthcare, with providers or with managed care organizations, and the majority are Certified Medical Coders and all are Certified Medical Insurance Specialists to better serve our provider community. In addition, one provider engagement regional manager and one provider engagement representative are also Certified Medical Compliance Officers.

The figure identifies our provider engagement regional managers and our provider engagement representatives and their assigned geographic territories. The provider engagement representatives support all providers within their territory assignment as well as out-of-state providers in contiguous counties who serve West Virginia Medicaid members.

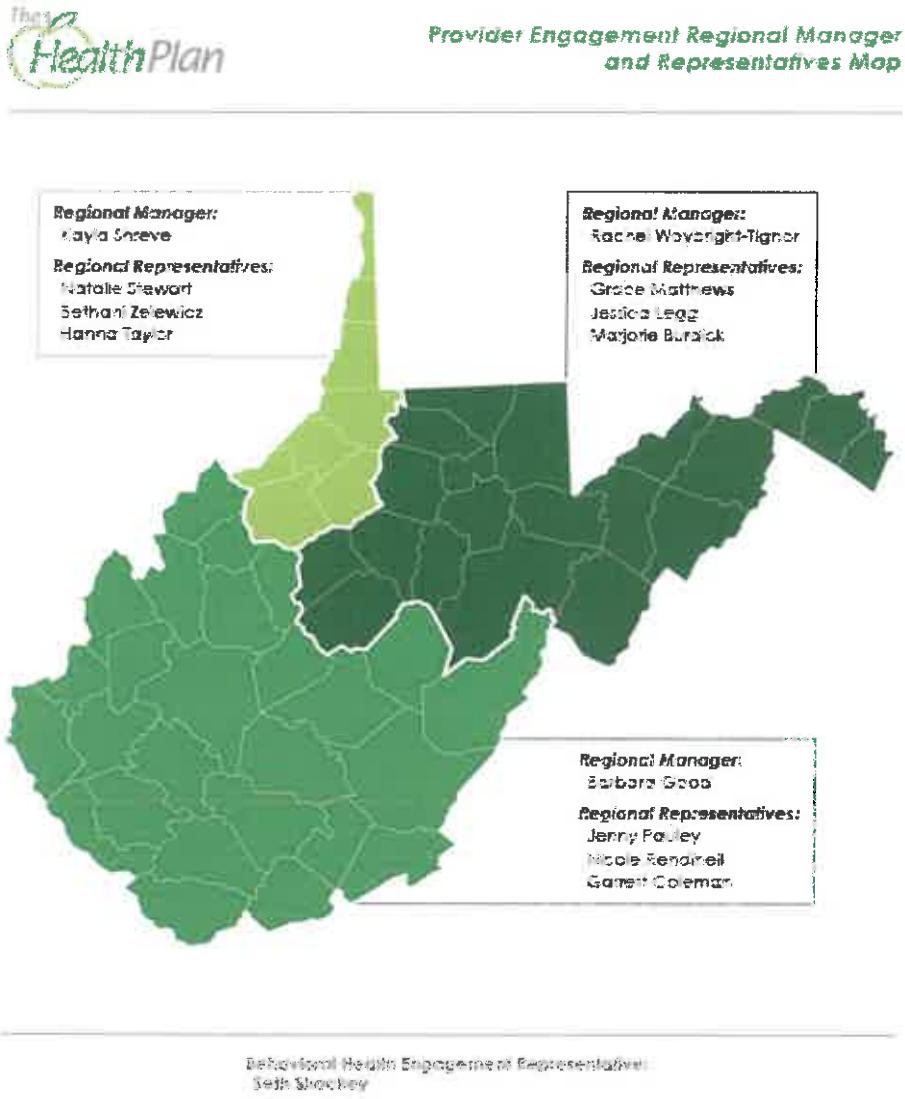


Figure 1: Regional representation. Our regionally placed provider engagement teams live in the communities they serve. We also employ a provider engagement representative who is dedicated to working the behavioral health providers, including substance use disorder (SUD), across the state.

In addition to our nine regionally based provider engagement representatives, THP also employs a dedicated behavioral health provider engagement representative (Seth Shockey in the figure) who has a wealth of behavioral health experience and provides targeted support to our behavioral health and substance use disorder (SUD) providers across the state. He works collaboratively with the other provider engagement representatives to serve as a subject matter expert to ensure our entire team recognizes the needs of and effectively responds to issues unique to behavioral health

providers. As our dedicated behavioral health provider relationship owner, Mr. Shockey also works in tandem with THP's behavioral health medical directors and Sheila Kelly, who is a clinical psychologist. THP supports collaboration between our clinical staff and our provider engagement staff. Often the inquiries received from providers are clinical in nature and require that the provider engagement representatives consult with clinical staff on the response. This is particularly true in the behavioral health arena. As a result, our behavioral health medical directors and the clinical psychologist works closely with our behavioral health provider engagement representative to synthesize a uniform approach to provider questions regarding BMS requirements, clinical necessity/requirements, billing and claims. The behavioral health community is familiar with THP staff members and as a result, feels comfortable in requesting clarification on THP policy and procedure when necessary.

Outstanding Responsiveness
"WVUHS has long had an excellent relationship with THP in managed Medicaid. Of all Medicaid Managed Care Organizations ("MCOs") with which we participate, both in West Virginia and surrounding states, THP has always been the easiest and most responsive MCO to work with."

-- Albert L. Wright, Jr.
President and CEO
West Virginia University Health System, 1/7/20 letter

THP's CSRs, provider relations representatives and provider engagement representatives all work collaboratively and seamlessly with one another to efficiently and effectively address the needs of our providers. They can warm transfer providers to other team members and work as a team to ensure the highest level of service to network providers. They document provider contacts and interactions in one customer relationship management tool that allows the entire team to quickly access information regarding prior provider contacts, issues and concerns that drives operational efficiency and provider satisfaction.

Innovation in Action

In mid-summer 2019, the Ohio Valley was devastated with the news that two of our local hospitals, Ohio Valley Medical Center in Wheeling, WV, and East Ohio Regional Hospital in Martins Ferry, OH, directly across the border from Wheeling, would be closing their doors. To help alleviate the stress on our members and providers, our provider engagement team quickly put together a plan to track these providers in their upcoming transitions.

The provider engagement team went office-to-office throughout both facilities (private and hospital-owned physicians) to meet with providers, determine their new practice location and document their transition plans. Our team created an internal database for member-facing staff to use for outreach to members to notify them of primary care provider (PCP) and relevant specialist changes. Members were also notified via letter about these changes and the ability to change their PCP. These actions reduced provider abrasion during a high anxiety time, reduced confusion for our members and ensured that our network remained compliant with Service Provider Agreement requirements and member needs.

Our provider engagement team is committed to our THP providers and members, and regularly identify innovative ways to provide exceptional support to our Medicaid communities of members and providers. They take a proactive approach, and often anticipate and resolve issues before they evolve into major concerns for the populations we serve.

Community Engagement

Our provider engagement representatives are also responsible for maintaining relationships with the community-based organizations and collaborate with community-based organizations throughout the year and across the state to support local health and wellness initiatives, to educate regarding accessibility and cultural competency, and to advance programs designed to address social determinants of health. THP is deeply committed to improving our communities and the health and wellness of the vulnerable populations of West Virginia.

In 2019, THP's provider engagement representatives attended and participated in 293 unique community events that were attended by 18,234 participants. As part of our participation in community events, provider engagement representatives have developed educational activities related to healthcare initiatives, distributed literature,

and facilitated relationships by making introductions between local community resource leaders and event attendees. They actively network at a grassroots level to understand our member population in an effort to enhance their care. These community engagements attended were in addition to their provider support functions. The table provides just a sample of the events our provider engagement representatives attended during the 2019 calendar year.

THP Community-based Organization Event Attendance - 2019	
Provider Engagement Regional Manager	**Community Meeting/Event**
Barbara Good	▪ Family Resource Network County Meetings ▪ Cabell County Baby Shower ▪ DXC Provider Workshop – Huntington, Parkersburg, Charleston & Beckley, West Virginia ▪ Project Hope for Women and Children ▪ Minnie Hamilton Women's Health Fair ▪ Calhoun County Back to School Bash ▪ Fayette County Substance Abuse Task Force ▪ Tobacco Free Day at the Capitol ▪ West Virginia State Medical Association Healthcare Summit ▪ Immunization Conference ▪ Kids Strong ▪ Lincoln County Health Fair ▪ Grand Central Mall Safety Day ▪ Summers County Brothers and Sisters Health Fair ▪ West Virginia Medical Group Management Association
Kayla Shreve	▪ Family Resource Network County Meetings ▪ Pleasants County Back to School ▪ Reynold's Memorial Annual Health Fair ▪ Marshall County Back to School Fun Fair ▪ Pleasants County Coalition ▪ 5th Annual Medina County Senior Walk & Health Fair ▪ DXC Provider Workshop – Wheeling, West Virginia ▪ Equip the City ▪ Tyler County Back to School Fair ▪ Ritchie County Baby Shower ▪ Marshall County Food Drive ▪ Pleasants County Town Hall Meeting w/ Attorney General Patrick Morrisey
Rachel Waybright-Tignor	▪ Barbour County Back to School Bash ▪ Berkeley County Health Advisory Meeting ▪ Berkeley County Early Head Start Community Resource Fair

THP Community-based Organization Event Attendance - 2019	
Provider Engagement Regional Manager	**Community Meeting/Event**
	▪ DXC Provider Workshop – Martinsburg, Morgantown & Roanoke, West Virginia ▪ Opequon Elementary Literacy Night ▪ Gilmer County Community Baby Shower ▪ Top of West Virginia Resource Fair ▪ Baby & Me ▪ Grandparents & Kinship Caregiver Resource Fair ▪ Youth Mental Health Meadowbrook Mall ▪ Children's Safety Fair ▪ Healthy Grandfamilies Training ▪ DXC Provider Workshop - Morgantown ▪ Mommy & Me

The figure illustrates the total number of community events attended by THP provider engagement representatives in 2019, by regional manager territory.

Transition to NaviNet

THP strives to continually improve the resources and tools available to our network providers. In 2020, THP will begin transitioning to NaviNet to compliment our provider portal. NaviNet is America's leading healthcare provider portal connecting over 50 health plans and 75% of the nation's physicians. NaviNet assists health plans and provider offices to exchange real-time administrative and

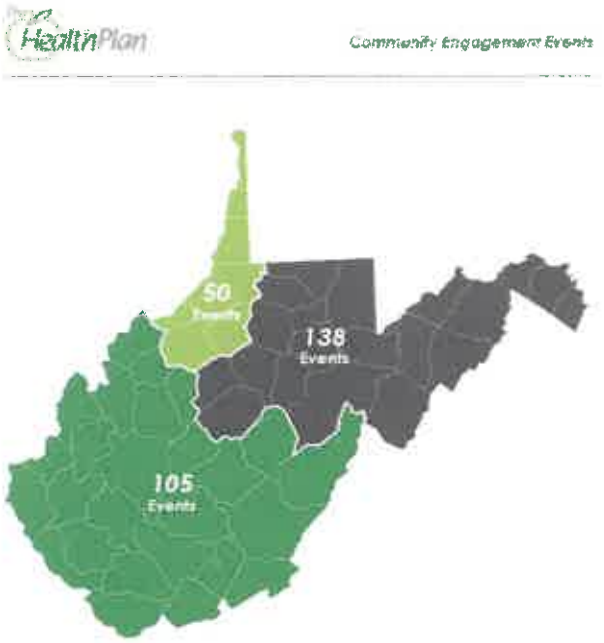


Figure 2: Our regionally placed provider engagement teams attended community events in all three regions. Note that the number of events along the Ohio border are lower; this provider engagement team also works with Ohio providers and community-based organizations in contiguous counties.

clinical information electronically, saving health plans significant operational expenses while enhancing provider utilization and satisfaction.

The majority of provider end-users of NaviNet report a reduction of at least 25% of onerous paperwork and call volume. In West Virginia, NaviNet is used by multiple payers and it is considered to be the most widely accepted gold standard of provider portals. THP's transition to the NaviNet provider portal will afford our network providers a portal solution that is more familiar and that fully supports the functionality most important to network providers. The figure shows the physician adoption of NaviNet nationally.

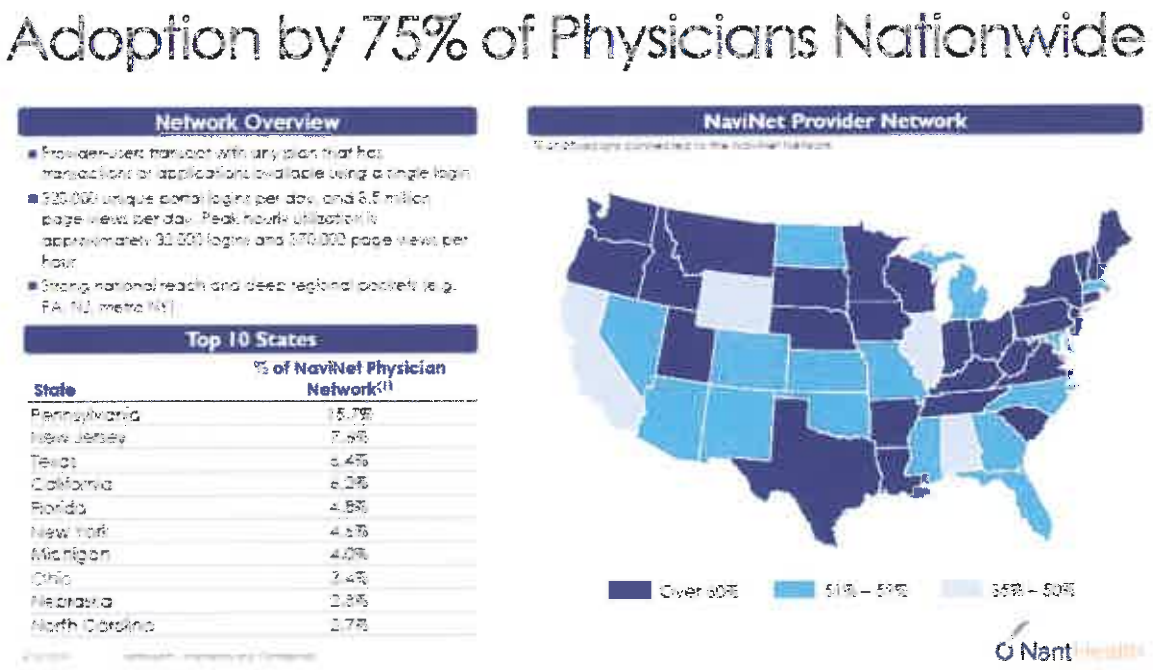


Figure 3: NaviNet is a national organization with significant provider adoption. We are excited to transition our provider portal to NaviNet and anticipate provider utilization and adoption.

Provider Portal Functionality. NaviNet offers a standards-based, extensible application that includes comprehensive functionality to assist providers in accessing real-time information and eliminates the need to call the health plan directly:

- ***Member Eligibility and Benefits***: Allows provider offices to access patient coverage information, including:
  - Real-time benefit look up
  - Member ID cards
  - Provider network details
  - Explanation of benefits (EOBs)
- ***Claim Status Inquiry and Investigation:*** Allows provider offices to access financial and claim status information, including:
  - Claim status lookup
  - Electronic remittance advices (835 transactions)
  - Links to online EOBs
  - Provider ability to conduct a two-way dialogue with the payer about the adjudication of a claim
- ***Claims Management:*** Includes a cloud-based application that allows providers to submit, correct and adjust claims, including:
  - Submission of professional medical claims through simple, real-time data entry
  - Allows providers to edit and resubmit claims to a health plan on a pre- or post-adjudication basis
  - Allows providers to upload and attach documents to expedite the claims adjudication process
- ***Referrals/Advanced Referrals:*** Allows providers to direct members to the highest quality in-network providers at the most affordable costs:
  - Allows PCPs and specialists to verify that necessary referrals are on file prior to rendering services;
  - Guides provider choice by driving referral selection based on member benefits and contracted provider networks
- ***Authorizations:*** Includes a cloud-based application that enables provider staff to submit authorization requests and access real-time authorization information:
  - Allows providers to verify that required authorizations are approved
  - Pre-determination checks answer most common provider questions regarding authorization requirements
  - Configured for each service type to guide the end user through providing the necessary information
  - Streamlined entry of medical necessity evaluation criteria directly into the payer's utilization management system
  - Allows providers to upload and attach documents
  - Allows providers to initiate an appeal online and manage a two-way dialog with the payer through resolution
- ***Document Exchange:*** Includes near real-time exchange of essential clinical and administrative information to enhance and improve care outcomes:

- Includes an actionable, bi-directional solution to shift information exchanges from costly fax and mail channels to near real-time electronic workflows
- Closed-loop communication backed up by a digital audit trail
- Multiple modes and rich metadata to ease the integration into payer systems and workflows

THP is confident our transition to NaviNet will further enhance our provider services model and operational efficiencies through the implementation of this efficient, familiar, widely accepted provider portal that will ease the administrative burden on our network providers.

PS002: The Vendor should describe how its Provider Services Department will provide initial provider orientation, annual training, and support to its provider network.

THP is committed to ensuring our network providers receive extensive training to assist them in the care of our West Virginia Medicaid members. Our provider engagement representatives take a "high-touch" approach to provider training as approximately 90% of our provider training is conducted on an in-office, face-to-face basis to maximize provider understanding and retention of the information. We also leverage other methods of provider training including webinars, email blasts, presentations at medical professional organization meetings, community events and state-sponsored meetings.

Initial Provider Training/Orientation

THP sends all new network providers a provider orientation welcome packet and welcome letter that includes the following provider orientation information:

- Information about THP's organization
- Our provider engagement territory map
- THP's service area map
- Sample member ID cards
- Network services contact list
- Information regarding electronic claims clearinghouses and a billing and EDI authorization and set up form
- Information about and a link to our Provider Practitioner Manual

- An office procedure form for the provider's completion that defines the diagnostic procedures offered at their location
- Pre-authorization and notification requirements (medical and behavioral health)

In addition, new PCPs, OB/GYN providers and high-volume specialists including behavioral health receive an on-site visit and survey as required by BMS. The provider engagement representative assigned to the provider's geographic location schedules an on-site appointment with the provider and/or office staff to complete initial training/orientation and to complete the required site visit survey within 180 days of the provider's credentialing approval date. The provider engagement representative completes the initial provider orientation, which includes, but is not limited to, training regarding:

- West Virginia Medicaid programs and benefits
- Provider contractual and regulatory requirements
- The Provider Practitioner Manual and health plan operational policies and processes
- How to access on-line provider resources including the Provider Practitioner Manual, provider newsletters and education and training materials
- How to verify member eligibility, file claims, verify claim status and request reconsiderations via the provider portal
- Approved and prohibited marketing policies relative to West Virginia Medicaid
- Cultural competency and SDOH training (additional detail can be found in **PS004**)
- Fraud, waste and abuse
- Quality of care reports including gap-in-care and provider analytics
- The new provider training and orientation can also be conducted via webinar at the provider's request

Annual Provider Training

THP affords network providers with the following annual, ongoing and ad hoc provider training opportunities:

- ***Provider On-Site Visits:*** THP's provider engagement representatives offer and complete provider training on a regular basis throughout the year during their on-site provider field visits. A variety of topics are covered including billing; prior

authorizations/referrals; quality; compliance; fraud, waste and abuse; cultural competency and SDOH; and updates on new policies, programs and requirements. High volume PCPs are also included in review of the peer-to-peer provider analytics reporting.

- ***Ongoing Provider Training:*** THP has a comprehensive program for ongoing written provider training that includes ongoing communication with providers via email/postal mail regarding policy and regulatory changes, fee schedule updates, changes to THP policies and procedures, changes to prior authorization requirements, reminders regarding key provider requirements, etc.
- ***DXC Workshops:*** THP's provider engagement representatives present provider education topics and updates at DXC Workshops on a bi-annual basis. In 2019, THP provider engagement representatives presented at 16 DXC Provider Workshops across the state.
- ***Professional Conferences:*** THP provider engagement representatives provide ongoing provider training and updates at a variety of provider professional conferences and meetings throughout the year, including West Virginia Medical Group Management Association Meetings and West Virginia Medical Group Management Association/West Virginia Healthcare Financial Management Association Conference, State Medical Association Healthcare Summits and West Virginia Office Managers Association.
- ***Targeted Provider Training:*** Provider engagement representatives complete targeted provider training and education throughout the year in response to requests from THP's SIU, the quality management department, customer service or in response to member complaints. The provider engagement representatives provide focused training on the issue(s) contributing to member complaints, quality concerns and/or non-compliance with provider responsibilities and expectations.
- ***Cultural Competency and Social Determinants of Health:*** THP integrated SDOH information into our current cultural competency provider education and training. The cultural competency training was provided previously in a webinar and is available on THP's website for viewing and attestation. THP demonstrates how cultural competency and SDOH are married and will be providing an updated webinar in the first quarter of 2020. In addition, the provider engagement representatives offer Cultural Competency/SDOH training when visiting provider offices during on-site reviews, at conferences and workshops and at various professional organization meetings. An article in THP's ProviderFocus first quarter 2020 newsletter will remind providers that Cultural Competency/SDOH training is available for completion and attestation.

Provider Support and Resources

In addition to THP's formal provider training programs and provider engagement representative on-site visits, we support network providers by maintaining access to a

comprehensive library of provider resources available on the THP website. Support resources include:

- ***Quick Reference Guide:*** A quick reference to key THP telephone and facsimile numbers providers may need on a routine basis.
- ***Prior Authorization Forms:*** THP maintains medical and behavioral health prior authorization forms available for download.
- ***Policies and Fee Schedules:*** THP's website includes a link to key claim policies, information regarding claim submission and reconsiderations, electronic claim submission, fee schedules, and member rights and responsibilities.
- ***Compliance and Fraud, Waste and Abuse:*** Information on our website addresses how to recognize and prevent fraud, waste and abuse. The information also covers HIPAA privacy requirements.
- ***Patient Care Programs:*** Information is available to providers regarding a variety of care programs including West Virginia Medicaid, dental benefits, advance directives, medical management, behavioral health services and quality measures.
- ***Provider Practitioner Manual:*** THP publishes a comprehensive provider manual on our THP website. The Provider Practitioner Manual is updated bi-annually and provides network providers with a detailed resource regarding all West Virginia Medicaid and BMS policies and requirements, THP policies and procedures, and detailed operational and program information.
- ***Cultural Competency/Social Determinants of Health Training:*** THP's newly revised and enhanced training materials relative to cultural competency and SDOH will be available on THP's provider portal for provider review and attestation of training completion.
- ***Provider Newsletter:*** THP develops and distributes a quarterly provider newsletter (ProviderFocus). The provider newsletter reminds providers of key policies and processes, notify providers of non-emergent state and/or THP policy and procedure changes, changes to NCQA requirements and federal regulations, notifications regarding upcoming provider trainings and community events, etc.
- ***Marketing Policies:*** THP includes information regarding BMS marketing policies and approved and prohibited marketing practices and the requirements relative to social media marketing practices in our Provider Practitioner Manual. In addition, THP is developing an additional provider resource to post on our website in the provider resource library that educates and reminds providers regarding BMS marketing policies.

PS003: The Vendor should describe its process for specialists serving as Primary Care Providers (PCPs), and related monitoring activities.

Specialist Serving as a PCP

THP recognizes that specialists are sometimes best qualified to serve as PCPs for members with complex or chronic conditions, which allows the designated specialist to coordinate the benefits and authorize other specialty referrals for appropriate members. THP's process for facilitating specialists to serve as a PCP is through authorization of a Specialist Practitioner Coordination Referral. The following process is followed:

- The PCP or treating practitioner is responsible for initiating the Specialist Practitioner Coordination Referral and for supplying appropriate member history. A treatment plan is formulated by both the practitioner and the member.
- The treatment plan (or referral request) is subject to review by the THP medical department. Behavioral health practitioners/providers send the treatment plan for review to THP's behavioral health services personnel.
- Short-term specialist care (six months or less) is requested on a specialist referral form. Ongoing care over an extended period of time is requested on a standing referral. The number of requested visits are based upon the treatment plan and are limited to a one year period of time.
- Upon approval of the Specialist Practitioner Coordination Referral, the specialist practitioner is documented as such in THP's care management system. The specialist practitioner is authorized to provide and refer for healthcare services in the manner of a PCP.
- To ensure appropriate coordination of care, the specialist practitioner must provide the PCP or treating practitioner with regular reports on the care provided to the member.
- For the specialist to continue to coordinate the care, the PCP or treating practitioner is required to request an extension of the Specialist Practitioner Coordination Referral every year and to provide updated reports and treatment plans to support medical appropriateness (not applicable to Behavioral Health Services).

Secondary Care Provider

In addition to allowing specialists to serve as PCPs, THP allows members to select a secondary care provider. A secondary care provider is a contracted sub-specialty practitioner who provides specialty care to a member on a routine basis. Members may designate a secondary care provider by calling THP's customer service.

The following provider specialties may serve as secondary care providers: OB/GYN, endocrinologists, oncologists and nephrologists. In most cases, members with a designated secondary care provider pay that provider their primary care co-payment, if applicable. Both the PCP and secondary care provider are listed under the member on the provider portal.

Secondary care providers can obtain their patient rosters through THP's provider secure portal that offers the ability to generate a member roster at any time. The member information is updated every 24 hours. Secondary care providers will only have access to patients who have listed them as their secondary care provider. Secondary care providers may issue referrals only in cases where the referral is related to care pertaining to the secondary care provider's specialty. Specialty providers not listed as a member's secondary care provider require a referral.

PS004: The Vendor should describe how its Provider Services Department will provide training to its provider network regarding culturally competent care.

THP is committed to fostering cultural competency across our provider network that encourages the provision of services to MHT members with sensitivity and understanding and that respects members' culture and background. A key component of our approach is training our providers on cultural competency, health equity and about SDOH and how providers can help connect members to resources that address their SDOH concerns to achieve health equity and optimal outcomes.

Provider Curriculum and Resources

Our provider training and education director collaborates with others and leverages a variety of external resources to develop comprehensive provider training curriculum and

provider resources relative to cultural competency, health equity and social determinants of health. These provider resources include:

- ***Provider Curriculum:*** THP's Cultural Competency and Social Determinants of Health Training curriculum meets industry standards and includes information regarding the importance of assessing, identifying and taking action on SDOH, particularly employment and income, housing concerns, educational level, food insecurity, and social cohesion to help ensuring health equity for all members. Our training curriculum includes:
  - Definitions of cultural competency
  - Provider network expectations relative to cultural competence
  - How cultural differences can influence medical care
  - Introduction to National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)
  - Berlin and Fowkes' LEARN for conducting cultural assessments
  - What providers can do to improve cultural competency
  - Information regarding health equity and SDOH
  - The importance of assessing for health equity and SDOH and addressing health disparities as part of each provider visit
  - Documenting the findings of the health equity/SDOH assessment
  - Using ICD-10 codes to track SDOH and related services and how appropriate billing regarding SDOH needs and services will help THP track the needs of our members and ensure they receive the necessary services
  - Information regarding community referral programs and resources such as Aunt Bertha, WV211, Birth to Three and WIC
  - Links to additional external resources
- ***Social Determinants of Health:*** THP has integrated SDOH and health equity information into our current cultural competency provider education and training program. THP demonstrates how cultural competency and SDOH are related and is facilitating an updated webinar in the first quarter of 2020 to continue our efforts to educate network providers on the importance of understanding SDOH when providing care to our members. The newly revised training materials are available on THP's provider portal for provider review and attestation. In addition, the provider engagement representatives offer Cultural Competency/SDOH training when visiting provider offices during on-site reviews, at conferences and workshops and at various professional organization meetings. An article in THP's ProviderFocus first quarter 2020 newsletter reminds providers that Cultural Competency/SDOH training is available for completion and attestation.
- ***Cultural Competency and Social Determinants of Health Resources:*** THP also houses our Cultural Competency/SDOH Training presentation and other provider resources and coding guidelines on our provider portal.

- ***Provider Newsletters:*** THP publishes reminders, information and articles about cultural competency and SDOH in our provider newsletters. Provider newsletters are also published on our provider portal.

Provider Training

Our provider engagement representatives take advantage of multiple opportunities to deliver our cultural competency/health equity/SDOH training to our network providers throughout the year. Our training opportunities include:

- ***Required Provider Training:*** THP initially implemented our provider cultural competency training through a webinar program in 2018 in response to newly implemented federal regulations. Since that time we have continued to expand and evolve the training program content and to complete the outreach and training of additional network providers. At the conclusion of their training, THP providers submit a training completion attestation. On an ongoing basis, THP's director of provider training and education works with our IT department to monitor a list of providers who have not yet submitted attestation of cultural competency training. Reminders to complete the training are addressed at each opportunity through our provider engagement representatives, including during workshops, conferences and professional organization meetings throughout the year as well as through reminders in our provider newsletter. In the first quarter of 2020, providers who have not attested to completing the training are invited to a webinar to receive cultural competency/SDOH training. In addition, THP's provider engagement representatives will continue to contact PCPs, OB/GYN providers and behavioral health providers who have not submitted an attestation to schedule on-site training dates. The provider engagement representatives will also begin scheduling training with high volume providers in other specialties. THP's provider directories indicate if contracted providers have completed cultural competency training to assist members with the selection of providers to better meet their needs.
- ***Cultural Competency Training at Initial Credentialing:*** In addition, THP requires new providers to complete cultural competency/SDOH training and to complete and submit their training attestation as a provision of their initial credentialing.
- ***Provider Engagement Representative On-Site Training:*** Our provider engagement representatives offer providers and their staff cultural competency, health equity and SDOH training during routine site visits and during all network seminars and workshops throughout the state.

PS005: 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 Manual Annual Review Process

THP recognizes the importance of maintaining an accurate, comprehensive provider manual. The THP Provider Practitioner Manual is available to providers on our website. Provider engagement representatives educate providers regarding how to access the Provider Practitioner Manual as a part of their initial provider training and education during the contracting process. Provider engagement representatives train providers on the content of the manual during initial training as well. THP developed a policy and procedure to ensure our Provider Practitioner Manual contains accurate, up-to-date information and complies with the requirements of the Service Provider Agreement, Section 2.6.2 Provider Manual. Our procedure for provider manual maintenance includes the following steps and requirements:

- The THP Provider Practitioner Manual is reviewed and updated on a bi-annual basis in July and December. Documentation of the bi-annual review, along with the executive review and approval, is maintained by THP's provider training and education director.
- On a bi-annual basis, THP's provider training and education director initiates the Provider Practitioner Manual review process by notifying THP operational departments that the manual is scheduled for review.
- A Microsoft Word version of the document is placed in a designated folder on a shared drive accessible to assigned reviewers. The track changes function is turned on to track all changes made to the documents during the manual review process.
- THP operational departments review the content applicable to their functional areas carefully and entirely, and make updates/additions/deletions to their assigned sections as appropriate.
- When the departments assigned for review have completed their assigned sections, they notify the provider training and education director. The provider training and education director maintains an accounting of all Provider Practitioner Manual review assignments and tracks when each operational area has completed their review. The provider training and education director sends reminders, as needed, to the operational departments and follows up as needed until all assigned reviews are completed.
- After all assigned reviews are completed, the provider training and education director notifies the THP marketing department. The marketing department reviews the document to ensure formatting consistency and compliance with

THP marketing and publication standards. The marketing department finalizes the Provider Practitioner Manual and sends it to the provider training and education director and all operational departments who complete a final review and validation of the content.

- Following completion of the final operational department review, the Provider Practitioner Manual is distributed to THP's medical director and our Medicaid contract liaison/MHT administrator for review and sign off. The executive approval of the Provider Practitioner Manual is documented.
- The mid-year provider manual review cycle is scheduled to ensure the final Provider Practitioner Manual is submitted to BMS annually by July 1st. BMS reviews and approves the revised manual.
- Upon approval, the marketing department updates the Provider Practitioner Manual on THP's website and validates that all links are functioning correctly. The marketing department then notifies the provider training and education director that the updated Provider Practitioner Manual is posted and viewable.
- Providers are notified when the manual is updated via announcements in THP's ProviderFocus newsletter.
- In the event there are mid-cycle BMS policy or program changes or THP procedure or service site changes that require more immediate notification, the provider training and education director sends communications to all network providers at least 30 calendar days before the intended effective date of the change via email and/or postal mail. The updated content is posted and maintained on the THP website with the Provider Practitioner Manual. Those mid-cycle changes are then incorporated into the manual during the subsequent review cycle.

PS006: The Vendor should describe how members are held harmless and protected from balance billing for covered services.

THP is committed to protecting our West Virginia Medicaid and WVCHIP members from being billed for covered services. To ensure compliance, our contracts, resources and procedures offer the following protections to members, regardless of line of business or health insurance program, which includes the protection of our West Virginia Medicaid and WVCHIP populations:

Provider Contracts: All THP provider agreements contain the following verbiage prohibiting providers from billing all members for covered services:

- "Physician agrees to accept the payment from The Health Plan in accordance with Section 8.1 as full compensation for Covered Services provided to

Members. Physician shall not bill or balance bill a Member for services which The Health Plan determines would be Covered Services under a Plan, but for which payment is disallowed, in part or in whole, because of the failure to meet any of the requirements of the Agreement, or the Utilization Management and Quality Management programs, or policies, rules or regulations adopted pursuant to this Agreement."

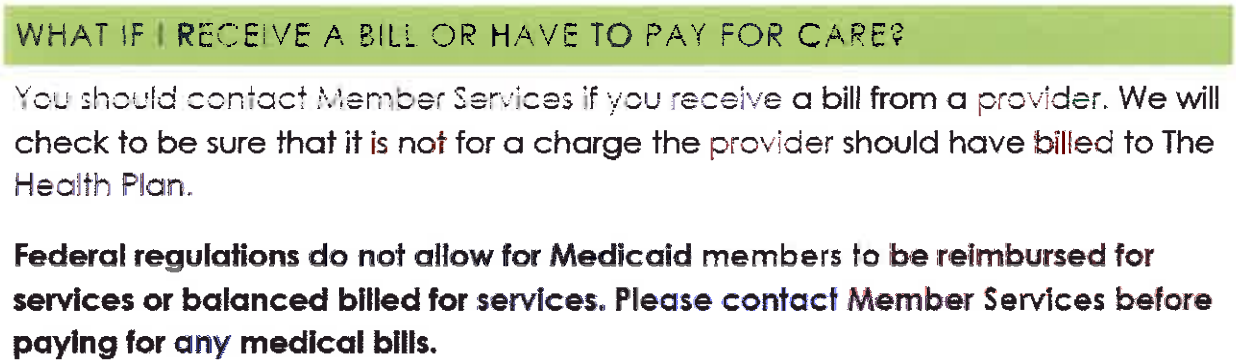
"Physician further agrees that he shall not under any circumstances, bill, charge, demand a deposit from or otherwise seek to be compensated by a Member for the cost of Covered Services, except for any applicable co-payment, coinsurance and/or deductible. Physician hereby agrees that in no event, including, but not limited to non-payment by The Health Plan, The Health Plan's insolvency or breach of this Agreement, shall provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement, or have any recourse against the Member or persons other than The Health Plan acting on their behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of non-covered benefit charges or co-payments or reasonable deductibles, where applicable, on The Health Plan's behalf made in accordance with the terms of this Agreement and the agreement between The Health Plan and the Member. Physicians providing services for Medicare Advantage Plans shall meet the above requirements as well as any additional requirements listed in Attachment G. Providers providing service for West Virginia Medicaid Plans shall meet the above requirements as well as any additional requirements listed in Attachment I.

Provider Practitioner Manual: THP's Provider Practitioner Manual includes instructions to providers that Medicaid and WVCHIP members cannot be billed for covered services.

Provider Training: THP's provider training and education programs and materials include training on the prohibitions regarding balance billing West Virginia Medicaid and WVCHIP members for covered services.

Provider Engagement Representatives: THP's provider engagement representatives remind providers regarding the prohibition of balance billing Medicaid and WVCHIP members during on-site engagements, telephonic communications and during other trainings and provider interactions.

Member Handbook: Our Member Handbook assures members that they cannot be billed or held financially responsible for payment for covered services, and the handbook provides instructions for members should they receive a bill. THP's CSRs will intake those calls, collaborate with the provider engagement representatives to educate the billing provider and resolve the billing issue. The figure displays the instructions to members from THP's Member Handbook if they receive a medical bill.



WHAT IF I RECEIVE A BILL OR HAVE TO PAY FOR CARE?

You should contact Member Services if you receive a bill from a provider. We will check to be sure that it is not for a charge the provider should have billed to The Health Plan.

Federal regulations do not allow for Medicaid members to be reimbursed for services or balanced billed for services. Please contact Member Services before paying for any medical bills.

Figure 4: Our Member Handbook educates members on what to do if they receive a bill from a provider.

The above provisions ensure our West Virginia Medicaid and WVCHIP members are protected from being billed for covered services from network providers. In the event one of our members needs to receive services from a non-contracted provider, THP executes a single case agreement with the provider for the required services. All THP single case agreement documents include verbiage that explicitly prohibits the non-contracted provider from billing the member for any services rendered. In this way, we ensure the full protection of our members from balance billing from both contracted and non-network providers.

PS007: The Vendor should describe how they will develop comprehensive Value-Based Payment (VBP) strategies that link provider payment levels to quality of care outcomes.

We have one of the most robust value-based payment (VBP) programs in West Virginia based upon the breadth of VBPs offered and size of VBP partners, including the largest health system in the state. Our VBP strategy aligns with BMS' vision and priorities for the implementation of VBPs in West Virginia. BMS supports a value-based healthcare system where member experience and population health are improved, the trajectory of healthcare cost is contained through aligned incentives with the managed care organization (MCO) and provider partners and there is a commitment to continuous quality improvement and learning.

As of January 1, 2020, **approximately 23%** of our members were covered by a Category 3 (shared savings arrangement) VBP.

THP deploys a number of VBPs for various provider types throughout West Virginia, including care coordination payments with shared savings for meeting quality measures and total cost of care models. By analyzing multiple years of financial data and three years of clinical-based analytic data, THP creates VBPs that help achieve the quadruple aim of healthcare — improving the quality of care, achieving lower costs, promoting better health outcomes and reducing provider burnout.

THP has the ability to transition its models to risk-sharing with ready/willing provider partners. Our existing shared savings models provide the infrastructure support to build strong care coordination and population health processes. THP's VBPs are flexible and accommodative to provider needs. That is, there are no minimum panel sizes or other constantly evolving quality measure targets.

Experience Cultivating Value-Based Care and Partnerships
Joshua Austin, THP's Director of Provider Strategic Initiatives and VBP lead, coordinated the Centers for Medicare & Medicaid Services (CMS) State Innovation Model (SIM) grant for the State of West Virginia. He was the primary liaison to the DHHR Cabinet Secretary's Office regarding the SIM grant, which developed a plan to transform the state's health care delivery and payment system toward value.

THP is excited by the prospect of serving WVCHIP members, and our existing and future VBP agreements can be adapted to suit pediatric needs. WVCHIP, in terms of member risk, is most similar to the TANF population, as are member needs. Since WVCHIP benefits mirror those of the TANF population, THP will consider WVCHIP members, except for pregnant women, as though they are TANF members when developing the risk-mix for any VBP. THP's current VBPs include pediatric HEDIS measures, but these will be bolstered by incorporating 2020 Core Set of Children's Health Quality Measures as modified to reflect annual administrative or other changes.

As presented in the figure, we seek to meet providers where they are on the VBP/ alternative payment model (APM) framework risk continuum. To date, THP's VBPs are either category 2A through C or 3A. These VBPs include payment bonuses or upside risk only. No payments are taken back or withheld from providers. THP collaborates with providers to develop VBPs that are the best fit for their needs, as well as the needs of our members.

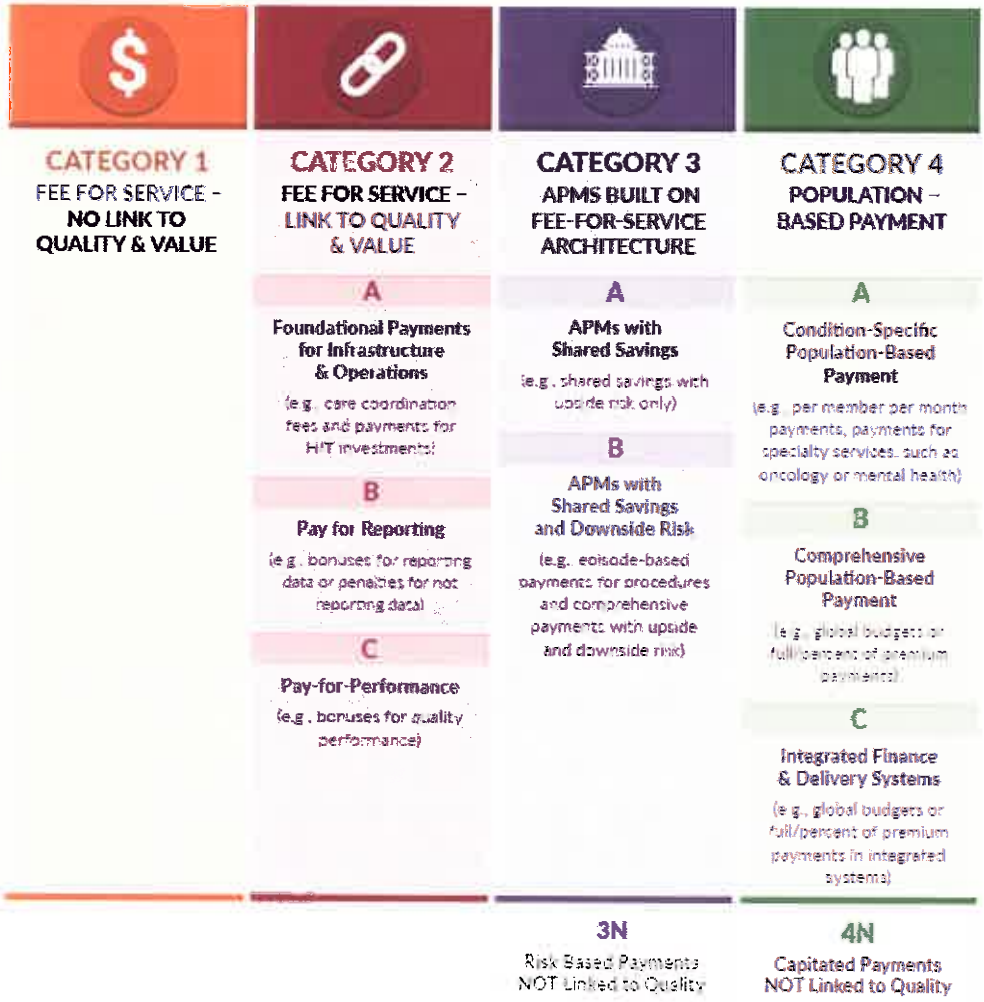


Figure 5: VBP framework risk continuum. THP's VBPs are category 2A through C or 3A and include payment bonuses or upside risk only. THP's VBPs are flexible and accommodative to provider needs. There are no minimum panel sizes or other constantly evolving quality measure targets. No payments are taken back or withheld from providers. **Figure credit:** The Health Care Payment Learning & Action Network.

Current Contracted VBP Relationships

We currently have three contracted VBP relationships in West Virginia and are in discussions with providers and major academic centers in the state to implement additional VBP contracts. We have previously submitted our initial VBP plan to the Department and will continue to submit an annual VBP plan, per **MD006**. Our VBP contracted relationships include the following.

Total Cost of Care Pilot Project with the Prestera Center for Mental Health Services

THP is piloting a total cost of care arrangement with Prestera Center, a major comprehensive behavioral health center that serves southwestern West Virginia. This pilot facilitates the integrated delivery of physical health and behavioral/mental health for Medicaid members determined mutually by THP and Prestera Center using an analysis of high ER utilization. Through this pilot, THP is meeting members where they most frequently access care (e.g., the comprehensive behavioral health center). The pilot is assessed on the ability of Prestera Center to reduce costs and meet one or more quality goals:

- ***Measure 1:*** Reduce the patient risk score (care need index) by 10% or greater.
- ***Measure 2:*** Reduce ER visit total by 10% or greater.
- ***Measure 3:*** Ensure that 88% or more assigned members have a claim originating in a primary care setting for any reason during the performance year.

After two months implementing the total cost of care pilot, however, it became apparent that the transient nature of the population, extreme illness of the members (e.g., two members died before intensive care coordination could begin) and myriad, conflicting care coordination programs necessitated a change in approach. These challenges do not nullify the value of the increased communication and engagement opportunities created by the pilot. Therefore, Prestera Center and THP are revising the pilot to emulate the approach and successes seen in a community health worker program that THP is also supporting (detailed in the next paragraph).

Beginning in March 2020, the pilot will include a community-based health navigator—paid for 100% by a THP care coordination fee—based at Prestera Center to supplement their chronic care management team in Cabell, Kanawha and Putnam counties. The

community-based health navigator will be employed by Prestera Center and charged with supporting THP members who need extra support in managing their healthcare challenges, such as coordinating a PCP or specialist appointment, completing laboratory testing, resolving dietary needs/food insecurity or non-emergent transportation. The community-based health navigator will have access to Prestera Center's electronic medical record system, as well as THP's care management systems to see a complete picture of the patient/member's healthcare utilization and unmet needs. Should this approach to coordinating care prove successful, THP will enlist other comprehensive behavioral health centers as partners in the model—chiefly those located in counties with disproportionate behavioral health utilization.

WVU Medicine

WVU Medicine is the largest integrated healthcare delivery system in West Virginia. Our VBP with WVU Medicine covers an average monthly Medicaid membership of 16,945 members. It is a shared savings arrangement in category 3A. In THP's shared savings arrangements, providers receive contracted fee-for-service reimbursement, a per member per month care coordination fee and increased access to claims and population health and risk stratification data (e.g., patient health risk scores, HEDIS care gap reports and customized data analytics, by request of the provider). In turn, providers are expected to build out care coordination infrastructure and manage the needs of the attributed membership. Our VBP with WVU Medicine tracks attainment of six HEDIS measures:

> THP care managers have access to Epic, WVU Medicine's electronic health record. Through Epic, care managers collaborate with WVU Medicine providers and care coordinators by allowing them to access information about our members who are served by WVU Medicine. This includes information, such as discharge plans, member appointments, case notes, assessments and treatment plans. THP care managers can also update each member's electronic health record when providing the member with care coordination services.

- BCS: Breast Cancer Screening
- ABA: Adult Body Mass Index Assessment
- WCC: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – Body Mass Index Assessment for Children/Adolescents
- CDC: Hemoglobin A1c (HbA1C) Testing
- AWC: Adolescent Well-Care Visits
- IMA: Immunizations for Adolescents (Combo 2)

For performance year 2019, THP is projecting that WVU Medicine will successfully attain quality measures for at least three of the above quality measures, as well as meet targeted medical loss ratios. This means THP should make a shared savings payment to WVU Medicine.

A Successful and Growing Value-based Partnership

"[…] WVUHS and THP continue to partner in ways that benefit West Virginia Medicaid members and the state. WVUHS and THP are now in the second performance year of our innovative Medicaid Shared Savings Program. Under this program, WVUHS and THP collaborate to identify high-risk and rising-risk Medicaid members in order to provide targeted care coordination and other resources to improve quality of care and efficiency. In our first performance year, we succeeded in reducing cost of care of Medicaid members attributed to the program."

- Albert L. Wright, Jr., President & CEO of West Virginia University Health System (WVU Medicine), in a letter of support for this RFP response

Community Care of West Virginia, Inc.

Building on our community health worker pilot, THP recently began a VBP arrangement with Community Care of West Virginia, Inc., the second largest federally qualified health center in the state. Our VBP with Community Care of West Virginia covers an average monthly Medicaid membership of approximately 2,000. It is a shared savings arrangement in category 3A and tracks attainment of seven HEDIS measures:

- CDC: Comprehensive Diabetes Care: Eye Exam
- CDC: Comprehensive Diabetes Care: BP Control [140/90]
- BCS: Breast Cancer Screening
- AWC: Adolescent Well-Care Visits
- CHL: Chlamydia Screening in Women
- CCS: Cervical Cancer Screening
- W34: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Community Care of West Virginia is a high performer in quality terms, and this VBP arrangement focuses on challenging measures for Medicaid members, as well as certain measures of consequence to WVCHIP, such as AWC – Adolescent Well-Care Visits and W34 – Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life. By increasing resources to Community Care of West Virginia through a care coordination fee, we anticipate incremental improvement in quality measures, reductions in avoidable costs and overall member health improvement. This should increase further in 2021, the second year of the VBP, as Community Care of West Virginia and THP collaborate and better align on patient/member care.

Implementing a Community Health Worker Program

In September 2018, THP partnered with Marshall University, Community Care of West Virginia and the Claude Worthington Benedum Foundation to implement a community health worker program. THP is supporting the program by covering 25% of the cost to employ a community health worker for year one at Community Care of West Virginia site(s). Marshall covers the remaining 75% of costs through grant funding. The program incorporates a community health worker as part of an interdisciplinary care team. The community health worker conducts home visits with patients or meets with patients after primary care appointments in office—based on the patient's preference—to help him or her with a range of chronic conditions, including diabetes, high blood pressure and obesity, among others.

Average per member health care spending **dropped from $26,639 to $14,135** in the first year, a substantial **reduction of 46.9%.**

On Nov. 1, 2018, Community Care of West Virginia enrolled 40 high-risk THP Medicaid members in the program who have chronic conditions and poor patterns of utilization of

healthcare services. Comparing the period Nov. 1, 2018, to Oct. 31, 2019, we have seen significant improvements in the average:

- Patient risk score, an indicator of a member's health risk, dropped 8.8% from 3.07 to 2.80.
- Number of ER visits dropped 23.1% from 3.55 to 2.73.
- Number of admissions dropped 85.9% from 0.64 to 0.09
- Number of prescriptions increased from a total of 59 to a total of 80, indicating more members receiving appropriate care

This collaborative pilot program will continue for an additional two years, with THP's share of costs for the community health worker increasing each year. We will continue to conduct an actuarial analysis of healthcare spending, care patterns and overall quality of care as enrollment of individuals in the program continues.

PS008: 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.

The THP network department administers a Provider Satisfaction Survey on an annual basis. The purpose of the survey is to provide THP with insight into our network providers' level of satisfaction with the plan, and to identify opportunities to develop interventions to improve provider satisfaction that will drive high network retention rates and maintain and/or improve access to services by our members. THP submits Provider Satisfaction Survey analysis and results to BMS on an annual basis prior to June 30th of each year. Key components of the Provider Satisfaction Survey include:

- The Provider Satisfaction Survey is mailed annually to a sample selection of physicians and providers based upon West Virginia Medicaid membership volume.
- The provider population selected for the survey includes PCPs, secondary care physicians, specialists and behavioral health providers.
- The providers selected must meet the following criteria: providers must participate in West Virginia Medicaid, they must have rendered services to West Virginia Medicaid members in the previous contract year, and they must have

provided services to no less than 65 West Virginia Medicaid members during the previous contract year.

- The survey requests providers complete information regarding their provider specialty and their participation in THP lines of business to allow analysis and compilation of trends particular to specific provider specialties and/or lines of business.
- The survey is structured to prompt providers to supply a satisfaction rating for each question under each sub-category.
- The respondents are asked to rate each question on a scale from one to five, with one being the lowest satisfaction rating and five being the highest. For certain questions, the respondent has the option to supply a "not applicable" response.
- For analysis, the satisfaction scale is then weighted and a percentage is supplied for each category and subcategory.

The table defines the Provider Satisfaction Survey categories and sub-categories.

THP Provider Satisfaction Survey	
Survey Category	**Sub-Category Assessment Categories**
Clinical Services	▪ THP's medical and behavioral preauthorization process ▪ Utilization management/inpatient initial and concurrent review process for coverage determinations and appeal processes for medical and behavioral health facility admissions ▪ Access to clinical services staff for peer-to-peer discussion ▪ Satisfaction, understanding and integration with clinical service member population health programs including wellness/outreach initiatives, case management/care navigation and disease management programs
Claims Payment	▪ Timeliness of claims payments ▪ Accuracy of claims processing and payments ▪ Reasons for denied and pended services are clearly documented and available
Customer Service & Courtesy of THP Staff	▪ Initial response time by CSR ▪ Timeliness of THP's response to provider inquiries ▪ Questions answered appropriately ▪ Friendliness, courtesy and respect shown to providers and staff by THPs personnel
Education/Communication	▪ THP policies and procedures are easily accessible ▪ The accessibility and "user friendliness" of the electronic provider manual ▪ Effective communication regarding new, or changes to, policies and procedures via email blast, provider newsletter and website ▪ THP provider portal is intuitive and easy to navigate

THP analyzes Provider Satisfaction Survey results on an annual basis to identify opportunities for improvement that will enhance provider satisfaction with THP. The

network department identifies annual interventions for implementation and tracks and trends the impact to overall satisfaction over time. Interventions are designed to enhance THP's service level to providers or to reduce administrative burdens on providers, with the ultimate goal of maintaining a high level of provider satisfaction with THP to ensure continued network retention and availability of services to THP members.

2019 Provider Satisfaction Survey Results

In 2019, there were 700 Practitioner Experience Surveys mailed to PCPs, behavioral health practitioners and secondary care physicians. We received 91 responses for a return rate of 13 percent. The return rate remains low, but is up from past survey years. For 2020, THP is considering face-to-face Practitioner Experience Surveys using provider engagement representatives during on-site visits to increase response rate and allow for immediate feedback in addition to the mailed version.

As with previous surveys, an internal benchmark of 90 percent positive response rate for all questions is THP's goal. Responses for 2019 remained positive and on track exceeding the goal in all categories with satisfaction scores for Utilization Management showing: 97.62% positive response for Preauthorization Criteria Flexibility, 97.62% for criteria fairly applied on a case by case basis, 98.73% for UM nurse navigator clinical expertise and 98.65% for Medical Director availability for peer to peer. Satisfaction scores for responses related to Case Management also exceeded the benchmark with: Nurse Navigators helped me find services/supported member access at a 94.03% positive response rate, Nurse Navigators encouraged compliance with my treatment plans at 97. 01%, Nurse Navigators provide useful information to my patients/families at

98.53% and my patients who engage with nurse navigators have better outcomes at 96.97%.

As a result of this survey, we are planning ongoing provider education to support identified provider topics of interest. This provider education will be delivered through seminars, newsletters, email blasts, provider engagement representative visits and THP's website. Our goal is to increase understanding regarding the various Clinical Service Programs, and how to contact our medical directors for discussion of review decisions.

TheHealthPlan

Attachment 6
Quality

9. Quality

The Vendor should refer to the business specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D. Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Quality (QU) as part of their bid. The Vendor's narrative response should not exceed 75 pages.

The Health Plan (THP) has operated a Medicaid Quality Assessment and Performance Improvement (QAPI) program in West Virginia since 1996. Our QAPI program features an integrated clinical, utilization management (UM) and quality management (QM) oversight structure and an interdisciplinary set of QM principles, policies and systematic processes and workflows that evaluate whether we are delivering positive outcomes in terms of member experience, outcomes and quality of life and the quality and cost of care. Our QM program helps to identify members who have unmet needs, confirms the effectiveness of care delivered to members and verifies the effectiveness of our care management programs.

Our QAPI Program meets NCQA standards and has been evaluated by the State's external quality review organization (EQRO). According to the EQRO 2019 Performance Measure Validation (PMV) report, our QAPI program:

- Can effectively evaluate the performance of our Medicaid program and confirm we deliver comprehensive, high-quality healthcare services.
- Has no identified deficiencies
- Uses performance standards that are objective, clearly and unambiguously defined, and based on current knowledge or health services research, to assess our performance

Per the EQRO vendor 2019 PMV Report, THP met or exceeded the National Medicaid Average for the following measures:

- Childhood Immunization Status: Combination 3
- Dental Sealants for 6-9 Year Old Children at Elevated Risk
- Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment: Initiation of AOD Total
- PQI 05: Chronic Obstructive Pulmonary (COPD) Disease Admission Rate
- PQI 08: Congestive Heart Failure (CHF) Admission Rate
- PQI 15: Asthma in Younger Adults Admission Rate
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Counseling for Nutrition
- Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life

- Complies with all validation components and rates and our rates were determined to be reportable
- Has appropriate systems in place to correctly process claims and encounters

QU001. The Vendor should describe its Quality Assessment and Performance Improvement (QAPI) Program.

Our QAPI program monitors performance, seeks opportunities for improvement across all healthcare services provided and addresses meaningful clinical issues that reflect the health needs of significant groups within our member population. It is designed and operationalized to monitor and evaluate the degree to which healthcare services, operational processes and customer service compare to expected outcomes and identify opportunities and strategies for improvement. The goals and objectives of our QAPI program include:

- Improve quality of care and service outcomes across all healthcare settings, including behavioral health and substance use management, for our members.
- Use quality objectives to drive strategic performance improvement.
- Demonstrate compliance with all external quality improvement oversight and regulatory agencies.
- Use a multidisciplinary approach to monitor, analyze and evaluate the effectiveness, efficiency, safety and overall quality of care and services.

Key Features of Our QAPI Program

Our multifaceted QAPI program includes integrated oversight and member- and provider-driven policies, processes, measures and data analytics tools that help us continually evaluate the effectiveness of our health plan operations so we can offer the highest quality, cost effective care to our members. Core components of our QAPI program, discussed in the following sections, include:

- ***Documenting our QAPI program through our QAPI program description and program evaluation:*** Our QAPI program description defines the range of clinical care and service issues relevant to our members. It includes our Work Plan, which documents and monitors quality improvement activities throughout the organization for the upcoming year.

- ***Providing integrated oversight of our QAPI program and promoting collaboration and integration:*** Our oversight body includes seasoned staff, THP medical directors and local board-certified physicians who represent a variety of specialties. They provide oversight of all activities related to quality through our established QM workgroup and committee structure, discussed in our response to **QU002**.
- ***Implementing systems capable of monitoring the effectiveness of our programs:*** The EQRO vendor evaluated our data systems and the processes we use to construct our performance measures, assessed our calculated rates for algorithmic compliance to required specifications and verified our reported rates are reliable and based on accurate sources of information.
- ***Using nationally recognized measures to monitor the effectiveness of our QAPI program:*** Our QAPI program evaluates the effectiveness of service delivery through the adoption of objective performance standards, such as Consumer Assessment of Healthcare Providers and Systems (CAHPS), surveys, Medicaid Healthcare Effectiveness Data and Information Set (HEDIS) measures, CMS-specified Core Measures and Early and Periodic Screening, Diagnosis and Treatment (EPSDT). We will track the measures in the 2020 PMV Report and incorporate the 2020 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) into our QM activities.
- ***Using our measures to assess performance and develop interventions to improve:*** Our QAPI program serves as a gateway to care management, disease management and wellness program by identifying members who have not been connected to care. For instance, when reviewing trends in HEDIS rates, we identified lagging improvement on several measures related to women's preventive care. As a result, we are developing a Women's Health Initiative 2020, designed to support and improve evidence-based breast cancer, cervical cancer and chlamydia screening rates in women enrolled in the Mountain Health Trust (MHT) program.

Documenting our QAPI Program through our QAPI Program Description and Program Evaluation

We document the framework for our QAPI program in our QAPI program description, which defines the range of clinical care and service issues relevant to our members. Our QAPI program description was reviewed and approved by the EQRO vendor in March 2019. It will be reviewed when the quality portion is surveyed in March 2020 for review of 2019. The QAPI program description includes our Work Plan that documents and monitors quality improvement activities throughout the organization for the upcoming year. Our Work Plan includes measurable goals and objectives based upon

opportunities for improvement identified from the previous year and strategic initiatives. We update our Work Plan at least quarterly to assess the progress of the QM activities.

Our program evaluation is the yearly evaluation of the previous years' activities in the work plan. The evaluation provides measurable performance analysis with emphasis on the effectiveness of the activities as well as identified barriers and opportunities for improvement. The QAPI program description, Work Plan and program evaluation are reviewed and approved by the Continuous Quality Improvement (CQI) Workgroup, Quality Improvement Committee (QIC) and Executive Management Team (EMT). We discuss our QAPI oversight structure in our response to **QU002**.

Providing Integrated Oversight of Our Program/Promoting Collaboration

Our oversight body includes seasoned staff, THP medical directors and local board-certified physicians who represent a variety of specialties. They provide oversight of all activities related to quality through our established QM workgroup and committee structure, discussed in our response to **QU002**. Through this structure, we oversee all aspects of our QAPI program, coordinate QM activities and promote communication and collaboration among every THP department. This provides a multidisciplinary approach from clinical, non-clinical and operational areas to monitor and address quality concerns and promote continuous improvement of our programs.

Implementing Systems Capable of Monitoring the Effectiveness of our Programs

Throughout 2019, the EQRO vendor evaluated our automated systems, management practices, and data control procedures necessary to ensure all required information for performance measure reporting is captured, translated, stored, analyzed and reported. The EQRO vendor evaluated our data systems and the processes we use to construct

the measures, assessed our calculated rates for algorithmic compliance to required specifications. In its 2019 PMV Report, the EQRO vendor verified:

- Our reported rates are reliable and based on accurate sources of information
- We are compliant with all validation components and our rates were determined to be reportable
- We have appropriate systems for accurate claims and encounter processing
- We have a medical record over-read rate of 100% for all measures

Using Nationally-recognized Measures to Monitor the Effectiveness of our Program

Our QAPI program evaluates the effectiveness of service delivery through the adoption of standards of performance that are objective, clearly and unambiguously defined, and based upon current knowledge or health services research, to assess our performance. They include CAHPS, provider surveys, satisfaction surveys, Medicaid HEDIS measures, CMS-specified Core Measures, EPSDT and nationally recognized clinical guidelines, such as InterQual. We will track the measures identified by the EQRO vendor in the 2020 PMV Report and incorporate the 2020 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) into our QM activities.

We already track our performance against 15 of the 26 of the 2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set). In anticipation of the addition of WVCHIP members to the MHT program, we are incorporating the 11 remaining measures into our quality monitoring and care management programs.

Using Our Measures to Assess Performance and Develop Interventions

Our QAPI program serves as a gateway to care management, disease management and wellness program by identifying members who have not been connected to care. For instance, when reviewing trends in HEDIS rates, we identified the lack of improvement in rates of adolescent well child visits. We worked with a network provider to help us offer services through school-based clinics. We identified the counties that

had school-based clinics, identified the children and adolescents from those counties who had not seen a PCP or had a well child visit in over 12 months. We mailed letters to the parents/guardians of these children to educate them about the availability of these services at the school at no cost to them. We are trending the visit rates on this population to evaluate improvement.

Improving Access to Dental Services among Children

In Q1 2018, we implemented a performance improvement project (PIP) to improve access to dental services among children as measured by the Annual Dental Visits for 2-3 Year Olds (HEDIS) measure and the Percentage of Eligible That Received Preventive Dental Services (Child Core Set Measure). Our annual HEDIS rates for Annual Dental Visits ***increased from 27.40% in 2018 (MY2017) to 36.29% in 2019 (MY2018)***. Additionally, the Percentage of Eligible That Received Preventive Dental Services ***increased from 34.98% in 2018 (MY2017) to 43.35% in 2019 (MY2018)*** This was the first re-measurement year and interventions will be ongoing.

QU002. The Vendor should describe how they will coordinate Quality Assessment and Performance Improvement (QAPI) activities with other performance monitoring activities.

QU004. 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).

We provide oversight of our QAPI program through our established QM committee structure presented in the figure. Through this structure, we oversee all aspects of our QAPI program, coordinate QM activities and promote communication and collaboration among every THP department. This provides a multidisciplinary approach from clinical, non-clinical and operational areas to monitor quality, address quality concerns and promote continuous improvement of our programs.

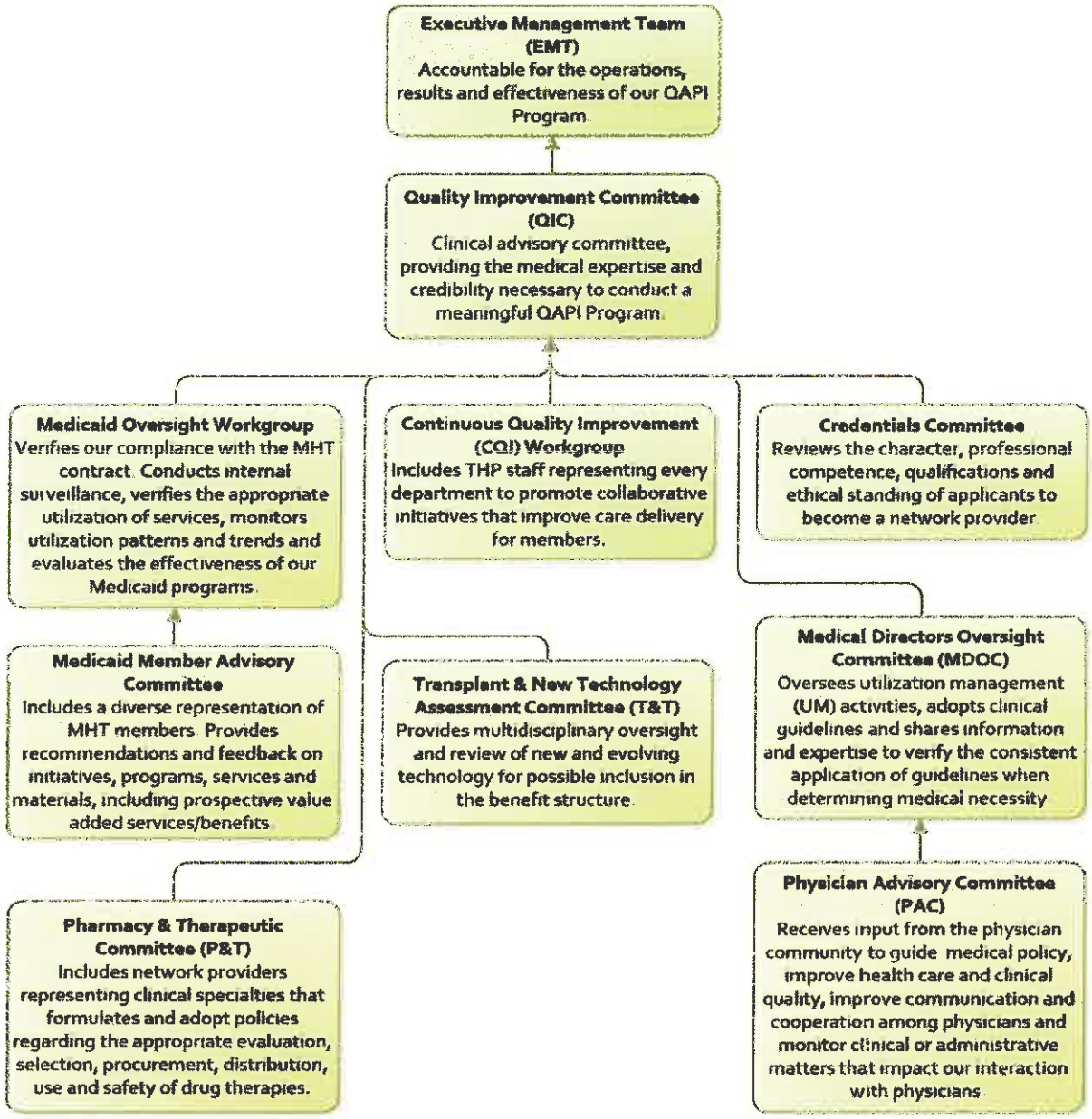


Figure 1: QAPI Program Oversight. Through our established QM workgroup and committee structure, we oversee all aspects of our QAPI program, coordinate QM activities and promote communication and collaboration among every THP department. This provides a multidisciplinary approach from clinical, non-clinical and operational areas to monitor quality, address quality concerns and promote continuous improvement of our programs.

Medicaid Oversight Workgroup

Our Medicaid Oversight Workgroup verifies our compliance with the West Virginia Medicaid contract. The Workgroup meets monthly and includes THP department leads who work directly with the Medicaid contract. The Workgroup:

- Reviews all appropriate Medicaid correspondence, meeting notices or issues and concerns regarding EQRO reviews.
- Acts as the implementation team for new products and services required under the Medicaid contract.
- Conducts internal surveillance through review of population health data analyses to follow trends across the state and determine if further drill down, investigation, or corrective action is needed based on patterns of care.
- Verifies the appropriate utilization of medical and behavioral resources in the amount, duration and scope necessary to achieve desired enrollee health outcomes.
- Evaluates the effectiveness of our Medicaid care management programs
- Monitors utilization patterns and identifies trends and provides actionable information about our members to our care teams and providers.

A subcommittee of our Medicaid Oversight Workgroup, our newly formed Member Advisory Committee will include a diverse representation of MHT members, including WVCHIP parents/members. Committee members will provide recommendations and feedback on initiatives, programs, services and materials, including prospective value added services/benefits. Through our quarterly newsletter, we will offer members the opportunity to participate in our member advisory committee and other pilot programs or surveys.

When the Medicaid Oversight Workgroup identifies issues that need to be addressed systemwide, such as utilization concerns, it forwards the issue to our CQI Workgroup to develop a solution. Analyses that indicate potential fraud, waste and abuse (FWA) are forwarded to our special investigations unit (SIU) for investigation.

CQI Workgroup

Working under the auspices of the EMT and QIC, our primary mechanism to coordinate quality improvement activities and promote communication and collaboration is through our CQI workgroup. The Workgroup, which is chaired by a representative from the quality improvement department, includes THP staff representing every department to promote collaborative initiatives that improve care delivery for members.

Representation from each department provides a multidisciplinary approach from clinical, non-clinical and operational areas to promote problem identification and problem-solving and oversight of THP quality improvement activities in accordance with

Article III, 6.5.5 QAPI Communications in the Service Provider Agreement. The CQI establishes subcommittees to identify opportunities for improvement and potential interventions.

Experience Collaborating to Develop Programs to Improve Our Performance

The CQI Workgroup meets to discuss their department's work plan indicators and barriers and opportunities for improvement. The following are examples of actionable items that have been implemented as the result of barrier analysis discussion:

Creation of Accreditation Readiness Team

The CQI Workgroup addressed opportunities for improvement identified during our recent NCQA survey. The workgroup's observations consistently addressed that information was only strongly shared at a leadership level within THP with fragmented portions shared at the day-to-day operational level. Employees were aware of standards applicable to their areas of focus versus corporate wide. This was felt to be a barrier that was creating a silo within the organization. Previous communication was shared via email to employees. Employees who were surveyed mentioned that they wanted more engagement versus email communication. Email for newer employees, who were not familiar with accreditation standards, was not effective.

THP needed to develop a more structured platform to help others (THP board members, EMT, senior staff and THP employees) understand the purpose of the accreditation standards and how the compliance of the standards benefits our members, providers and our overall business. We needed to adopt a culture of continuous accreditation compliance to better position ourselves for future reaccreditations. As a result, the CQI implemented the Accreditation Readiness Team,

which included designated employees representing all departments to engage in efforts to improve processes aimed at improving health outcomes, accreditation and HEDIS.

Designated employees representing all departments engage in efforts to improve processes aimed at improving health outcomes, accreditation and HEDIS.

- Accreditation Kickoff Campaign
- Creation of employee in-services and communication
- Interactive accreditation campaigns with mandatory employee testing to improve knowledge deficit related to mission critical areas (NCQA, HEDIS)

Creation of Denial Letter Review Tool

The CQI Workgroup also identified an opportunity for improvement related to UM standards for NCQA with regard to denial and appeal notification. Previously, denial and appeal letters were submitted to a nightly file for mail delivery. To confirm NCQA UM standards were met (e.g., denial and appeal language being in easily understandable language to the member, including the cited rationale for which the decision was made), a letter review tool was developed and implemented in early 2019. The tool allows the QM and clinical services teams to audit the timeliness and appropriate letter content. Data are now collected and used for remediation and education to reinforce compliance and best member experiences.

Through the CQI, our QM, clinical services and information technology (IT) teams collaborated to develop and implement a system that houses each member and provider denial notification. Each letter is reviewed daily by QM and Clinical Services for NCQA compliance and timeliness. Errors are rerouted to the registered nurse (RN) reviewer to correct and resubmit for final approval. Once approved, the letters are released to IT for final processing and mailing. Analyses are performed by department

and individual nurse reviewer with formal remediation and education in-services as needed.

Development of Communication Focus Group

Our CQI developed a focus group for EMT and leadership to bring barriers and opportunities to improve communication with members, practitioners and employees through different venues. The focus group, facilitated by our community engagement and quality director evaluated the following:

- Developing yearly training/competencies improving current processes for new employee orientation.
- Focus group to be used as a pilot group for text messaging platform as a method of improved communication.
- A survey is completed at the end of new member calls to assess our effectiveness welcoming the member to the plan and explaining benefits, enrollee rights, etc. The surveys are analyzed and reported in the workplan and CQI. It was determined that some of the questions could be misinterpreted by members leaving room for subjectivity to the survey results. The CQI decided this was a barrier and that an opportunity existed to improve our call script to assure we were capturing accurate data that would be analyzed for best possible member outcomes.

QU003. 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.

Methodologies for Collecting Quality Measures for Different Populations to Identify Barriers to Care

Our population health management team provides a comprehensive analysis on numerous data points to identify individuals with special healthcare needs and also identify barriers to care, and share the data to create programs based on this information. The team gathers data that helps us identify barriers to care from a variety of sources, such as the following.

New member welcome call and initial screening. During the new member welcome call, our member advocates document social determinants needs or barriers to

accessing care. Our adult and pediatric health risk assessments (HRAs) each include two questions related to social determinants of health (SDOH). Depending upon the member responds to these questions, the member advocate may use our SDOH assessment, discussed below, to obtain additional information about the member's SDOH needs.

SDOH Assessment. Many of our care management system's assessments identify members who have SDOH needs. For instance, the adult and pediatric HRAs each include two questions related to social determinants. Depending upon the member responds to these questions, our member advocate or the member's care manager use our SDOH assessment to obtain additional information about the member's socially necessary services. The assessment asks 16 questions related to SDOH, such as housing, education, employment, safety and income. The figure presents the first page of the SDOH assessment in our care management system.

Figure 2. SDOH assessment. The assessment asks 16 questions related to SDOH, such as housing, education, employment, safety and income.

Additionally, THP's care managers also have access to WVU Medicine's EHR, Epic, which gives them the ability to collaborate with WVU Medicine providers and care

coordinators by allowing them to access information about our members who are served by WVU Medicine. This includes information obtained by Epic's SDOH assessment tool. The tool identifies SDOH needs across domains, including education, financial risk, social connections, intimate partner violence, food insecurity and transportation needs.

ICD-10 codes. One of the key barriers to expanding access to nonmedical care for social needs is a lack of coding standardization. We are implementing ICD-10 codes that help us identify the impact of social determinants on our members' ability to access care and track the delivery of services to address social determinants, while avoiding additional administrative work for providers.

Quality measures. Our QAPI program adopts objective standards of performance that help us monitor the effectiveness of our programs, including identifying barriers to accessing care. These standards include CAHPS, provider surveys, satisfaction surveys, Medicaid HEDIS measures, CMS-specified Core Measures, EPSDT and nationally recognized clinical guidelines, such as InterQual. We will track the measures identified by the EQRO vendor in the 2020 PMV Report and incorporate the 2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) into our QM activities.

Methodologies for Analyzing Quality Measures for Different Populations to Identify Barriers to Care

Annually, our population health management team evaluates the needs of our members and uses that information to assess whether current programs need modification to better address the needs of its membership. Each year, we examine data to evaluate

the needs of member subpopulations, including individuals with special healthcare needs as follows:

- Evaluation of the characteristics and needs of the member population including an analysis of the impact of relevant SDOH.
- Evaluation of health status and risks by using utilization data broken out into at least the following cohorts based on the enrolled product lines: ages 2-19, ages 20-64 and ages 65 and over. Additionally, members with special healthcare needs are evaluated in separate cohorts, such as Children with Special Health Care Needs (CSHCN) or members receiving transplants.
- Evaluation of the needs of members with disabilities.
- Evaluation of the needs of members with severe and persistent mental illness (SPMI).

We have developed a Barrier Report that analyzes information obtained from the initial HRA and annual HRA and the health and disease-specific assessments completed by care navigators. The report trends access to services and concerns that resources are not adequate within a region. The report also identifies SDOH barriers, such as transportation issues and financial concerns. The report provides us the opportunity to take immediate action and refer to services that can support the individualized needs of each member.

The population health management team reports separately by product line to facilitate an understanding of similarities and differences in health needs and status by product line. When the data analysis is complete, our population health management and clinical services teams determine if changes are required to care management programs or resources. In addition, there is an evaluation of the extent to which our programs facilitate access and connection to community resources that address member needs outside the scope of the health benefit plan. Modifications to program design and resources are made based on these findings.

Population Stratification. The population health management team combines data from multiple sources to use in its population stratification and program eligibility process. The following data are incorporated: data from our initial HRA, SDOH and other assessments, medical and behavioral claims, pharmacy data from Department of

Health and Human Resources (DHHR), lab results, consumer data, electronic health records, data from our UM and care management programs, advanced data sources such as all-payer claims databases or regional health information exchanges, West Virginia Health Information Network (WVHIN) and publicly available data from sources, such as the U.S. Census Bureau, County Health Rankings and Roadmaps, data from DHHR, such as diabetes prevalence in West Virginia, the CDC, the Food Research & Action Center and West Virginia Food Link.

Our population health management team uses a variety of advanced data analytics tools to analyze the data we collect and produce reports, dashboards and scorecards that help evaluate our performance, including identifying barriers to care for all populations including individuals with special healthcare needs. They include:

- ***Impact Pro*** integrates data from our initial HRA, SDOH and other assessments, medical behavioral claims, pharmacy data from DHHR, lab results, consumer data and publicly-available data. Impact Pro then analyzes variables at the member- and population-level to stratify members into care management levels in alignment with their health risk and identify population trends and member sub-populations within the larger member population so we can deliver interventions relevant to our members.
- ***CCGroup Marketbasket*** analytical software provides reports related to prevalence of medical conditions and the utilization patterns of services used to treat these conditions, and builds practice pattern variation reports based upon providers of the services.
- ***Cotiviti*** allows us to collect HEDIS data through electronic means, such as claims data and lab values, and supplemental data, such as blood pressure readings and cervical cancer screenings, and analyze our performance against HEDIS measures. Underperforming HEDIS measures indicates underutilization of HEDIS preventive services.

Using the Findings from Our Analyses to Address Barriers

Our QAPI program serves as a gateway to care management, disease management and wellness program by identifying members who have not been connected to care

and identifying barriers to care for all populations, including individuals with special healthcare needs. For instance:

- When reviewing trends in HEDIS rates, we identified minimal improvement on several measures related to women's preventive care. As a result, we developed the Women's Health Initiative 2020 to improve evidence-based breast cancer, cervical cancer and chlamydia screening rates.
- We have developed value-based payment (VBP) models that include the opportunity to impact up to 18 HEDIS measures that are included in the agreements.
- Our Medicaid Adult CAHPS survey identified opportunities for improvement, including customer service, shared decision making and rating of the member's personal doctor. The Medicaid Child survey identified opportunities for improvement related to shared decision making rating of personal doctor. To address these improvement opportunities, we have just concluded a simulated off-cycle survey to help identify the causes of these concerns to allow targeted intervention. A deep dive into the responses that the off-cycle survey provides will help us understand why and where members have responded less positively and see if it may be regional, related to specific medical conditions, special needs or access to services. From that information, we will create an action plan to support and educate both members and providers to drive improvement of member satisfaction.
- We implemented a PIP to improve access to dental services among children as measured by the Annual Dental Visits for 2-3 Year Olds (HEDIS) measure and the Percentage of Eligible Who Received Preventive Dental Services (Child Core Set Measure). During its first year of implementation, each quarter we continually evaluated and modified the PIP interventions as we identified barriers to connecting members to these services. For example, we discovered that members may not be aware of or may not be able to access free transportation services for members to attend dental exam visits. To resolve this concern, we:
  - Are working with DHHR to obtain the number of members who have used transportation services, the regions or locations of these services, and member issues, dissatisfaction or complaints regarding transportation services for our members to identify issues obtaining transportation.
  - Augmented our education to members about the availability of transportation services and how to access them by posting information about transportation on our website, including transportation information in our Member Handbook, including education about transportation member outreach team calls and providing educational materials to provider offices for office staff and members.

QU005. 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).

There is widespread recognition and evidence that the social determinants of health – social, economic and environmental factors – are primary drivers for health outcomes, healthcare costs and quality. Our HRA and care management program identifies social and economic barriers and health disparities that stand in the way of members meeting their healthcare goals and connects them to resources that resolve those barriers. A key component of our approach is training our staff and providers on cultural competency, health equity and about SDOH and how to connect members to resources that address their SDOH concerns to achieve health equity and optimal outcomes.

In June 2019, a representative from the Ohio County WIC office visited our office to provide training in the WIC program to our care managers, perinatal team and outreach staff. The training covered a variety of topics, including:

- Who is eligible for WIC and how to encourage members to participate
- How to refer members to the WIC program
- Nutrition education
- Additional programs for WIC-eligible members, such as Right from the Start or pregnancy assistance programs
- WIC-eligible foods
- WIC clinics across West Virginia

We have implemented a comprehensive cultural competency, health equity and SDOH training program for providers and staff that includes the following:

Annual THP staff training includes:

- Every THP employee is required to complete annual cultural competency, health equity and SDOH training as well as upon employment, attested to with an 80 percent passing score. We last completed this training in January 2020. The training is web-based and covers several important topics, including the importance of health equity, defining social determinants and explaining why they are important and how they can impact a member's care. It addresses the
- Resources available to address member needs across West Virginia and how to refer members to these resources.
- Using Aunt Bertha, a database tool of social care resources, to identify social services in the member's community that can meet their SDOH needs.

Aunt Bertha's social care network connects people and programs — making it easy for people to find social services in their communities and for nonprofits to coordinate their efforts.

- Using our care management system's SDOH assessment tool, including using the findings from the assessment to develop interventions to address SDOHs in the member's treatment plan, making referrals to SDOH resources using Aunt Bertha and tracking Aunt Bertha referrals so we can follow-up with members to confirm their needs have been met.

Annual provider training: Our provider engagement team takes the lead on providing face-to-face and web-based education on the importance of assessing, identifying and taking action on health equity and SDOH, particularly, employment and income, housing concerns, educational level, food insecurity, and social cohesion and ensuring health equity for all.

Additionally, provider engagement representatives assess for health equity and SDOH, address health disparities as part of each provider visit and document the findings of the assessment. We also encourage providers to use resources available to them to document and track SDOH needs. For example:

- Use ICD-10 codes to track SDOH and related services. Appropriate billing on social determinants needs and services will help us track that our enrollees actually receive the necessary services while avoiding additional administrative work for providers
- Refer to programs and resources such as Aunt Bertha, WV 211, and others such as Birth to Three and WIC.
- Access our care management system through the provider portal and the functions available to providers to coordinate member care, including SDOH resources.
- Assess a member's needs using assessment tools available through our care management system and referring them to our care management team to help with health equity or SDOH needs.
- Use our care management system's SDOH assessment tool, including using the findings from the assessment to develop interventions to address SDOHs in the member's treatment plan, making referrals to SDOH resources using Aunt Bertha and tracking Aunt Bertha referrals so we can follow-up with members to confirm their needs have been met.

QU006. 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.

THP's subcontractor oversight policies and procedures include receipt and review of reports and data from subcontractors, pre-delegation audits, auditing and monitoring processes conducted at various levels of the organization, corrective actions, as needed, and reporting to a Subcontractor Oversight Committee, THP executives, the Corporate Compliance Committee (CCC) and the Audit & Corporate Compliance Committee (A&C). Our subcontractor oversight process complies with the requirements in Section 8.5 of the Service Provider Agreement. THP accepts the financial, legal, ethical and other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors and other entities that support or will support THP in the performance of the Medicaid Contract.

Subcontractor Oversight Committee

The Subcontractor Oversight Committee includes members from Medicaid operations, internal audit, compliance and quality management. The Committee receives reports from the subcontractor account manager, VP Medicaid Christy Donohue, on a form designed to capture all auditing and monitoring activities related to each subcontractor. Ms. Donohue coordinates the monitoring activities associated with all Medicaid subcontractors. The Subcontractor Oversight Committee regularly reviews the monitoring and auditing activities conducted to ensure each subcontractor performs its delegated duties in a manner consistent with THP's expectations and the requirements of the Bureau for Medical Services (BMS) contract, including continuity of care, access to care and member satisfaction

Reporting Requirements and Performance Monitoring

Each subcontractor must submit periodic performance reports to THP. The name, purpose and frequency of each report is documented on the applicable Subcontractor Monitoring Plan and Report Form that is part of the Subcontractor Monitoring Plan. The applicable business owner provides the day-to-day oversight of THP's Medicaid subcontractors through a review of reports and ongoing monitoring activities. Pertinent information from these reports is captured through documented monitoring metrics that permits the tracking and trending of the subcontractor's performance with respect to its delegated duties.

Vision and Dental Benefit Administration. THP receives regular reports from its vision and dental benefit subcontractors. Such reports address, as applicable, provider network including network adequacy, provider credentialing, call volume and call center metrics, appeals and grievances, credible allegations of fraud, utilization management and third party recovery.

Encounter Data Submission and Administration. THP communicates on a weekly basis with its encounter data subcontractor and receives reports related to the percentage and types of encounter data errors. Pertinent information will be captured through documented monitoring metrics which permit the tracking and trending of the subcontractor's performance with respect to the delegated duties.

Utilization Management. Utilization management subcontractors are required to submit performance reports, as applicable, related to standard and expedited pre-service requests, standard and expedited appeals, and grievances.

Control Report Reviews

THP requests and reviews each subcontractor's applicable SOC 1, SOC 2 and HiTRUST reports on an annual basis. The SOC 1 and SOC 2 reports are abstracted by the business owner using a structured Excel spreadsheet. The abstraction process reviews the auditor's opinion to determine if the opinion is qualified or unqualified and reviews any control testing exceptions. Follow-up is conducted in the event of a qualified auditor opinion, although this has not been necessary to date. Care is taken to review any applicable complementary user entity controls (CUECs) with an emphasis on the identification of THP's corresponding controls. Any exceptions in the reports are evaluated by THP to ensure there is no impact on THP's internal control environment.

Contract Management
THP has a contract management system called iContracts. iContracts is used to house its Medicaid subcontractor agreements including any applicable delegation agreements and other relevant documents. iContracts provides reminders to the applicable business owner(s) when contracts are coming up for renewal. iContracts is also used to alert business owners when it is time to request updated SOC 1, SOC 2 and/or HiTRUST reports from the subcontractor.

Corrective Actions

The Subcontractor Oversight Committee reviews the results of all subcontractor monitoring, auditing and oversight activities. The Subcontractor Oversight Committee assesses any identified deficiencies and determines if there is the need for a corrective action plan (CAP) and provides oversight of the implementation of any CAPs. Corrective actions may include:

- Documentation of corrective actions (minor or isolated issues)
- Formal CAP (significant or systemic issues)
- Termination of Contract (serious deficiencies or no improvement after corrective actions)

QU007. The Vendor should describe how they will administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.

QU008. 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.

Annually, in the late winter and early spring, THP conducts a CAHPS satisfaction survey of our Adult and Child Medicaid membership to assess the perceptions of our Medicaid members. Since 2012, THP has contracted with a certified CAHPS vendor, and currently uses SPH Analytics, to conduct these surveys. The CAHPS Survey is designed to measure, compare and report on the consumer's experience with THP and the healthcare they received. THP works with SPH Analytics by providing our membership files during the specified timeframe, as required to perform the survey.

Each year, a new random sample of health plan members is selected to participate in the CAHPS survey. The surveys are administered between March and June, distributed by mail and include a telephone-assisted survey for participants who have not responded. The information obtained from the survey is blinded as to specifics regarding responder or providers and provides an overall analysis of member satisfaction.

An opportunity analysis of the findings from the 2019 CAHPS survey displays both high-performing measures and measures that are opportunities for improvement. Measure strengths are identified as summary rates at or above the 75th percentile, measures to monitor are the rates at or above the 50th

Higher than National Average
For standardization and analysis, the CAHPS survey groups related questions into scoring composites. The composite rates are calculated using a combination of the percentage of those answering "Usually" and those answering "Always."

Of the eight measures scored – getting needed care, getting care quickly, how well doctors communicate, customer service, rating of doctor or nurse, rating of specialist, rating of health care and rating of health plan – All measure performance rates were above the national average.

percentile and below the 75th percentile, and a measure for opportunity is the rate that fall below the 50th percentile.

The Medicaid Adult survey analysis identified Rating of Health Plan, Rating of Health Care and Rating of Personal Doctor as key drivers. Performance on these measures may be driving the member's overall experience rating. The Medicaid Adult survey did show strong correlation on the survey questions related to Rating of Health Plan. The questions with strongest correlation were as follows:

- Providing Needed Information
- Rating of Health Care
- Getting information/help from customer service
- Obtaining needed care right away
- Obtained appointment for care as soon as needed

Interventions, Prioritization and Action Plan

Once CAHPS results are received, results are reviewed and analyzed. Possible interventions are discussed and prioritized. Prioritization is given to areas that would have the greatest impact on member safety, quality of care or overall satisfaction with THP. An action plan is then developed and implemented. For example, our Medicaid Adult CAHPS survey identified opportunities for improvement in customer service, shared decision making and rating of the member's personal doctor. The Medicaid Child survey identified opportunities for improvement related to shared decision making rating of personal doctor.

To address these improvement opportunities, we have just concluded a simulated off-cycle survey to help identify the causes of these concerns to allow targeted intervention. A deep dive into the responses that an off-cycle survey provides will help us understand why and where members have responded less positively and see if it may be regional,

related to specific medical conditions, special needs or lack of services. From that information, we will create an action plan to support and educate both members and providers to drive improvement of member satisfaction.

Conducting a Member Experience Analysis

We conducted a member experience analysis comparing member experience data from Q1 2018 to Q1 2019. The analysis helps THP identify aspects of performance that do not meet member expectations and initiate actions to improve performance. THP monitors multiple aspects of member experience, including member complaints, member appeals, out-of-network utilization and member satisfaction surveys.

Analyzing Member Experience Related to Complaints and Appeals

The quality management department uses formalized processes for review of member complaints and appeals, including a thorough review of the member's comments in conjunction with claims analysis, medical record review and evidence based standards of care. Member appeals and complaints reviewed by the QM department result in a case summary with case analysis presented to the QM team and medical directors. Each case summary follows a documented process for case resolution and is tracked and trended for further intervention. Practitioners and providers are required to provide a documented response and corrective action when applicable.

Medicaid Complaint Analysis and Provider Engagement to Remediate

Quality of care accounted for the highest number of complaints in Q1 2018 and Q1 2019. The majority of the complaints in this category are related to the member's perception of care received. No specific trend was identified related to the type of practitioner or any one particular practitioner. In 2019, Q1 complaints included member quality complaints regarding care at two facilities in our network. Seven complaints were

related to care and more specifically to wait times and overall care in the ER, and two complaints were regarding overall quality of care received at the facility.

We engaged both providers and facilities in each case and notified them of the concern brought to our attention. We discussed with administrative staff at the facilities the potential quality of care concerns expressed by members with a return response submitted from the facilities. Their root cause analysis revealed no evidence of substandard care and or delay in care based. Members were triaged appropriately by ER personnel. Because care provided to the members did not result in adverse outcomes and no other provider/practitioner trends were noted, the facilities agreed to track these issues for internal purposes and we concluded our evaluation. We will continue to monitor member complaints received for these providers and all member complaints.

QU009. The Vendor should describe how they will gather, report, and utilize audited Healthcare Effectiveness Data and Information Set (HEDIS) measures.

QU010. 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).

We understand the importance of using HEDIS performance data and core adult and child quality measures to identify opportunities for improvement, monitor the success of quality improvement initiatives, track improvement and help the State compare the performance of MCOs serving MHT members. We have established a comprehensive program to gather, report and use HEDIS and CMS core adult and child quality measures.

Gather

We use Cotiviti, an NCQA-certified software, to gather, trend and report our HEDIS data. Cotiviti allows us to collect HEDIS-related data through electronic means, such as claims data and lab values, and supplemental data, such as blood pressure readings and cervical cancer screenings, which we obtain through medical record reviews performed by THP RNs and load into the Cotiviti software. We also gather immunization records from West Virginia and Ohio state registries, and lab data submitted electronically from our lab providers. The information we enter into Cotiviti is validated by an NCQA-certified HEDIS auditor to confirm the validity of the data gathered and the processes we use to collect the data. We have added the ability to track and trend our performance against the PMV measures identified by the EQRO vendor in the 2020 PMV report into the Cotiviti software as well and will report on this monthly.

Report

Once the data are validated, the HEDIS data are submitted to the EQRO vendor, which evaluates the reported measures through the PMV process. This evaluation helps us determine those measures where we are underperforming and may recommend PIPs or other programs to improve performance on those measures. The EQRO vendor also compares our performance against the other MCOs to determine if there is a statewide issue that needs to be addressed by all MCOs. All HEDIS data are reported and submitted annually to NCQA as part of our ongoing accreditation process.

Utilize

Our QIC reviews our performance, providing input into quality improvement plans designed to improve performance against HEDIS measures we want to improve. The EQRO vendor analysis provides information to the State BMS to develop area for

improvement projects. Additionally, the HEDIS data are analyzed to understand differences among PCPs, social determinants, geographic variations related to access to care and quality of care. For example, we are using HEDIS measures to develop our Women's Health Initiative 2020, which we discuss in detail in **QU013**. Our VBP models include the opportunity to impact up to 18 HEDIS measures that are included in the agreements. Additionally, we have an agreement with a statewide urgent care center that can provide screening services to address gaps in care when individuals receive services at those locations.

Through member outreach by member advocates, care managers and nurse analysts, we educate members on the need for preventive and evidence-based care that we identify throughout the year.

Sharing Gap in Care Reports and Peer-to-Peer Comparisons with Providers

Our provider engagement team provides comprehensive provider education on HEDIS and PMV measures, the correct coding required to capture the services, and assists in developing in-office processes that enhance closing the gaps in care, both proactively and retrospectively to help PCPs understand the membership they serve. We provide summaries of HEDIS and PMV rates that are updated quarterly for practices in a VBP contract and provide a breakdown of missing quality services as actionable data. Additionally, this report is available to any PCP who requests it; not just those in VBP models. In the fourth quarter of 2019, we implemented a pilot incentive program that included bonus payments to PCPs who closed gaps in care on a select population of enrollment. Once the impact of this pilot is fully understood, decisions to expand this quality initiative will be considered.

Our practice pattern variation report uses advanced data analytics to identify variation in practice patterns and provides detailed specialty specific peer-to-peer trends related to cost, utilization and quality of care. Overall trends are reviewed by the Medicaid Oversight Workgroup, network and provider services, and the Medical Directors Oversight Committee, as this report provides us with data based on adherence to best practices, tracks practice-level improvements and gives us an opportunity to partner with providers to implement initiatives that improve the quality of care and service provided to members.

Our analytics identify provider practice variation patterns by building longitudinal episodes of care from claims data and ties those episodes to specialty-specific medical conditions. An episode of care links together the services used to treat a patient's medical condition within a specified period of time. This linkage allows examination of a provider's global pattern of treatment for a specific member with a specific condition, such as diabetes, arthritis or upper respiratory infections. These episodes are analyzed for trends related to cost, utilization and adherence to evidence-based quality measures.

For example, THP recently conducted an analysis of variations in the treatment of degenerative joint disease that guided conversations with treating providers on the cost and utilization of services. The reports are available on the secure provider portal and our provider engagement team completed education across the network.

The figure represents a sample cost of care and effectiveness report. The report shows the provider how they perform compared to other providers delivering cost-effective care while adhering to quality of care.

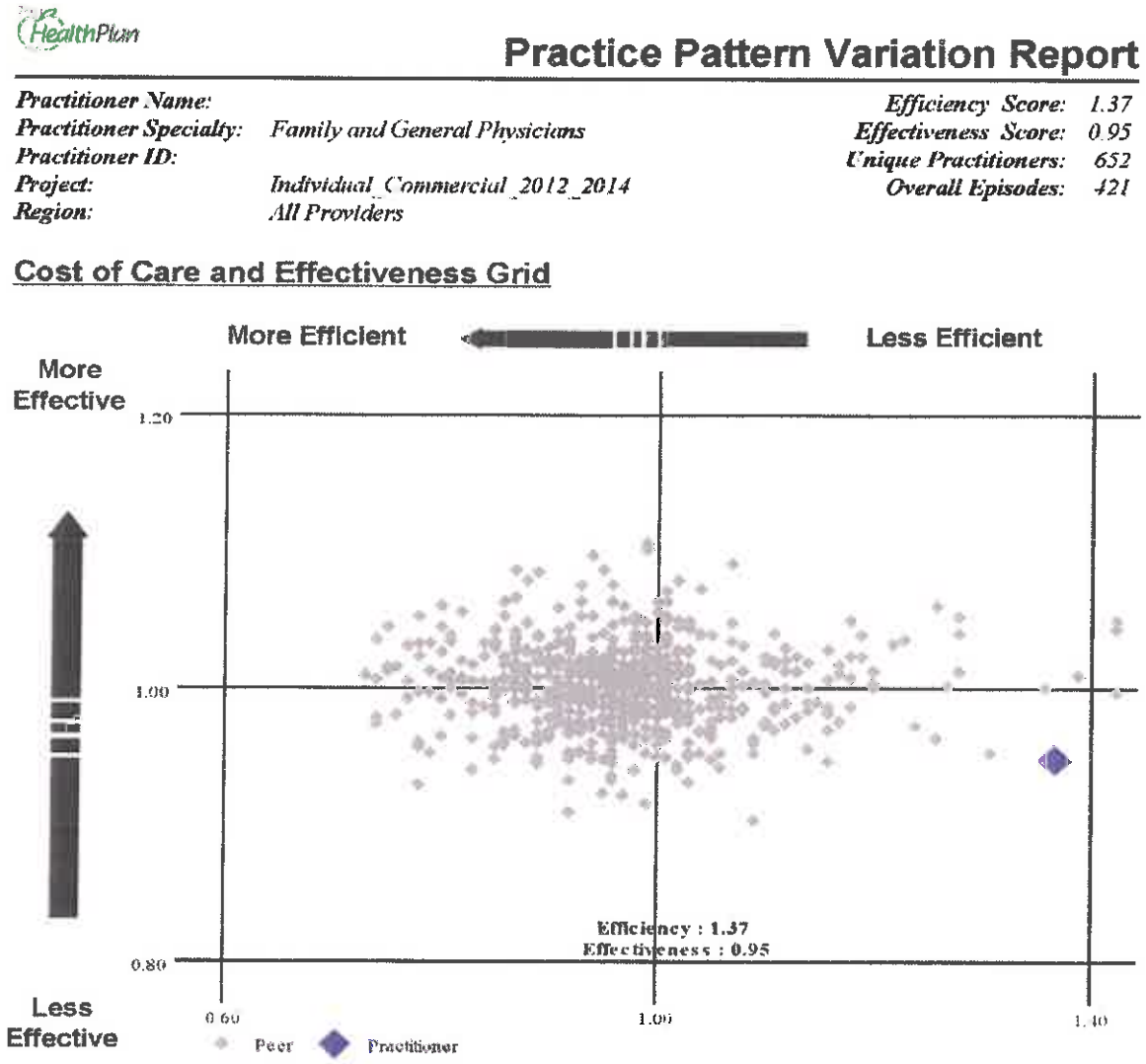


Figure 3: Sample cost of care and effectiveness grid from our family and general physicians practice variation report. The grid shows the provider how they perform compared to other providers delivering cost-effective care while adhering to quality of care.

Closing HEDIS Gaps in Care for All Members

Our strategic process for closing gaps in care uses our HEDIS software and provides monthly updates on HEDIS and PMV measure rates. Reports are analyzed with focus given to those that may require more lead time to succeed, and those that may be impacted by seasonality of office practices. For example, in Q1 2019, we outreached to members to close gaps and educate on colorectal screening and assisted members in getting those scheduled. We also outreached to members on the importance of well

child visits in the late spring to encourage scheduling those over the summer. Additionally, we track members with elevated A1c levels and follow-up with the PCP and member to assure follow-up visits are scheduled appropriately. We have a team of nurse analysts who review data for patterns of gaps in care to develop corrective action plans on identified issues.

Our provider engagement team assists in educating and coordinating the gap closure process with our primary care and OB/GYN practices.

Member advocates on our outreach team have call lists to engage and educate members on HEDIS and PMV gaps in care and will identify barriers to accessing services and make the appropriate referrals to resources as needed, including THP nurse navigators and social workers, as well as non-emergency medical transportation (NEMT) services. During the new member welcome call, our member advocates educate members about the importance of preventive care while completing the HRA. Our adult and pediatric HRAs each include questions related to SDOH. Depending upon the member responses to these questions, the member advocate may use our SDOH assessment to obtain additional information about the member's SDOH needs.

Closing Care Gaps for Members in Care Management

Our care management system monitors compliance with preventive and chronic care standards, such as EPSDT screenings. We can incorporate any measure the state wants us to track into our care management system. It uses member demographic data to identify members who have not received required screenings, allowing the care manager to conduct targeted outreach to members with gaps in care. As presented in the figure, our care management system presents the care manager with the members

with care gaps and allows the care manager to take action, such as creating an opportunity, goal and intervention (OGI) for each required preventive service.

Figure 4: Quality measures scorecard. Care managers and member advocates can view members with gaps in care in our care management system and use this information to take action to close the care gaps, such as scheduling an appointment for the member with their PCP. Note: This screen shot does not include actual member data.

The OGI will be added to the member's treatment plan to confirm the timely completion of the screening. For example:

- ***Opportunity:*** Member well-child and EPSDT checkups are not up-to-date
  - ***Goal:*** Well-child checkup and EPSDT services are up-to-date
    - ***Intervention 1:*** Educate member/caregiver about importance of well-child checkup and/or help member set up appointment (Duration: 60 days)
    - ***Intervention 2:*** Confirm member has completed office visits for well-child checkup and EPSDT (Duration: 60 days)

Helping Providers Track and Remediate HEDIS Gaps in Care

Our care management system gives authorized providers a variety of capabilities to track and remediate gaps in care. It integrates data analyses and provides this information to the interdisciplinary care team (ICT) in an actionable way. For instance, through the secure portal, providers monitor the member's adherence to their treatment plan, such as a member not filling a prescription. The portal also helps providers identify members with gaps in care using a customizable Quality Measure Dashboard,

presented in the figure, which allows providers to view their members with care gaps using HEDIS quality measure data, refreshed twice monthly.

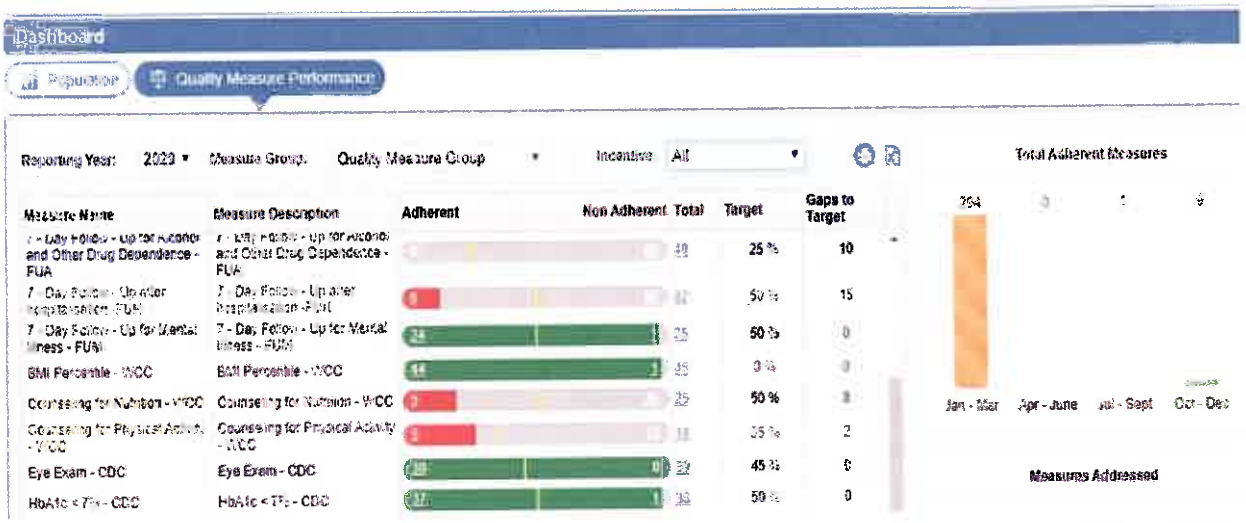


Figure 5: Quality Measures Dashboard. The dashboard provides summary scorecard of performance against HEDIS or EPSDT measures with quick-access links to identify those members in the provider's panel who have gaps in care. Note: This screen shot does not include actual member data.

QU011. 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.

We establish standards of performance using a variety of performance measures that are objective, clearly and unambiguously defined, and based upon current knowledge or health services research, to assess our performance. We use HEDIS, CAHPS, provider and member satisfaction surveys, CMS-specified Core Measures, EPSDT and nationally recognized clinical guidelines, such as InterQual. We will track the measures identified by the EQRO vendor in the 2020 PMV Report, such as Adolescent Well-Care Visit (HEDIS), the Percentage of Eligibles That Received Preventive Dental Services and PQI 01: Diabetes Short-Term Complications Admission Rate. We will incorporate the 2019 Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) into our monthly reporting and trending and include those in provider

gap in care reports and member advocate outreach communications, including calls to members, letters and provider notifications.

QU012. 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.

In accordance with Article III, Section 6.2 of the Service Provider Agreement, we develop performance improvement projects (PIPs) that are designed to achieve, through ongoing measurement and intervention, significant improvement sustained over time in significant aspects of clinical care and non-clinical services that can be expected to have a beneficial effect on health outcomes and enrollee satisfaction. We develop PIPs based upon feedback from the EQRO vendor PMV Report. Per the 2019 PMV Report, we had an opportunity to improve our rates for the following measures that were below the National Medicaid Averages:

- Adolescent Well-Care Visits
- Annual Dental Visits for 2-3 Year Olds
- Comprehensive Diabetes Care: HbA1c Testing
- Follow-Up After Hospitalization for Mental Illness: 7 Days Follow-Up
- Medical Assistance with Smoking and Tobacco Use Cessation: Advising Smokers to Quit
- Percentage of Eligible (Children) that Received Preventive Dental Services
- QI 01: Diabetes Short-Term Complications Admission Rate
- Prenatal and Postpartum Care: Postpartum Care

Based upon this report, we have two active PIPs in place, which are discussed in detail below, to improve performance for Adolescent Well-Care Visits and Annual Dental Visits for 2-3 Year Olds.

PIP: Promoting Health and Wellness for Children and Adolescents

Assessing physical, emotional and social development is important at every stage of life, particularly with children and adolescents. Behaviors established during childhood or adolescence, such as eating habits and physical activity, often extend into adulthood. Well care visits provide an opportunity for providers to influence health and development. In February 2019, we implemented a PIP to improve children and adolescents well-being by increasing the HEDIS rates for the following measures:

- Adolescent Well-Care Visits, the number of members 12-21 years of age who are continuously enrolled during the measurement year.
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile Only, the number of members 3-17 years of age who completed a BMI percentile during the measurement year.
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescent – Counseling for Nutrition Only, the number of members 3-17 years of age who received counseling for nutrition completed during the measurement year.

HEDIS 2020 (MY 2019) will be the first re-measurement with full year of interventions in place, for a thorough analysis to determine successes and/or failures, identify opportunities for improvement, and barriers to care to improve care and service to members. The benchmark and goal for this PIP is a 10% increase of baseline rate, 88% NCQA 90th percentile.

In Q1 2019, we mailed 530 $25.00 gift cards to members for completion of an adolescent well child visit. Our member advocates on our outreach team completed 968 calls to new Medicaid enrollees. As part of the welcome call, the member's parent/guardian is educated regarding the importance of child and adolescent well visits. Based upon these findings, we continued the PIP and mailed 914 $25.00 gift cards for completion of an adolescent well child visit in Q2 2019.

Additionally, provider education is completed by the provider engagement department. Through these efforts, providers and their office staff are educated on HEDIS medical record documentation and coding specifications related to the referenced measures, point of care reminders encouraging providers to use any patient visit to complete a BMI or discuss nutritional counseling. Guidance for efficiently and effectively completing the Preventative Health Check List during a well care visit also will be completed.

Opportunities to partner with community resources will include targeting the population that may benefit from wellness examinations provided at school-based clinics and urgent care settings. The objective and goal is to provide more flexibility for members to have access to care.

PIP: Annual Dental Visits for 2-3 Year Olds

According to the Centers for Disease Control and Prevention (CDC), tooth decay is the most common chronic condition in the country. If left untreated, tooth decay can lead to pain and infections. It may also lead to issues with eating, speaking and even learning. The CDC reports the following regarding cost and prevention:

- Total U.S. dental expenditures for children 0 to 21 years in 2012 exceeded $25 billion.
- 830,000 ER visits were due to preventable dental conditions.
- Delivering sealants to high-risk children can save Medicaid $6 per tooth sealed over a four-year period.

According to a 2007 CDC report, 28% of children ages 2 to 5 were found to have cavities. Children, ages 5 to 19 years, from lower low-income households (25%) were twice more likely than children from higher-income households (11%) to have untreated decay.

The 2014 *Burden of Oral Disease in West Virginia Report* indicates West Virginia children had significant experience with tooth decay. A statewide survey from the 2010-2011 school year showed that 34% of the universal pre-K population had experience with tooth decay and 21% of the children had untreated dental decay. The report also indicated that tooth decay is largely preventable, childhood years are the perfect time for preventive measures and dental visits in the early ages can help.

The MHT weighted average for Annual Dental Visits for 2-3 Year Olds improved between MY 2014 and MY 2016, but remains below the National Medicaid Average. The MHT Weighted Average for MY 2016 of 34.03% was 5 percentage points below the National Medicaid Average of 39.03%, which indicates an opportunity for improvement.

In Q1 2018, we implemented a PIP to improve rates related to accessing dental services among children as measured by the following measures:

- Annual Dental Visits for 2-3 Year Olds (HEDIS), which identifies the number of members 2-3 years of age who had at least one dental visit during the measurement year.
- Percentage of Eligible That Received Preventive Dental Services (Child Core Set Measure), which measures the number of members 1-20 years of age who are eligible for EPSDT services for at least 90 days who had at least one preventive dental service in the measurement year.

We implemented this PIP in Q1 2018. At initiation, we implemented the following interventions:

- Developed and a mailed a dental postcard to parents/guardians, "Taking Care of Your Teeth is as Easy as...," to provide dental awareness and member education on the importance of early screenings and cleanings. The postcard was a coloring page postcard designed to get the child's attention instead of just throwing the postcard away. The postcard is presented in the figure.
- Member advocates on our member outreach team contacted parents/guardians whose children have not had a dental appointment to educate them about the importance of dental care and using NEMT to get their child to dental

appointments. Member advocates also help parents/guardians find a provider and arrange transportation to visits.

- Provider engagement representatives participated at events to provide educational opportunities for members and families, such as regional baby showers and wellness events.
- Used social media posts on Facebook to educate and encourage change in member's dental habits with emphasis on dental during February for Children's Dental Health Month.

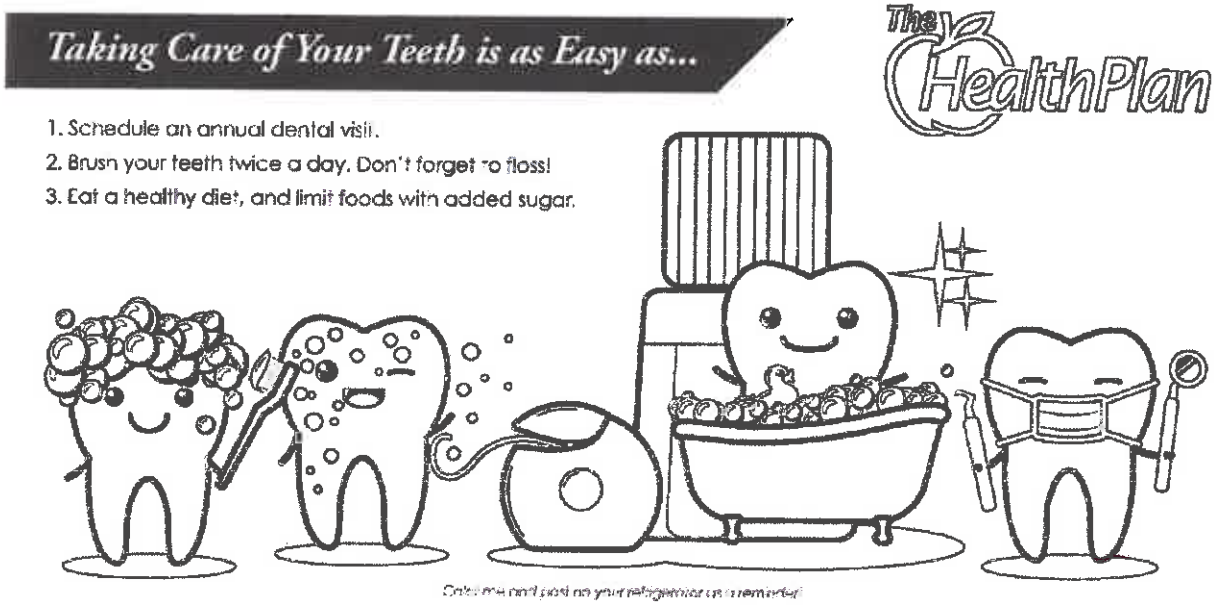


Figure 6. Our Dental Postcard. We developed a mailed a dental postcard to parents/guardians, "Taking Care of Your Teeth is as Easy as...," to provide dental awareness and member education on the importance of early screenings and cleanings. The postcard also provides information on what to do if the member has questions about their dental benefit and if they need help finding a provider.

The PIP goal was to increase our rate on Annual Dental Visits for 2-3 Year Olds measure from the HEDIS 2018 (MY 2017) Final Rate of 27.40% by 5% by the end of the project. Due its success, the PIP is ongoing and we have modified the PIP interventions as we identified barriers to

Our annual HEDIS rates for Annual Dental Visits increased from 27.40% in 2018 (MY2017) to 36.29% in 2019 (MY2018). Additionally, the Percentage of Eligible Who Received Preventive Dental Services increased from 34.98% in 2018 (MY2017) to 43.35% in 2019 (MY2018). This was the first re-measurement year and interventions will be ongoing. These increases exceeded our goal to improve these measures by 5%.

connecting members to these services. For instance:

- In Q4 2018, instead of annually, we began mailing our dental postcards reminding parent/guardians on the importance of early screening and cleanings for children 2-3 years of age during the month of the child's second birthday.
- Starting Q1 2019, our member outreach team performs welcome calls for all new members and educates members who have children 2-3 years of age on the importance of establishing dental services.
- Starting Q1 2019, we began offering a $25 gift card incentive for qualifying members 2-3 years of age that completed a dental visit. This incentive is one of our value-added services. We distributed 691 gift cards to qualifying members during the first and second quarters of 2019. The gift card can be used for healthcare items, such as over-the-counter medications and dental hygiene products. With HEDIS 2020 (MY2019) we will be able to analyze the effectiveness of this intervention.

Monitoring Non-Clinical Measures

We also monitor our adherence with non-clinical measures that help determine the effectiveness of our operations and our adherence to BMS requirements for the MHT program. Non-clinical services include the following objectives, measures and goals:

- Objective: To improve member experience
  - Method of Measure:
    - Member complaints
    - Member appeals
    - CAHPS survey results
    - Out of network (OON) requests
    - Member satisfaction surveys
  - Goal:
    - Complaints & Appeals 1:1000 members
    - OON requests 5:1000 members
- Objective: To improve member experience with timely access to member services
  - Method of Measure:
    - Telephone standards
    - Member complaints
    - CAHPS survey results
  - Goal:
    - Complaints & Appeals 1:1000 members
    - At least 83% of all calls answered within 30 seconds

- Objective: To improve member experience by ensuring network adequacy for primary care, behavioral healthcare and specialty care and monitor effectiveness of network meeting cultural/racial/ethnic/language needs and preferences of membership
  - Method of Measure:
    - US Census Data
    - GeoAccess reports
    - Member complaints
    - Practitioner availability survey
    - Practitioner data collected during credentialing process
    - Practitioner accessibility survey
    - CAHPS surveys
    - OON requests
  - Goal:
    - Meet network needs as outlined in RFP with regard to GeoAccess, practitioner availability and accessibility
    - Practitioner completion of cultural training
- Objective: To ensure optimal quality of services and experiences for members with physician and hospital directories
  - Method of Measure:
    - Office location
    - Hospital affiliates
    - New patient acceptance
    - Web-based directory transparency
    - Hospital directory transparency
    - Usability testing for font size, reading level intuitive content
  - Goal: 90% accuracy in all indicators listed above
- Objective: To provide members with accurate information to understand their benefit coverage to obtain care
  - Method of Measure: New member surveys
  - Goal: Successful contact with at least five members per month to complete a survey about understanding their benefits with 100% understanding met
- Objective: To monitor and evaluate the functionality of telephone and website activities to ensure members can easily understand and use their benefits
  - Method of Measure:
    - Audit functionality of website for the request of ID cards-change of PCP-referral and authorization information-benefit & financial responsibility
    - Audit member services email communication & calls regarding above
    - Quality of email responses
    - Email turnaround times

- Determine how and when to obtain referrals and authorizations for specific services(phone)
- Determine benefit and financial responsibility for a specific service or treatment from a specified provider or institution(phone)

- Goal:
  - 100% web functionality
  - 90% telephone accuracy
  - 100% turnaround time on email inquiries in one business day

Example of monitoring and resolving an issue related to non-clinical services:

Through ongoing measurement of trends in claim denials, it was determined that there was inconsistency in claims processing. The Medicaid operations team implemented an edit tool that now provides auto-adjudication of claims and auto denials. When a claim includes a service that cannot be auto-adjudicated to pay or deny, the edit tool directs the claim to the analyst who receives a message that identifies exactly what triggered the edit alert and offers a rationale for reviewing the claim. For instance, if the service requires prior authorization, it directs the analyst to look for the prior authorization. The analyst then reviews the claim, looks for the authorization, and determines if the claim should pay or deny. This addition of the edit tool has increased the quality and efficiency of claims processing.

QU013. 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.

As we discussed in **QU011**, we have implemented objective quality indicators and have integrated them into our NCQA-certified HEDIS software so that we may trend the rates throughout the year, with monthly updates and data analysis completed by a team of quality analysts. This integration provides an opportunity for educating targeted areas in need of improvement by increasing member outreach, tapping into community resources and conducting additional provider engagement educational sessions. Our

comprehensive provider education program focuses on these key performance indicators. Rates are analyzed and discussed at the Medical Directors Oversight Committee and QIC as appropriate, where we determine what activity can improve rates of services and quality of care.

Using an Objective, Clearly and Unambiguously Defined Measure

An example of how we are using objective, clearly and unambiguously defined measures to assess our performance include developing our Women's Health Initiative 2020 using the Breast Cancer Screening, Cervical Cancer Screening and Chlamydia Screening HEDIS measures.

This initiative is designed to support and improve evidence-based breast cancer, cervical cancer and chlamydia screening rates in women enrolled in the MHT program. Healthy People 2020 established goals in preventive and screening services to reduce the number of new cancer cases, and illness, disability and death caused by cancer, as cancer remains a leading cause of death.

Disparities, particularly socioeconomic status, predict the likelihood of access to education, healthcare services along with safe and healthy living and working conditions. All of these factors are associated with the risk of developing and surviving cancer. Additionally, behavioral risk factors such as smoking, obesity and excessive alcohol use play a major role in those with a lower socioeconomic status. Rates for breast and cervical cancer screenings as well as chlamydia testing have been less than 50% in the MHT population eligible for these services.

We are analyzing geographic variations and provider relationships to screening rates and identifying comorbidities (e.g., substance use disorder, behavioral health condition)

and barriers to care that may influence screening rates in our population. Based upon this analysis, we will implement provider education that targets those providers with the highest volume of members and the lowest HEDIS rates for these screenings, evaluate additional VBP/care manager models based upon patterns of care and design member

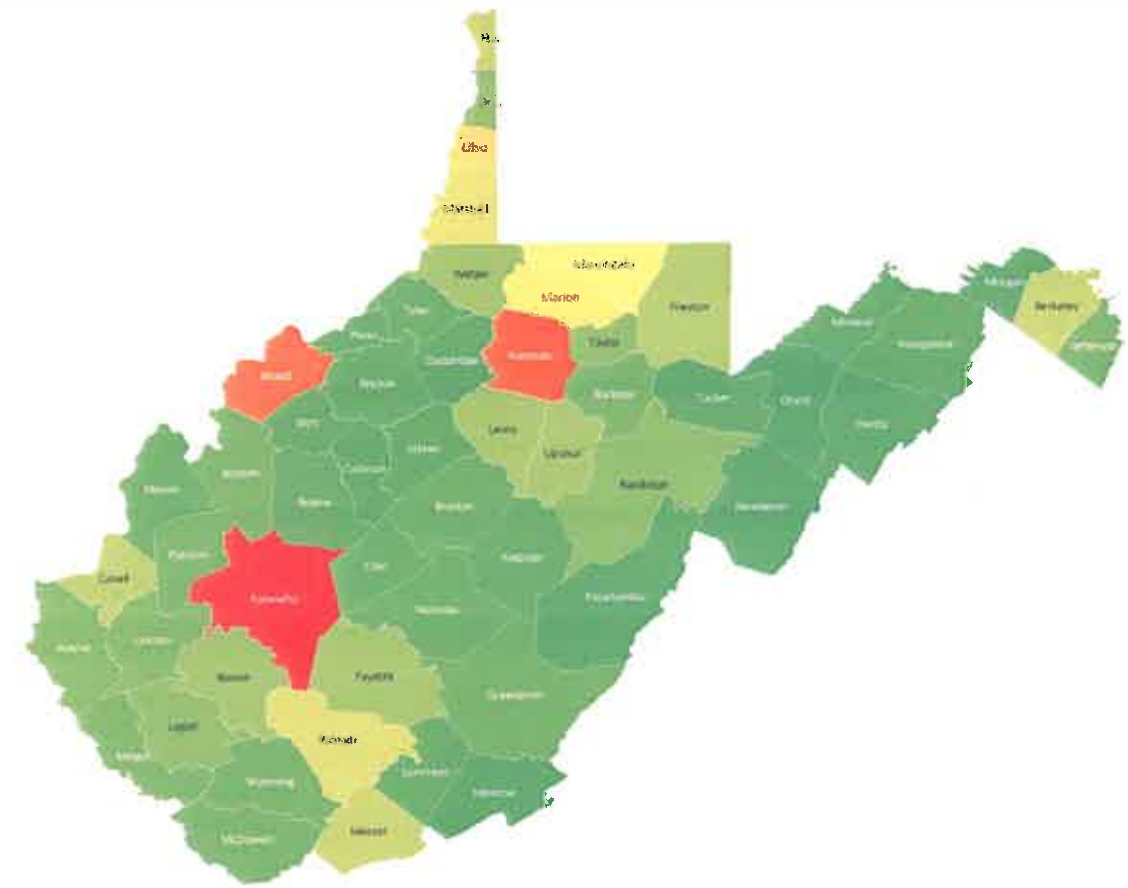


Figure 7: We completed an analysis of quality gaps in care for our MHT members related to rates of breast cancer screening, cervical cancer screening and chlamydia cancer screening. Red and orange represent the counties with the highest rates of these care gaps. Based upon this analysis, we developed the Women's Health Initiative to connect women to these services.

education and incentive programs to connect women to these screenings. The figure presents an analysis of quality gaps in care for our MHT members related to rates of breast cancer screening, cervical cancer screening and chlamydia cancer screening. Red and orange represent the counties with the highest rates of these care gaps.

After reviewing several years of trends on closing gaps in care on these measures specifically for women, rates were reviewed by our OB/GYN medical director. After discussion and review of variations in regions, further drill down analysis is being completed to target areas where there may be issues with access to care, comorbidities related to behavioral health conditions, and lack of understanding of the importance of screening. Improvement activities will include:

- Provider engagement conducting face-to-face education to providers on how to identify the women with gaps in care and the need to engage women in preventive screening
- Member advocates outreaching to members with all three gaps in care
- Engaging specialists who are providing care to women with all three gaps in care, including OB/GYN and behavioral health providers
- Leveraging our VBP relationships to close these care gaps
- Implementing community-based health navigators to work with members and providers in the community to close these care gaps

Leveraging our VBP Relationships

We currently have three contracted VBP relationships in West Virginia and are in discussions with providers and major academic centers in the state to implement additional VBP contracts. Our VBP contracted relationships include the following.

Total Cost of Care Pilot Project with the Prestera Center for Mental Health Services

THP is piloting a total cost of care arrangement with Prestera Center, a major comprehensive behavioral health center that serves southwestern West Virginia. This pilot facilitates the integrated delivery of physical health and behavioral/mental health for Medicaid members determined mutually by THP and Prestera Center using an analysis of high ER utilization. Through this pilot, THP is meeting members where they most frequently access care (e.g., the comprehensive behavioral health center). The pilot is

assessed on the ability of Prestera Center to reduce costs and meet one or more quality goals, including:

- ***Measure 1:*** Reduce the patient risk score (care need index) by 10% or more
- ***Measure 2:*** Reduce ER visit total by 10% or greater
- ***Measure 3:*** Ensure that 88% or more assigned members have a claim originating in a primary care setting for any reason during the performance year

We are revising this pilot through the implementation of a community-based health navigator as discussed later in this section.

WVU Medicine

WVU Medicine is the largest integrated healthcare delivery system in West Virginia. Our VBP with WVU Medicine covers an average monthly Medicaid membership of 16,945 members. It is a shared savings arrangement in category 3A. In THP's shared savings arrangements, providers receive contracted fee-for-service reimbursement, a per member per month care coordination fee and increased access to claims and population health and risk stratification data (e.g., patient health risk scores, HEDIS care gap reports and customized data analytics, by request of the provider). In turn, providers are expected to build out care coordination infrastructure and manage the needs of the attributed membership. Our VBP with WVU Medicine tracks attainment of six HEDIS measures.

Community Care of West Virginia, Inc.

Building on our community health worker pilot, THP recently began a VBP arrangement with Community Care of West Virginia, Inc., the second largest federally qualified health center in the state. Our VBP with Community Care of West Virginia covers an average monthly Medicaid membership of approximately 2,000. It is a shared savings arrangement in category 3A and tracks attainment of seven HEDIS measures.

Implementing a Community Health Worker Program with Community Care

In September 2018, we partnered with Marshall University, Community Care of West Virginia, Inc. and the Claude Worthington Benedum Foundation to implement a community health worker program. THP is supporting the program by covering 25% of the cost to employ a community health worker for year one at Community Care of West Virginia site(s). Marshall University covers the remaining 75% of costs through grant funding. The program incorporates a community health worker as part of an interdisciplinary care team. The community health worker conducts home visits with patients or meets with patients after primary care appointments in office—based on the patient's preference—to help him or her with a range of chronic conditions, including diabetes, high blood pressure and obesity, among others.

On Nov. 1, 2018, we enrolled in the program 40 high-risk THP Medicaid members who have chronic conditions and poor patterns of utilization of healthcare services. Comparing the period Nov. 1, 2018, to Oct. 31, 2019, we have seen significant improvements. For instance, average per member healthcare spending dropped from $26,639 to $14,135 in the first year, a substantial reduction of 46.9%.

Implementing a Community-based Health Navigator Program with Prestera

After two months implementing the total cost of care pilot with Prestera, discussed previously, it became apparent that the transient nature of the population, extreme illness of the members (e.g., two members died before intensive care coordination could begin) and myriad, conflicting care coordination programs necessitated a change in approach. These challenges do not nullify the value of the increased communication and engagement opportunities created by the pilot. Therefore, Prestera Center and THP

are revising the pilot to emulate the approach and successes seen in the community health worker program through our partnership with Community Care.

Beginning in March 2020, the pilot will include a community-based health navigator—paid for 100% by a THP care coordination fee—based at Prestera Center to supplement their chronic care management team in Cabell, Kanawha and Putnam counties. The community-based health navigator will be employed by Prestera Center and charged with supporting THP members who need extra support in managing their healthcare challenges, such as coordinating a PCP or specialist appointment, completing laboratory testing, dietary needs/food insecurity or NEMT. The community-based health navigator will have access to Prestera Center's electronic medical record system, as well as THP's care management systems to see a complete picture of the patient/member's healthcare utilization and unmet needs. Should this approach to coordinating care prove successful, THP will enlist other comprehensive behavioral health centers as partners in the model—especially those located in counties with disproportionate utilization of behavioral health.

QU015. 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.

Our Medicaid Oversight Workgroup has established policies and procedures to correct and remediate significant systemic problems. The Workgroup meets monthly and comprises all THP department leads who work directly with the Medicaid population and verify our compliance with the West Virginia Medicaid contract. The Medicaid Oversight Workgroup conducts internal surveillance through review of data from multiple sources. These include trends from our customer service and quality departments, clinical and

provider services. Reports from claims, operations and payment integrity are reviewed and discussed, continually monitoring for any outlier trends or suspicious activity.

The Workgroup reviews and verifies the appropriate utilization of medical and behavioral resources, monitoring for trends in over and underutilization, as well as the duration and scope necessary to achieve desired enrollee health outcomes. Trends of adherence to HEDIS and PMV quality measures and the impact and effectiveness of our care management programs are reviewed. Through this continuous monitoring of utilization patterns, the Workgroup identifies trends and provides actionable information about our members to our care teams, providers and all our departments, including information on social determinants of health and barriers to care. Quarterly population health data analyses is completed and reviewed to follow trends across the state and determine if further drill down, investigation, or corrective action is needed based upon patterns of care revealed.

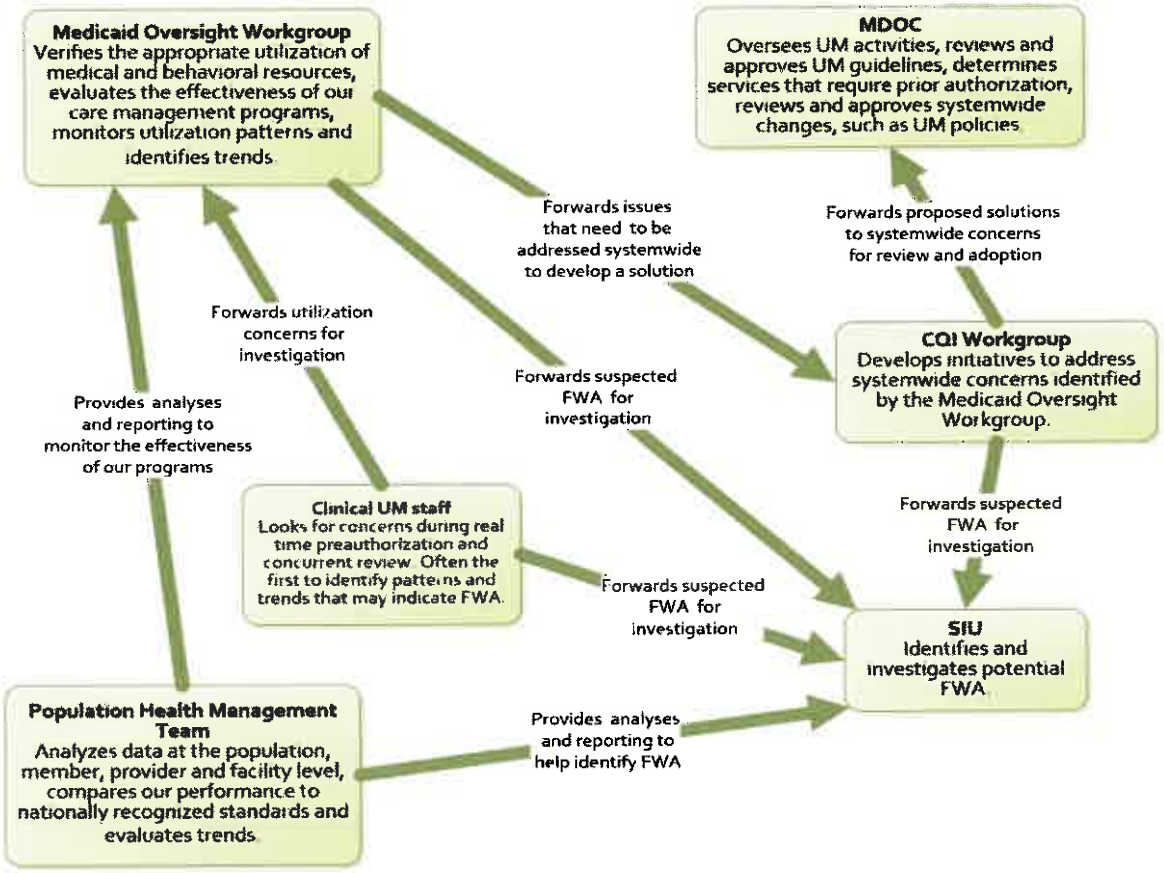


Figure 8: Utilization and FWA Monitoring Oversight. Our population health management team, Medicaid Oversight Workgroup, CQI Workgroup and SIU collaborate to verify we are delivering positive outcomes in terms of member experience, outcomes and quality of life and the quality and cost of care and identify and correct instances of FWA. Our MDOC reviews recommended system-wide changes developed by the CQI Workgroup.

Experience Correcting and Remediating a Systemic Problem

When a systemic problem is identified, the Medicaid Oversight Workgroup forwards the concern to our CQI Workgroup. Problems are corrected and remediated by developing a corrective action plan (CAP) in accordance with Article III, 6.3 Systemic Problems of the Service Provider Agreement. THP tracks CAPs using Gorman's Online Monitoring Tool (OMT), which permits the documentation of activities related to the CAP and permits the CAP owner to assign and track tasks related to the CAP. Our compliance department tracks CAPs to verify timely completion.

Each month, a member of the compliance department reviews all open CAPs and reaches out to the CAP owner to assess the status of its implementation. This activity is included on the Compliance and Audit Work Plan. We report the progress of CAPs to the EMT on the monthly Compliance Dashboard and to the Corporate Compliance Committee and the Audit & Corporate Compliance Committee during regularly scheduled meetings.

Analyses that indicate potential FWA are forwarded to our SIU for investigation. The quality improvement department reviews all quality of care issues, adverse events and member complaints during the provider's re-credentialing cycle. The quality improvement department communicates all actions to the credentialing department after investigating each quality issue. These actions include member complaints, sanctions, accessibility concerns, quality improvement issues and utilization issues. This department also communicates any quality of care issue taken to the Quality Improvement Committee and whether the provider is cleared by the Quality Improvement Committee and or QM medical director or whether an intervention and the type of intervention is recommended.

TheHealthPlan

Attachment 6
Claims and Encounters

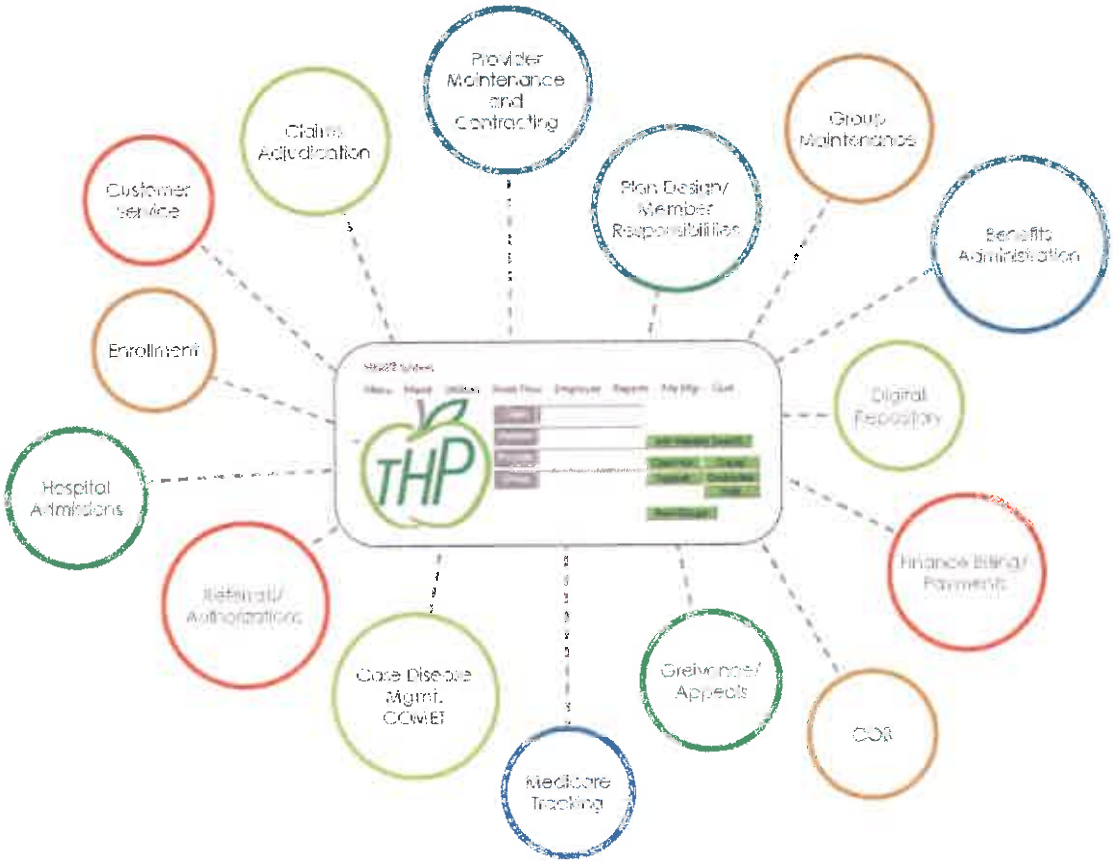
10. Claims and Encounters

The Vendor should refer to the business specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Claims and Encounters (CE) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

We recognize that claims payment accuracy and timeliness are key components in an effective service delivery system. We have over 40 years of proven experience as a trusted health plan in claims management for providers and members.

CE001: 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.

The Health Plan's claims payment process uses a proprietary system that is owned, advanced and maintained by our in-house Information Technology team. We originally used the COMPRECARE software system, which was a turnkey system specifically designed for HMO processing. THP began advancing the software to incorporate a more user-friendly interface several years ago, and this has evolved into what is now known as the HEART system. All core claims business functions are processed through HEART. The following diagram presents the components of our managed care information system.



Owning our claims payment system and having dedicated development staff in-house allows THP to establish initiatives and to prioritize objectives, allowing tremendous flexibility in meeting our client's specific requirements. Our core administration platform, HEART, has extensive claims processing capabilities and supports our Medicaid program requirements. Both medical and behavioral health claims are processed and paid in HEART.

Our claims processing model offers a significant amount of automation. HEART supports processing of in-network and out-of-network claims on the same system. Our current claims processing guidelines and systems requirements have demonstrated

results: We made a benefit determination and finalized over 99% of all clean claims within 30 calendar days of receipt in 2019.

Claims are processed on a first in, first out basis. In-network and out-of-network claims are handled the same and all are monitored and aged using the same process. As claims are loaded to the system by date received, they are divided into queues based upon certain criteria and parameters. Claims analysts are trained to pay certain claims types, and the queues are worked based upon age of claims to achieve our goal of paying all claims within 30 days of receipt. Inventory management reports are set up to run on a daily basis showing volume and age of claims. These reports are monitored by management and resources may be shifted to accommodate a high volume in a particular queue to process the oldest claims first.

We also have additional post-payment reports that show the percentage of claims processed in 1-30 days, and reports showing the number of claims where interest had to be paid because payment was outside the 30-day State requirement. These reports are automated and are reviewed monthly to confirm contractual requirements are being met. These statistics are also reported to BMS as part of the monthly reporting requirements.

See the following figure for a depiction of our claim process for both in-network and out-of-network providers.

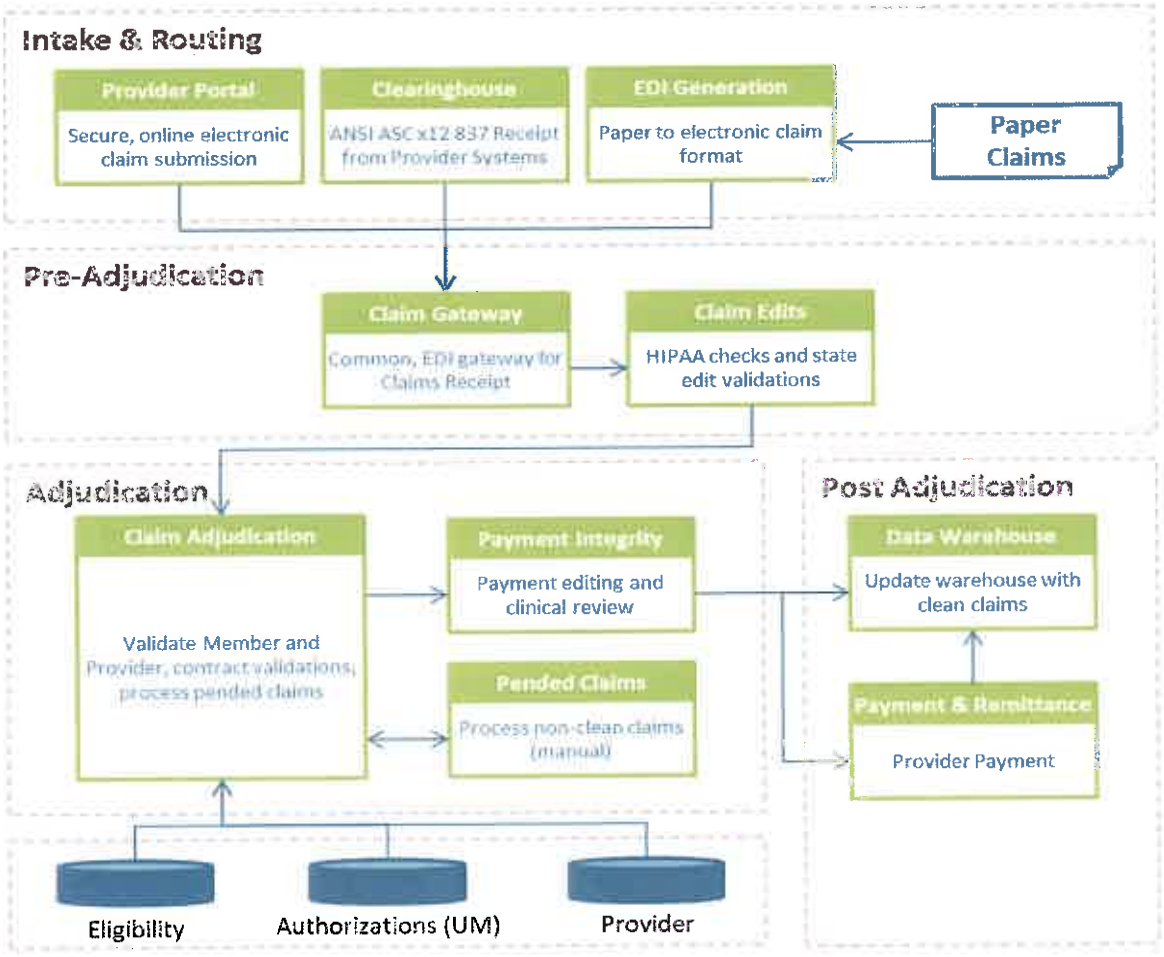


Figure 1: Claims Adjudication. THP's claims adjudication process allows providers to submit paper or electronic claims.

Claims Processing

Our HEART system collects, analyzes, integrates and reports data from all aspects of our operations. Our inventory management and integrated reporting and data analytics solutions enable us to maximize effectiveness and facilitate our ability to fully comply with claim payment accuracy and timeliness requirements.

Key capabilities of our HEART claims process include:

- Claims intake
- Pre-adjudication
- Edit Tool
- Authorization determination
- Claims adjudication

- Claims payment
- Reimbursement policies
- Fraud, waste and abuse
- Payment integrity, including review of high-dollar claims
- Claims auditing

These capabilities are described in detail below.

Claims Intake: Options for submitting claims include HIPAA EDI 837 format, paper and provider portal. We encourage providers to submit claims electronically through electronic data interchange (EDI). EDI greatly enhances the speed and accuracy of processing and paying claims. EDI claims are validated for HIPAA compliance and encounter reporting requirements and an acknowledgement of the claim is sent to the submitter. All paper claims received are initially sorted, scanned, batched and converted to electronic format. The following figure illustrates our intake and validation process.

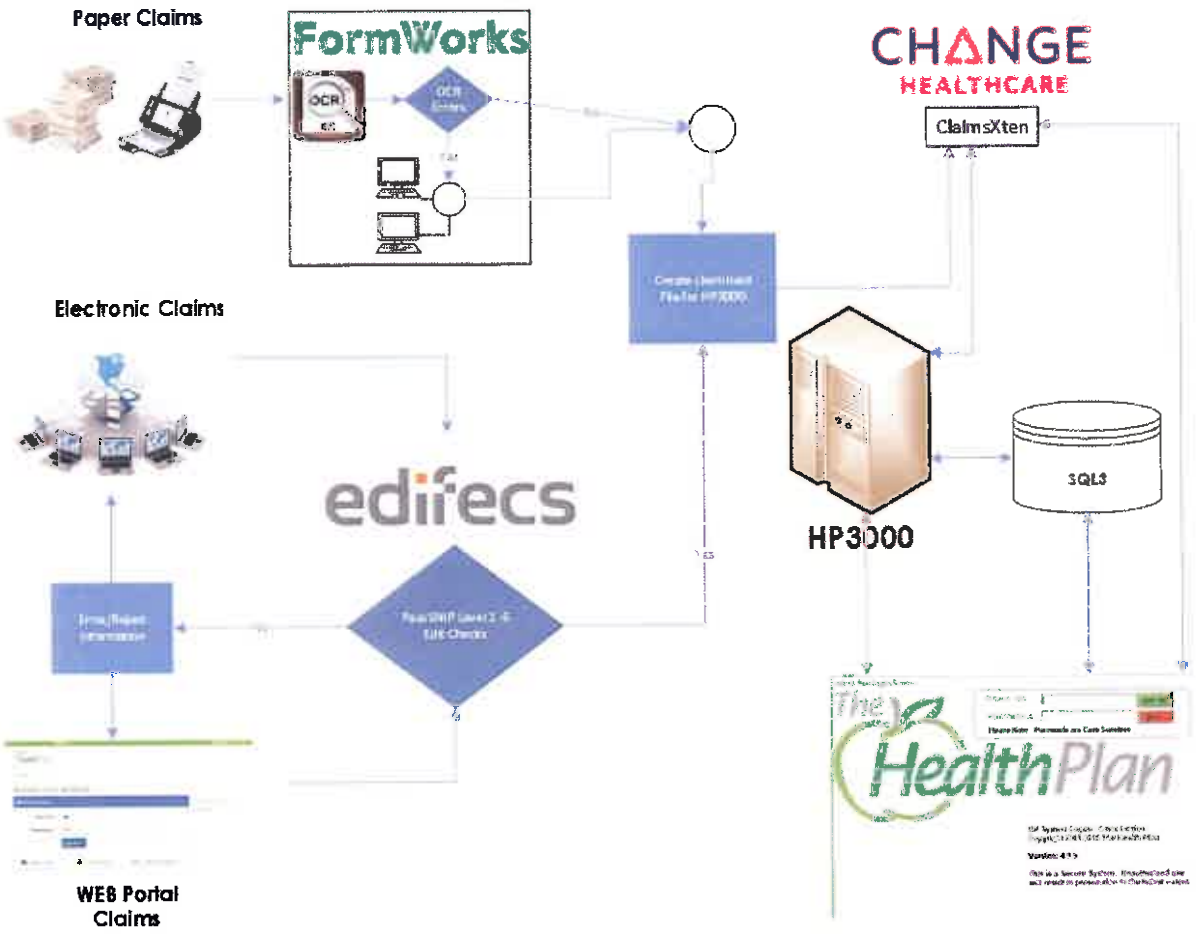


Figure 2: THP claims intake and validation process.

Pre-Adjudication: The data quality of the claims is subjected to Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) levels 1-7 quality checks for clean claim submission. Any claim not deemed to be a clean claim will be rejected back to the provider through the submitting trading partner. The provider will then need to correct and resubmit for consideration. These quality checks assure that data is clean prior to adjudication. We use EDIFECS to perform all upfront SNIP level and HIPAA compliance validations.

Edit Tool: The Edit Tool was developed internally by THP to improve the quality aspect of claims processing. The Edit Tool was designed to enhance our auto-adjudication of

claims and auto denial of claims. The edits are set up in the system by the director of Medicaid operations. For claims that cannot auto process or deny, the tool gives the analyst a message of exactly what they should review to clear the edit. It also indicates the denial codes for the analyst to apply if necessary.

Authorization determination: Our procedure validation tool, developed internally, allows us to determine if a specific CPT/HCPCS Code requires an authorization. It can be customized by different lines of business such as WVCHIP. The codes housed in this tool are updated and owned by THP clinical staff. The tool is integrated with our claims processing and customer service systems. If the code received on the claim requires an authorization, the system will assign an edit to advise the processor that an authorization is required.

The tool also has a place to add special instructions or notes for the claims and customer service team. This is an alert that will display to the user. The tool increases the efficiency and productivity by eliminating the need for the user to perform search functions to locate the authorizations. This reduces the need for the user to search to locate the authorization. It also increases the accuracy and consistency of the analyst and customer service representative (CSR).

Claims Adjudication: Our systems are set up to automatically evaluate claims, looking at various factors, including plan benefit design, utilization and eligibility. Our system is configured to allow pre-adjudication or post-adjudication claim edits, including but not limited to HIPAA and National Correct Coding Initiative (NCCI) edits received from Bureau for Medical Services (BMS).

Claims received electronically may be either auto-adjudicated or require a review by a claim's analyst. Because the system requires all electronic claims to be submitted with correct information, many claims received electronically go through our auto-adjudication process. However, as with paper claims, electronic claims also may be pended for claims analyst review when certain system edits are triggered. Whenever a system edit identifies information that needs to be investigated (such as coordination of benefits) before the claim can be processed for payment, the claim is pended until the investigation is complete.

Claims Payment: Our Electronic Payment System (EPS) provides options to receive payment via Electronic Funds Transfer (EFT) or paper check. EPS can capture and store payment preferences and use it to deliver electronic Automated Clearing House (ACH) payments and HIPAA EDI 835 remittance advice (ERAs) or paper check and paper remittance advice (PRAs).

Reimbursement Policies: Our reimbursement policies provide payment methodology guidelines for medical and surgical services submitted on professional claims (CMS-1500 or its electronic equivalent), for those submitted on facility claims (UB-04 or its electronic equivalent) and, when specified on dental claims (ADA or its electronic equivalent). Our reimbursement policies are provided in conjunction with other THP policies, including, but not limited to any applicable participating provider contract, provider manual and credentialing plan. Our policies are readily available online at healthplan.org.

Fraud, Waste and Abuse: Fraud, waste and abuse (FWA) processes prevent the physical and financial victimization of members, providers, subcontractors, the State

and THP. THP uses a number of system edits and programmatic reviews of data to detect potential FWA. The HEART system allows for retrospective review of claims, trending and outlier identification. Through claims analysis, THP can monitor billing behavior and identify suspicious activity.

THP also uses an advanced data analytics program to monitor, identify and evaluate outliers and potential FWA issues. Analysis results include provider alerts, identification of top scoring providers across numerous schemes, as well as pharmacy and member alerts, and identification of outliers related to prescription utilization. This software is a powerful analytics tool for identifying potential FWA, identifying claims containing potentially falsified procedure codes, services not rendered, upcoding, overutilization and other common fraud tactics. Using this software, over 100 data mining reports are created each month.

Additionally, the Special Investigations Unit (SIU) employs various data mining techniques monthly to identify outliers in targeted high-risk areas. Examples include, but are not limited to, monitoring of claims data to identify:

- Top prescribers
- Overutilization of controlled substances by members and providers
- Change in diagnosis after denial
- Duplicate claims
- Age-inappropriate procedures
- Unbundling
- ER services that indicate upcoding, double billing, or billing for services not rendered
- Claims violating the National Correct Coding Initiative (NCCI) edits
- Billing of comprehensive and individual component procedures
- Inappropriate utilization of consultation codes
- Inappropriate utilization of Evaluation and Management (E/M) codes
- Claims violating the Medically Unlikely Edit

Claims analysts evaluate claims for potential FWA, including overutilization. The claims payment system screens for potential false claims based on available criteria obtained through vendor resources, guidelines from CMS, and other relevant sources. Analysts also rely on their own experience and expertise in identifying potentially fraudulent claims. Suspicious claims are denied with the appropriate denial code that results in a request for supporting documentation. This process allows for tracking of all requests so that trends may be tracked and analyzed on an aggregate basis. The claims analyst will evaluate resubmitted claims, along with the supporting documentation. If at any point the claims analyst determines that a provider has knowingly submitted a false claim, it is reviewed by claims management. If management concurs, a referral is made to the SIU.

Payment Integrity: Our payment integrity team reviews claims for potential overpayments based upon standard coding guidelines and payment methodologies. The payment integrity team also performs review of high dollar claims, pre-service provider negotiation for out-of-network providers, and other services that can incur a large cost, on a pre-payment basis.

High dollar claim reviews are conducted for all claim payments exceeding $50,000. These claims are reviewed by a registered nurse (RN) who reports through the operations team. The purpose of this review is to perform a clinical type bill review to determine if further clinical review is required based upon the itemization review and to assure plan requirements have been met. The review requires confirmation of the following:

- Member data
- Benefit determination accuracy and application
- Medical necessity Indicators

- High cost single line items
- Appropriateness/Reasonable number of units
- Never events
- Hospital-acquired conditions
- Robotics charges
- Implant charges
- Itemized billing review
- Duplicate check
- Other insurance indicator
- Medicare eligibility
- Accident details
- Plan exclusions
- Third party liability
- Network confirmation
- External audit or review recommendation
- Prior authorization on file

Claims Auditing: As part of the claims review process, we audit a statistically valid sample of claims for payment accuracy. Our quality assurance process ensures that each claim is processed correctly according to the program requirements. Accuracy statistics are tracked for the month and year to date. Audit statistics are reviewed with claims analyst during monthly one-on-one sessions with managers. Statistics are tracked overall for the Medicaid line of business and reported to senior management.

Additional claim reviews and audits are conducted as claims are escalated through our claim level reviews based upon dollar authority levels that are assigned at the claims analyst level. Any claim exceeding the claims analyst's authority level is audited and released by someone with a higher level of authority. Authority levels can be adjusted up and down based upon tenure, audit results and training.

WVCHIP Claims Processing

THP's plan is to apply these same processes to WVCHIP claims. However, we recognize the WVCHIP plan is unique and are prepared to customize our processes to accommodate WVCHIP plan needs. Further, we expect to have dedicated claims analysts assigned to the WVCHIP plan since the benefit plan design is different than Medicaid.

CE002: 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.

CE004: The Vendor should describe how they will implement rate changes adopted by the Department within thirty calendar days of notification of the rate change.

Within our claims processing system, we are able to modify payment rates quickly. Our configurable claims processing system, HEART, allows us to extend the same payment methods to WVCHIP members. THP has systems in place that ensure payment at 100% of the prevailing MHT rate in cases where the service provider agreement indicates the requirement. For example, behavioral health and emergency transportation have requirements to pay no less than 100%. As outlined in Section 2.7 of the Service Provider Agreement, we are permitted in certain circumstances to reimburse providers below 100% of the prevailing MHT rate. Section 7.6.5 of the Service Provider Agreement also provides us the flexibility to negotiate an alternative payment schedule for certain services.

Our provider contracting and pricing team is responsible to receive and update rate information in the HEART claims system. All contracted providers are loaded with the Medicaid or WVCHIP prevailing rates unless THP has a signed provider contract in

place specifying the provider has agreed to accept something other than Medicaid's or WVCHIP's prevailing rates.

We have the following process in place to assure changes are completed within 30 days of notification from the Department.

- Notification of fee updates is sent from BMS to contract liaison/MHT administrator
- Contract liaison/MHT administrator notifies manager of pricing/contract compliance
- Manager of pricing/contract compliance oversees the fee loads into HEART
- Manager of pricing/contract compliance notifies contract liaison/MHT administrator when fee updates are complete
- Contract liaison/MHT administrator reviews the process for contractual compliance and notifies appropriate parties if contractual obligations are not met

CE003. 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).

Our current claims processing guidelines monitor for preventable provider conditions (PPC) and/or hospital-acquired conditions. We have built in validations to flag claims for PPCs or hospital-acquired conditions as part of our preauthorization and adjudication processes. Our validation is based upon indicators on the claim such as, present on admission and ICD-10 codes.

Additionally, other ways we monitor claims to make sure we deny claims payment are through concurrent reviews and quality department investigations.

Concurrent Reviews and Quality Department Investigation Process

Policies and procedures exist for all medical and behavioral health navigators to monitor for potential quality issues that may occur during any aspect of care and report those issues to the quality management department.

THP reviews and tracks admissions with identifiable never events and avoidable hospital conditions. When it is determined there were additional hospital inpatient days at a participating provider facility, which directly and exclusively resulted from an avoidable hospital condition (not present on admission), reimbursement for additional inpatient days and/or services may be denied. Further, avoidable hospital conditions and never events shall not be considered in DRG determinations for facilities reimbursed through a DRG methodology.

Denials for inpatient hospital days or services that are the result of such circumstances are not billable to the member. These reimbursement denials will not apply to hospital admissions in which the avoidable hospital condition was present on admission (POA), or where another secondary diagnosis is a major complication/comorbidity (MCC) or complication/comorbidity (CC) in addition to the POA diagnosis, and potentially impacted the avoidable hospital condition.

Never events, hospital-acquired conditions and healthcare associated conditions are investigated through THP by the clinical quality improvement RNs. When a potential quality of care issue is identified by the nurse navigator, a review is sent to quality management department via the internal tracking system in HEART. Current indicators are included in our tracking system that include variances, hospital-acquired conditions and never events screens as defined by federal and state regulations.

CE005: 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/nationalcorrectcodinited/index.html).

In 2019, THP invested and implemented a code editing tool, ClaimsXten, to enhance our code editing and validation process. Our claims processing system supports

healthcare reform mandates, including National Correct Coding Initiative (NCCI) edits and medically unlikely edits (MUE) we receive from BMS. The edits are performed in real-time during claims adjudication.

Our code editing software enables us to review claims for upcoding, unbundling, NCCI, multiple surgeries, assistant surgeries, age and gender, post-op and pre-op edits. Additionally, when an issue relating to potential FWA is detected by the claims processing staff, it is reported to our SIU for investigation. Refer to question **PI002** for more information regarding SIU investigations.

Cost Avoidance

Code editing: We project our Medicaid savings from code editing to be in excess of $3.4M per year. The savings estimate is calculated by comparing the pre-adjudicated/priced allowed amount that is sent to ClaimsXten for editing, to the post-adjudicated/paid claim allowed amount.

Potential duplicate payments: We have pre-adjudication duplicate claims identification that happens at various different levels within our EDIFECS edits, HEART edits, and ClaimsXten edits. We also have post-adjudication prepayment reporting to further identify potential duplicates. Our system is set up with rules to determine if claims are duplicate submissions; duplicate submissions are auto-denied. However, if the match logic is only partial and a definitive decision cannot be made, the claim is referred to a claims analyst for further review. We have a program that runs behind the scenes to monitor for potential analyst oversights in this area. These claims are then flushed out and escalated for another review. In 2019, we prevented $16.5M in potential duplicate claims.

Timely Filing: Claims filed outside the timely filing provisions of the plan are automatically denied. For the 2019 time period, we denied more than $1M in claims that were filed after the timely filing period had expired.

30-day re-admissions: Our medical management team reviews all admissions for related admissions during the prior 30-day period. Readmissions determined to be clinically related to the previous admission are not be separately reimbursed. Facilities will be notified that readmission authorization is denied for clinically related criteria and the previously approved inpatient authorization will be updated to cover the second stay. Facilities will receive written notice and instructions regarding how to submit a corrected claim. We review readmissions within 30 days for Medicaid members and deny if it was avoidable.

Retroactive terminations: Timely updates to eligibility records prevents claims from being paid after termination of coverage. We review retroactive terminations to identify claims paid after the termination date. Claims identified are reported to our funds recovery team to initiate the recoupment process.

Third Party and COB: For 2020 and forward, THP has contracted with HMS for third party reclamation recovery and for ongoing COB cost avoidance updates. These activities include:

- ***Third Party Recovery*** is the process where HMS identifies claims paid by Medicaid for which another health plan (third party) should have paid as primary. HMS will identify these situations, file a recovery claim with the other health plan and send THP the recovery on these claims.
- ***COB Cost Avoidance*** is the process where HMS will search other data bank health plan records and notify us if it finds other group health coverage that should pay before Medicaid. This is current other coverage information and is provided with carrier name, effective dates, term dates, type of coverage etc., and will allow us to make a determination if there is other coverage in place

before we pay a claim, preventing payment of the claim and trying to recover later. HMS will provide this information for our entire membership, not just those who have had a reclamation claim.

Both of these HMS programs are expected to reduce unnecessary expenditures in excess of $2M per year.

CE006: 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.

We currently administer MHT co-pays and cost-sharing requirements through our claims adjudication system. This system provides a high-level of flexibility and allows us to quickly update the system to meet changing business needs.

Monitoring and Waiving Co-pays

Our claims system monitors co-pays for Medicaid and future WVCHIP members. It monitors physical, dental, pharmacy, vision and behavioral health services as follows:

- For Medicaid members:
  - The State's enrollment file includes the income level for each member that determines the amount of the co-pay owed by the member.
  - When we process the enrollment file, our systems identify each member's income level to identify their co-pay and the member groups and services that are exempt from co-pays, such as members who are pregnant or under 21, and services, such as family planning or bahavioral health.
  - For those services, such as dental and vision, that we will subcontract for members under 21, we will waive co-pays because co-pays for these services do not apply to Medicaid members under age 21.
- For WVCHIP members, the State's enrollment file documents the member's benefit package, such as Blue, Gold and Premium. The benefit package determines the amount of the co-pay owed by the member.
- For Medicaid and future WVCHIP members, in addition to the co-pays owed based upon income level and benefit package, our claims system will set up co-pays by place of service, such as a hospital or office visit, and by CPT code, such as a non-emergent visit to the ER. This allows our claims system to auto-adjudicate co-pays when the provider submits their claim for services.

Tracking Co-pays

Our claims system tracks co-pays paid by members for medical, pharmacy (if applicable) and behavioral health services. To track co-pays for dental, pharmacy and vision services, we will exchange a daily "accumulator file" with the pharmacy benefit manager (PBM), dental and vision providers. For pharmacy, we will exchange a daily accumulator file with the Medicaid fiscal agent's PBM, DXC and the WVCHIP PBM, . The daily accumulator file will provide THP, the dental and vision providers and the PBMs with up-to-date information about the co-pays that have been paid by Medicaid and WVCHIP members. This allows THP, the dental and vision providers and PBMs to track each Medicaid member's quarterly household maximum and each WVCHIP member's annual out-of-pocket maximum so that we no longer collect co-pays when these limits have been reached.

CE007: 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.

CE009: 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.

CE010: 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.

CE011: The Vendor should provide its annual encounter data accuracy and completeness plan with its bid.

We understand BMS' emphasis on encounter data quality requirements and have a robust data quality, compliance validation and encounters processing system in place. For 2020 and forward, we have subcontracted with Episource to provide encounter submission and validation on behalf of THP and our subcontractors, SKYGEN and Superior Vision Benefit Management. We currently use Episource for our CMS Medicare encounters submissions and our acceptance rate is over 99%. Episource

processes Medicaid encounters submissions for over 550,000 members today across different states.

Data Quality and Compliance

As claims are received from trading partners (clearinghouses and direct provider connections), or after being keyed by our data entry team, the data quality of the claims is subjected to Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) levels 1-7 quality checks for clean claim submission. We use EDIFECS to perform all upfront SNIP level and HIPAA compliance validations. Any claim not deemed a clean claim will be rejected back to the provider through the submitting trading partner. The provider will then need to correct and resubmit for consideration. These quality checks assure that data is clean prior to adjudication and we have all data elements required to complete compliant 837 electronic encounters submission.

THP has business associate arrangements with its subcontractors including Superior Vision Benefit Management and SKYGEN. THP has inserted BMS-required language in its template business associate agreements (BAA) for use with its Medicaid subcontractors. The template BAA promotes subcontractor compliance with privacy and security requirements including the implementation of appropriate administration, technical and physical safeguards to protect the data of our members. These agreements also include BMS' reporting requirements in the event of an unauthorized use or disclosure. In addition, all subcontractors with access to protected health information (PHI) must complete an annual privacy and security attestation that further ensures our subcontractors have adequate privacy and security safeguards in place.

EpiEncounter is the encounter processing system that THP will be using to submit encounters, track responses and provides error correction and resubmission of medical, vision and dental encounters. In addition, EpiEncounter has robust reporting capabilities. We will report claim-level encounter data according to procedures and claims transaction formats as prescribed by the State in the current EDI specification document. The figure shows the processing of encounters data.

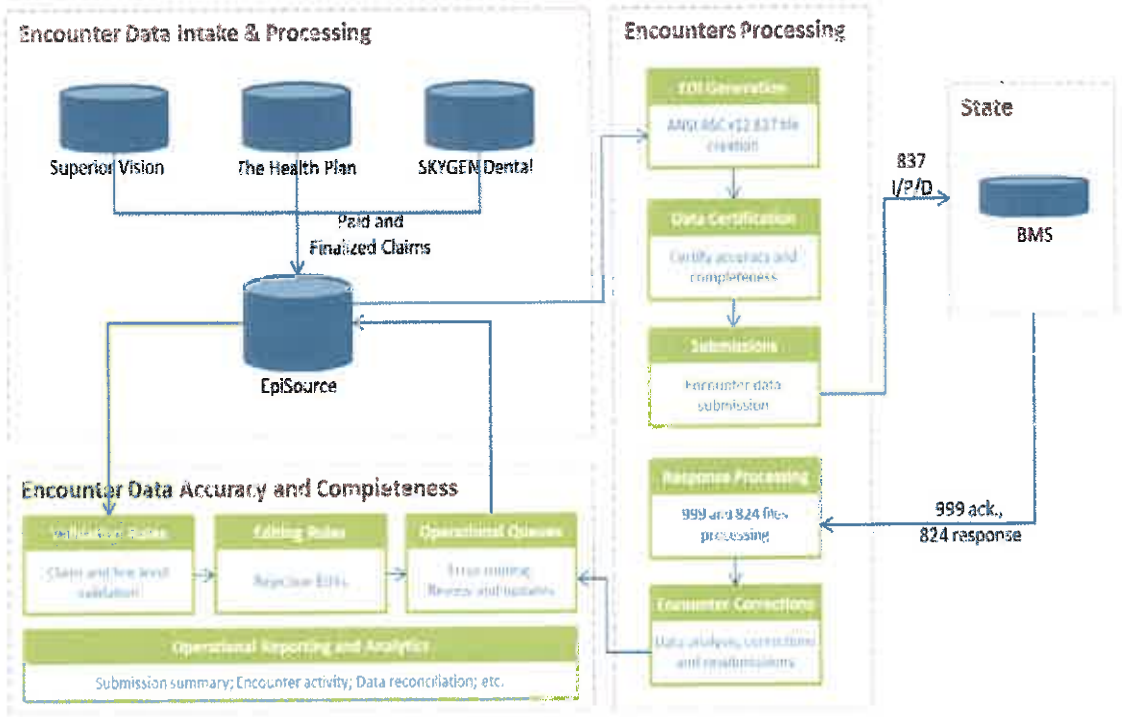


Figure 3: Encounters process flow.

In addition, we implemented BMS specific data requirements found in the EDI companion guides to ensure the integrity of the data.

Complete and Accurate Data

We have several checks and validations in place to ensure encounters submitted to BMS are timely, accurate, complete and consistent. We have standard edits and

validations we apply to our claims/encounter data during our intake process. A sample list of validations include:

- Duplicate check
- Field usage validation (required/optional)
- Field length
- Data type (alphabets/numbers/amount, etc.)
- Constant values check (EDI qualifiers, values populated in fields like gender)
- NPI check against the NPPES registry
- Data validations for several fields using master data (state code, Zip code, CPT code, DX code, value code, modifiers, revenue code, POS, TOB, etc.)
- CCI and NCCI edits
- Arithmetic validations
- Logical validations including data compatibility check

Our contracts with subcontractors include comprehensive service level agreements (SLAs) for timeliness, accuracy and financial completeness. Through these arrangements, we require providers/subcontractors to submit all encounters for services rendered to our members. This ensures complete and accurate encounter data is submitted to the Department on a monthly basis and no later than 30 calendar days after the end of the period in which the service was paid.

Data Accuracy and Completeness Monitoring Program

Our risk adjustment and EDI departments are responsible for the submission of encounter files to Episource. Episource will be responsible for submitting the encounter files to BMS. Our risk adjustment and EDI teams will coordinate with Episource to ensure that all BMS 837 Companion Guides are incorporated in the data accuracy and completeness monitoring program. Encounters will be submitted to Episource every two weeks after each THP check run. Episource will process received encounters and submit data to BMS. We monitor data accuracy and completeness issues tightly and

leverage a suite of reports to ensure quality and completeness. The following Monitoring Reports table has a sample list of reports we generate to reconcile data, identify issues and resolve data quality issues. Reports are generated using standard tooling, including modern SQL reporting.

Monitoring Reports

Report Name	Description
Internal Validation	This contains the details of claims rejected at internal validation stage
Top 5 Internal Errors	This dashboard report contains the top five rejections from internal validation process
Estimate Loss by Error Type	This dashboard report contains the financial impact to the health plans for the claims rejected at various levels including internal and state provided responses

As a continually improving organization, we value root cause analysis as a process step to ensure we identify the cause of identified issues so we can implement corrective actions so they do not re-occur. All high severity issues are reviewed for root cause analysis and adjustments made to avoid future issues.

Data Accuracy and Completeness Plan

Our data accuracy completeness plan outlines our the process / rules implemented to ensure accuracy and completeness of encounter data processed and submitted to the MCO by health care providers and Subcontractors. The Health Plan (THP) has processes in place to evaluate health care providers and Subcontractor compliance with contractual reporting requirements. These processes ensure THP is able to act on the information from the monitoring program to ensure full compliance with encounter reporting requirements.

As claims are received from trading partners (clearinghouses and direct provider connections), or after being keyed by our data entry team, the data quality of the claims

is subjected to Workgroup for Electronic Data Interchange (WEDI) Strategic National Implementation Process (SNIP) levels 1-7 quality checks for clean claim submission. We use EDIFECS to perform all upfront SNIP level and HIPAA compliance validations. Any claim not deemed a clean claim will be rejected back to the provider through the submitting trading partner. The provider will then need to correct and resubmit for consideration. These quality checks assure that data is clean prior to adjudication and we have all data elements required to complete compliant 837 electronic encounters submission.

THP has business associate arrangements with its subcontractors. THP has inserted BMS required language in its template business associate agreements (BAA) for use with its Medicaid subcontractors. The template BAA promotes subcontractor compliance with privacy and security requirements including the implementation of appropriate administration, technical and physical safeguards to protect the data of our members. These agreements also include BMS' reporting requirements in the event of an unauthorized use or disclosure. In addition, all Subcontractors with access to protected health information must complete an annual privacy and security attestation which further ensures our subcontractors have adequate privacy and security safeguards in place.

Our contracts with Subcontractors include comprehensive service level agreements (SLAs) for timeliness, accuracy and financial completeness. Through these arrangements, we require providers/subcontractors to submit all encounters for services rendered to our members. This ensures 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. THP will communicate on a weekly basis with its encounter data Subcontractor and receive reports related to the percentage and types of encounter data errors. Pertinent information will be captured through documented monitoring metrics which permit the tracking and trending of the Subcontractor's performance with respect to the delegated duties.

Our Risk Adjustment and EDI departments are responsible for the submission of encounter files to Episource. Episource will be responsible for submitting the encounter files to BMS. Our Risk Adjustment and EDI teams will coordinate with Episource to ensure that all BMS 837 Companion Guides and DXC 837 file layouts are incorporated in the data accuracy and completeness monitoring program. Encounters will be submitted to Episource every two weeks after each THP check run. Episource will process received encounters and submit data to BMS. We monitor data accuracy and completeness issues tightly and leverage a suite of reports to ensure quality and completeness. Monitoring Reports are generated to reconcile data, identify issues and resolve data quality issues. All high severity issues are reviewed for Root Cause Analysis and adjustments made to avoid future issues.

EpiEncounter is the encounter processing system that THP will be using to submit encounters, track responses and provides error correction and resubmission of medical, vision and dental encounters. We will report claim-level encounter data according to procedures and claims transaction formats as prescribed by the State in the current EDI specification document.

Encounter Submission System

epiEncounter, is a web-based Encounter submission platform hosted on a secure cloud to address the Encounter submission needs for Managed Care Organizations. There are several modules in the system to support submission of clean, accurate and complete encounter data to CMS and various MMIS / Medicaid State administrators.

epiEncounter Validation

Internal Validation is one of the key module in the platform that checks for data quality issues on all the segments / elements populated on an encounter in line with HIPAA SNIP validations. Besides, the system runs the claims data through all the edits that are possibly applied by CMS / MMIS State administrators at the following translation levels.

- 999 – Functional acknowledgments
- 277 – Claim Level acknowledgements
- Any CMS / state specific edits applied at levels including MAO-002, 835, 824, etc.

Categories of Validation:

To ensure accuracy and completeness of the data, the system performs several SNIP type validations as described below.

SNIP Type 1: Data Integrity Testing: In this level, the system checks the fundamental formatting and control elements of the X12 file and its internal structure. It includes checking of segments / elements / field and the data populated in it. System checks the order in which the segments are populated, the field length (Min and Max) and data type (ex: Alphabets, numbers, date, etc.). If the data received on the encounters are not in line with the X12 guidelines, then the system flags them as error.

SNIP Type 2: Implementation Guide Requirement Testing: In this level, the system verifies the following in line with the X12 implementation guides:

- Repeat counts of segments and loops
- Used/Unused, Recommended/Not Recommended segments/elements
- Valid code values
- Intra-segment testing
- Hierarchical level relationships between parent and child
- Sequencing of segments including HL and LX

If an element has an incorrect value, epiEncounter will flag it as rejection. The system also checks for required or situational segments or elements that needs to be present on a specific condition.

SNIP Type 3: Balancing: In this level, system performs arithmetic validation between few segments/ elements / fields to ensure that the sum of line level charges and payments are matching with the claim / header level charges and payments.

epiEncounter will reject the encounter and pushes it to the rejections queue for fixing, when there are quality issues found with Balancing of summary fields.

SNIP Type 4: Situational Testing: In this type, epiEncounter tests the specific inter-segment situations described in the X12 implementation guides. Per X12 guidelines, some of the segments / element / fields are identified as Situational, however they are mandatorily required when another segment / element is populated on the encounter. For ex: Admission date is a situational field by default but when the claim is submitted with Inpatient POS like 21, then the Admission date field becomes mandatory. All types of situational field validations are performed in this level. If the data is either missing or incorrect based on the presence of another field, then epiEncounter flags it as rejection.

SNIP Type 5: Code Set Testing: All the code sets used on the encounters (PROF, INST, DME and DENTAL) are verified to ensure whether they are valid for that DOS.

Some of the code sets that are currently validated for accuracy and completeness in the system are described below:

- ICD 10 CM
- HCPCS, HIPPS, CDT codes
- Revenue Codes
- Place of Service
- Type of Bill
- Value Codes
- Condition Codes
- Treatment Codes
- Remittance Advice codes
- Modifiers

SNIP Type 6: Line of Business Testing: In this level, system checks whether the data populated on the encounter are in compliance with the line of business including Medicare, Medicare Advantage, Medicaid and Managed Care Organization. Ex: Hospice care, Home Oxygen treatments have unique data requirements for submitting claims to a specific payer. All the requirements associated with the LOB / market are built in the system so epiEncounter validates whether or not the encounters are in compliance to ensure accuracy and completeness.

SNIP Type 7: Trading Partner Testing: In this level, system performs specialized testing between the trading partners including CMS / State MMIS administrators. All rules with the trading partners are identified and built in the system. When the data is not in compliance with the rules built for the trading partner, then epiEncounter flags them as error and pushes it to the rejections queue.

CE008: The Vendor should describe its encounter certification process that requires it's 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.

Our robust encounter certification process ensures accuracy and completeness of data at each step in the encounter processing. As shown in the figure, our certification process receives and reviews audits and controls as data moves from one step to next. Issues identified are further reviewed for root cause and fixed. In addition to our internal review, we receive and review the summary of top 10 errors from BMS.

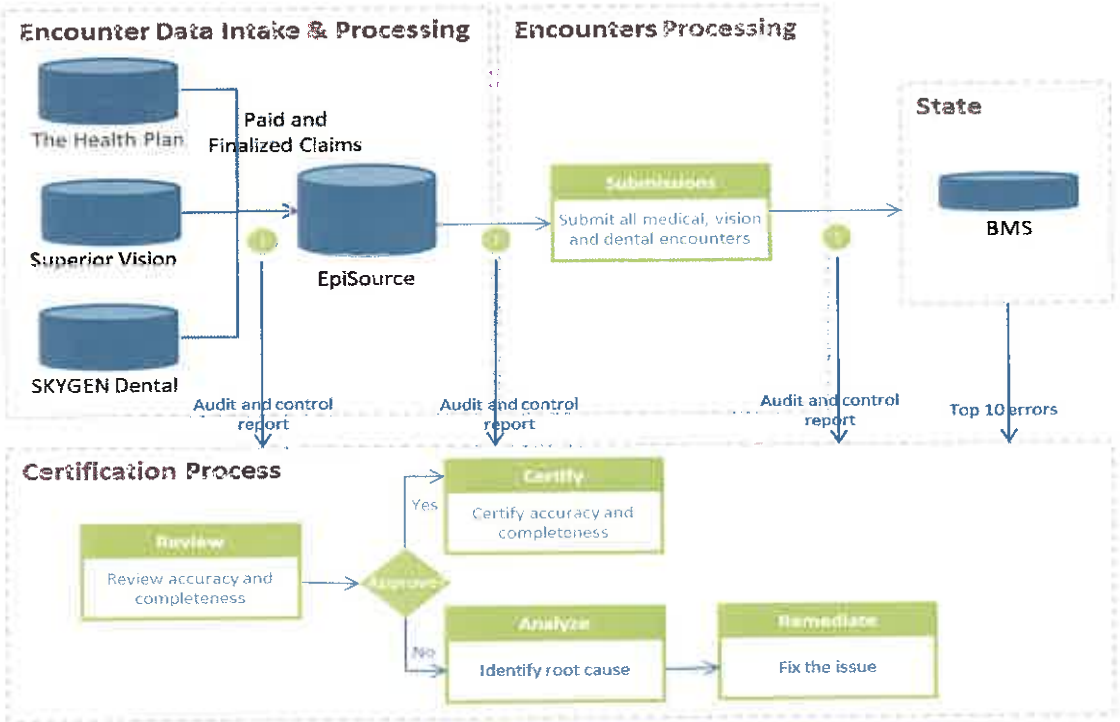


Figure 4: THP encounters certification process. Our encounters certification process includes validation reviews at each step. And identified issues are further reviewed for root cause and fixed.

Our encounters certification process includes the following data exchanges and reports:

1. After each check run (every two weeks) a report is created for claims and total dollar paid in that check run.
2. After the encounter files are submitted to Episource, Episource creates a report indicating received claims.
3. After encounters are submitted to the MMIS system, Episource reports back to THP indicating the claims that were accepted into the MMIS system.

4. Our finance team reviews the reports for accepted and rejected claims along with paid dollars to guide the certification process.

Our chief operations officer (COO) certifies all of THP's claims/encounter data submissions. We understand that the purpose of the certification statement is to attest that the information we submit is current, complete and accurate.

CE012: 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: A detailed summary of the file submission that includes total claims and dollars by service category

CE014: 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

We will submit reports to the Department summarizing encounters activity in the format and frequency as specified by the Department. Our reporting and analytics solution integrates medical, behavioral, dental and financial data to produce all of the reporting and analytics needed to conform to the Department's reporting requirements.

Leveraging our encounters solution (as described in **CE007**) and as required in the Service Provider Agreement, Section 5.10.5.1 Encounter Data Submission, we will submit a detail summary of the file submission that includes total claims and dollars by service category in the format and frequency as specified by the Department.

Change Management and Implementation

Our structured process builds or enhances any system or process with which we receive, load, process data from providers or BMS or to supply extracts. Our change management process is our disciplined approach for process development and test controls for validity and accuracy. Through our change management process, systems analysts, business analysts and plan executives consider HIPAA regulations, contract requirements, customer requests and user impact when reviewing changes, enhancements and upgrades to systems. Our business requirements and technical

specification documents capture our current and future state of any change including but not limited to correction and adjustment processing, range and domain of extract variables, values of extract variables, and relationships between extract variables. Our policies would have the definitions for any codes on the encounter record that are not defined in the public domain including but not limited to, provider specialty, type of service, place of service, and internal procedure codes.

As required in the Service Provider Agreement, Section 5.10.5.1 Encounter Data Submission, we will submit 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 in the format and frequency as specified by the Department.

CE015: 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.

Our reporting and analytics solution integrates medical, behavioral, dental and financial data to produce all of the reporting and analytics needed to conform to the Department's reporting requirements. We have reports to reconcile financials for adjudicated claims and for encounter data. Discrepancies identified are traced and resolved back to the claim adjudication system. We have similar processes to reconcile and identify errors after submission using the response file received from the fiscal agent.

As described in **CE008**, the audit and control reports created at each step in the process are used by our finance team to reconcile the biweekly and quarterly financial data reported to BMS, identify and explain any difference of 5% or higher.

TheHealthPlan

Attachment 6
Program integrity

11. Program Integrity

The Vendor should refer to the business specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Program Integrity (PI) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

The Health Plan (THP) confirms adherence to expectations and requirements outlined in Article III, Section 8 Fraud, Waste, and Abuse (FWA) Requirements in the Service Provider Agreement. Our FWA plan complies with 42 CFR 438.608 and all state and federal laws and regulations for healthcare in Medicaid programs. This demonstrates our commitment to detect, prevent, investigate, and report potential FWA among providers, subcontractors and members. Our Special Investigations Unit (SIU) is in place to detect, investigate, remediate and report FWA.

PI001. 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).

PI004. The Vendor should describe how they will maximize resources for fraud, waste and abuse (FWA) issues.

Our administrative and management procedures, outlined below, align with 42 CFR 438.608 and are designed to detect, prevent, investigate and report potential FWA.

Compliance (a)(1)

THP maintains an annually reviewed robust compliance and FWA plan designed to ensure THP fulfills all statutory and contractual obligations in a fair, accurate and consistent manner. The Compliance/FWA Plan not only addresses healthcare FWA, but the requirements and obligations set forth by CMS, Bureau for Medical Services (BMS) and other applicable laws and regulations. The plan is more fully described in **PI006-PI009**. It includes:

- Written policies, procedures and standards of conduct that articulate THP's commitment to comply with all legal and contractual requirements
- Designation and responsibilities of the compliance officer

- Establishment of a Regulatory Compliance Committee
- Training and education requirements
- Effective lines of communication
- Well-publicized disciplinary standards
- A system for routine monitoring and identification of compliance risks and prompt response to identified compliance issues

Prompt Reporting of Overpayments (a)(2);(d)(2);(d)(3)

THP uses the BMS template for timely reporting of all overpayments identified or recovered, specifying those that are due to potential FWA. This information is submitted on the FWA Monthly Report. In addition to documenting all program integrity activities related to the Medicaid line of business, the report includes information on all overpayments identified or recovered, including those unrelated to program integrity, such as administrative overpayments.

THP's provider manual advises providers of THP's policy regarding return of overpayments. The provider is required to notify THP in writing of the reason for the overpayment and return the full amount of the overpayment to THP within 60 calendar days after the date on which the overpayment is identified. In the event that THP makes an overpayment to a provider, THP recovers the full amount of the overpayment from the provider. This recovery is administered through the claims system by offsetting the overpayment against future claims payments.

Prompt Notification of Enrollee Changes Affecting Eligibility (a)(3)

When THP becomes aware of changes in an enrollee's circumstances that may affect the enrollee's eligibility, the MHT member advocate notifies BMS immediately. This includes changes in an enrollee's residence and the death of an enrollee.

Prompt Notification of Provider Changes Affecting Eligibility (a)(4)

THP reports promptly to the State when it becomes aware of any information related to a provider's suspension, termination, conviction or other actions that impact the provider's eligibility to participate in the program. All adverse enrollment actions are reported promptly and in accordance with the Service Provider Agreement. If a Medicaid provider is terminated for cause, the manager of credentialing sends all documentation, including any letters sent to the practitioner, to the program integrity lead, who sends notification to BMS. The documents identify the reason for termination and the effective date. In addition to the BMS referral, the SIU initiates a preliminary inquiry to determine if any claims were paid inappropriately. The SIU coordinates with the State and investigates as appropriate.

In addition to immediate notification, THP submits the Suspension & Adverse Enrollment Action report to BMS monthly. This report conveys information related to any healthcare professional, institutional provider or supplier that has been the subject of program integrity actions related to participation.

Verification of Services Rendered (a)(5)

THP verifies receipt of services by members. THP performs verification calls to a sample of Medicaid members each month to confirm services were actually provided. If the member denies receiving such services, or if the conversation indicates other FWA "red flags," a referral is made to the SIU. Additionally, the Explanation of Medicaid Benefits (EOMB) directs members to report to THP if they believe a provider has billed for services not rendered.

False Claims Act and Related Training (a)(6)

Policies and procedures are in place for the education of employees, contractors and agents about the Federal False Claims Act, in accordance with Section 6032 of the Deficit Reduction Act of 2005, for any entity that receives or makes Title XIX (Medicaid) payments of at least $5 million annually, as well as other relevant state and federal laws, including laws against retaliation and information about the rights of employees to be protected as whistleblowers. See **PI007** for details.

Prompt Referrals and CAF Payment Suspensions (a)(7),(8)

The SIU promptly refers all potential FWA cases and payment suspensions to BMS. The referral process is outlined more fully in **PI002**.

THP complies with the requirements outlined in 42 CFR 455.23, which requires suspension of provider payments if it is determined a credible allegation of fraud exists, for which an investigation is pending under the Medicaid program, unless a good cause exception is invoked. THP cooperates fully with BMS when it imposes a payment suspension. Upon notification from BMS, THP suspends payments within one business day, if the provider is in THP's network and is receiving payments. Further, THP responds to this notification from BMS within three business days and informs BMS that the suspension has been completed, or informs BMS of the reason for not suspending, such as instances where the provider is not part of THP's network.

Suspended Payments

In the fall of 2019, as a result of a sweep conducted by the Appalachian Regional Prescription Opioid (ARPO) strike force, several providers were charged with offenses related to "pill mill" crimes (the over-prescribing of controlled substances). As required by the contract, THP took immediate action and suspended payments to these providers within one day of notification from BMS.

Pursuant to the Service Provider Agreement, BMS is responsible for evaluating allegations of fraud and imposing payment suspensions, when appropriate, for those

managed care organization (MCO) providers who are a part of the State fee-for-service (FFS) network. THP is responsible for initiating payment suspensions based on the credible allegation of fraud for its in-network providers who are not a part of the State FFS network. For payment suspensions initiated by THP, required information is reported to BMS within one business day. Regardless of who initiates the suspension, THP reports to BMS the nature of the suspected fraud, basis for the suspension, date imposed, date the suspension was discontinued, reason for discontinuing the suspension, outcome of appeals, amount of payments held and, if applicable, the good cause rationale for imposing a partial payment suspension.

Provider Screening and Enrollment (b)

THP's policy requires physicians that order, refer or render covered services to be enrolled with BMS as a Medicaid provider. Such enrollment does not obligate the provider to offer services under the fee-for-service plan, and THP is not required to contract with a provider enrolled with BMS if the provider does not meet THP's credentialing or other requirements. See also **PI009** and **PI012**.

Disclosures (c)(1),(2),(3)

Prior to the beginning of each contract year, THP submits a completed MCO Disclosure Statement, attesting to our compliance with the disclosure requirements required under 42 CFR §438.610 and §455.104, relating to affiliations, ownership and control.

In the event our finance or reconciliation processes identify capitation payments or other payments in excess of amounts specified in the Service Provider Agreement, the MHT member advocate investigates the issue and coordinates with BMS to ensure any discrepancies are corrected.

Maximizing Resources for FWA Issues (PI004)

THP's SIU created a multi-MCO SIU Healthcare Fraud Workgroup consisting of representatives from the SIU of each MCO currently providing services to West Virginia Medicaid members. The purpose of the group is to discuss FWA-related trends and best practices, to share leads and find solutions to shared challenges with the ultimate goal being to magnify our impact on FWA across all plans.

THP's Program Integrity Committee consists of the VP of internal audit & quality, the VP Medicaid, the program integrity lead, the director of quality assurance & payment integrity, the quality management director and other leaders from contracting, credentialing, claims, provider engagement and administrative services. This Committee ensures a holistic approach to program integrity issues, and the involvement of upper management guarantees these issues receive appropriate priority.

The SIU, in partnership with the compliance department, delivers training to staff on identification of potential FWA. This training includes real-world scenarios they could encounter in the course of their jobs.

Claims analysts evaluate claims for potential FWA, including overutilization. They view both member and provider history, and identify suspicious behavior in the course of their day-to-day work. The claims payment system screens for potential false claims based upon available criteria obtained through vendor resources, guidelines from CMS and other relevant sources. Suspicious claims are denied with the appropriate denial code that results in a request for supporting documentation. The claims analyst evaluates resubmitted claims, along with the supporting documentation. If at any point

the claims analyst determines that a provider may have submitted a false claim, claims management reviews the claim. If management concurs, a referral is made to the SIU.

Customer service representatives (CSRs) may become aware of potential FWA based upon information gleaned from calls with members and providers. Suspect cases are referred to the SIU. Clinical/utilization management staff are also involved in detecting and correcting FWA. Those efforts are more fully detailed in **PI011** related to monitoring over and underutilization. Staff also lend their medical expertise to the SIU as needed.

PI002. 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.

THP maintains an SIU to uphold its commitment to prevent, detect and correct issues that could lead to FWA. Policies and procedures are in place to ensure compliance with laws and regulations, and employees regularly participate in related training to ensure they understand how to recognize and report suspicious activity. THP also creates and distributes member and provider education related to FWA.

THP SIU Continuous Improvement
In 2019, THP undertook the following initiatives:

- Doubled the size of its SIU
- Recruited a West Virginia Medicaid fraud subject matter expert to lead the SIU
- Implemented SIU-related provider onsite visits as an industry best practice
- Created a multi-MCO SIU Healthcare Fraud Workgroup
- All SIU personnel are Certified Medical Coders or must obtain within six months
- SIU staff must complete at least 10 hours of training each year
- Expanded the SIU's involvement across the organization, to include launching a collaborative between SIU, provider engagement and quality management
- Creation of a Suspicious Activity Indicators guidance document for provider engagement and quality management
- Initiated overhaul of the SIU's case management system to enable enhanced tracking and reporting capabilities

The SIU works with BMS, the Medicaid Fraud Control Unit (MFCU), the Office of Inspector General (OIG) and CMS to administer effective FWA detection and prevention practices. The SIU participates in

coordination activities with the State to maximize resources for FWA issues, meets regularly and as requested with BMS and the MFCU, and attends FWA training sessions scheduled by the State. THP's SIU stands ready to assist its state and federal partners in identifying, investigating or prosecuting healthcare FWA.

The SIU examines reported incidents of suspicious activity from all sources and provides a telephone tip line, a dedicated email address (SIU@healthplan.org), and a website portal to facilitate receipt of referrals. Investigations may be initiated based upon complaints or referrals from internal or external sources, alerts from government agencies or law enforcement, or due to the SIU's proactive efforts such as data mining or routine claims monitoring.

Referral sources include, but are not limited to:		
BMS	CMS	NBI MEDIC
Colleagues in the industry	HHS-OIG	Law enforcement
Media	Anonymous sources	Providers
THP staff, including provider engagement, claims analysts, customer service, quality management, grievance and appeals, and others		
Members, who may report of their own volition or in response to our member service verification efforts, notices included with EOMBs, or reminders posted in our newsletters and on our website		

The SIU's fraud analytics specialist conducts in-depth data analysis to vet the allegation and inform decision making as to case status. As the case progresses, the SIU uses its considerable experience and expertise to gather evidence and move the investigation forward.

In addition to data analysis, investigative activities may include review of prior cases, legal research, background research, interviews, site visits, review of contracts, medical records, provider or member correspondence or other documentary evidence, consultation with other subject matter experts, regulators or licensing boards and other

actions needed to complete a thorough investigation. Cases are reviewed regularly by the program integrity lead. In addition to responding reactively to incoming referrals or complaints, the SIU takes proactive measures to identify and investigate potential FWA.

Through claims analysis, THP identifies suspicious activity. THP uses an advanced data analytics program to identify and evaluate outliers and potential FWA issues. Analysis results include provider alerts, identification of top-scoring providers across numerous schemes, as well as pharmacy and member alerts and identification of outliers related to prescription utilization. This software is a powerful analytics tool for identifying potential FWA, identifying claims containing potentially falsified procedure codes, services not rendered, upcoding, unbundling, overutilization and other common fraud tactics. Over 100 data mining reports are created each month. Additionally, the SIU conducts data mining in targeted high-risk areas.

THP employs in-house pharmacy personnel who monitor pharmacies submitting suspicious claims. Upon review and investigation and when warranted, pharmacies may be barred from billing THP, members may be locked in to only one pharmacy for their controlled substance prescriptions or a referral may be made to the appropriate law enforcement entities.

THP also taps into the contracted pharmacy benefit manager (PBM) that it uses for the Medicare and Commercial lines of business to identify potential FWA in Medicaid. The PBM's SIU investigates fraud related to network pharmacies. It proactively identifies suspicious activity, monitors CMS alerts, Medic Risk Assessments, media tips and fraud tips. In addition to data mining activities that include use of a proprietary predictive modeling tool, the PBM also conducts member verifications to confirm the member

received the medication, prescriber verifications to confirm the prescriber ordered the medication and purchase verifications to confirm the pharmacy had sufficient inventory to justify the claim volume. The PBM's SIU conducts both desk and on-site investigations that include reviews of prescriptions, delivery records, quality assurance and other relevant documentation, and employee interviews. Substantiated improper conduct is referred to the appropriate authorities.

The PBM also conducts a number of audit programs to help ensure accurate submission and payment by using a collaborative approach that emphasizes the education of network pharmacies in proper claims submission procedures. The predictive model review process aids in the detection of high-risk claims, followed by additional review by auditors. The PBM's desk audit program completes an automated review, using a large number of outlier indicators, of all claims submitted by network pharmacies the previous day. The historical audit program is an ongoing retrospective review of claims, in addition to the daily claims selected during the desk audit. Lastly, on-site audits include in-person reviews of prescription claims and operating practices to evaluate a pharmacy's compliance with federal regulations, pharmacy practice and the PBM's provider manual. Pharmacies are selected for an on-site audit based on various criteria that may include findings from desk or historical audits, reliable tips or selection via the PBM's proprietary audit selection tool.

THP's SIU case actions are documented in a custom-built, in-house case management system, accessible only to SIU and certain compliance personnel. All investigative activities and case notes are documented in the electronic case file, and the case management system also houses all case-related files such as claims data, contracts,

correspondence, documentary evidence, chart review results, opinions from clinicians or other subject matter experts, provider education, site visits and results, correspondence with other stakeholders, referrals to law enforcement and regulatory agencies and all other files related to the investigation.

The SIU refers all suspected fraud cases to the appropriate regulatory and/or law enforcement authority. For Medicaid specifically, when the SIU identifies that FWA may have occurred, the case is immediately referred to BMS following the completion of ordinary due diligence. The SIU has an excellent working relationship with BMS and MFCU and is in frequent communication with BMS regarding any ongoing investigations related to Medicaid. When warranted, the SIU delivers the completed Medicaid Fraud Referral Form to BMS, along with a detailed report of investigation, claims data, documentary evidence and all other relevant information. In conjunction with the referral, the SIU may also meet with BMS or the MFCU to further discuss the case.

Criteria for referring suspected FWA cases to BMS
• Determination that the provider suspect is enrolled/credentialed for the Medicaid line of business or has some other means by which to impact Medicaid expenditures
• Determination that the member suspect is a Medicaid member or has some other means by which to impact Medicaid expenditures
• Identification of other parties involved that may impact Medicaid expenditures
• The SIU has completed its due diligence which may encompass a full investigation including interviews, record reviews, data analysis, legal and regulatory research, contact with licensing or other authorities, provider site visit, consultation with clinicians or other subject matter experts and other necessary investigative activity
• The investigation reveals indicators that FWA may have occurred
• The investigation has been reviewed and approved by the SIU Director

Pursuant to the Service Provider Agreement, if BMS accepts the case for State investigation, the SIU will not engage in investigation efforts other than coordination efforts with the State without first deconflicting with BMS and MFCU. The SIU may proceed with the investigation or payment recovery efforts if BMS so authorizes.

The SIU follows the deconfliction protocol created by the State. The SIU may request to pursue other investigative or recovery action related to a provider who is the target of a state investigation by submitting the required information and deconfliction request to BMS and MFCU.

Deconfliction Protocol
In May 2019, subsequent to a multi-million dollar civil settlement obtained by the MFCU and the USAO, the SIU identified additional overpayments based on the same scheme that occurred outside the time frame covered in the settlement. In adherence to the deconfliction protocol, the SIU obtained permission from the State to pursue over $31,000 in additional recoveries.

With appropriate deconfliction, other investigative outcomes may include:		
Claims monitoring	Provider education	Pre-payment review
Recovery of overpayments	Provider termination	Provider non-renewal
Referral to licensing boards	Referral for civil litigation	Referral to law enforcement
Referral to other THP departments such as quality management or credentialing		
Payment suspension in accordance with the CFR and Service Provider Agreement		

All investigative outcomes related to Medicaid cases are reported to BMS on the FWA Monthly Report and are deconflicted with the State as necessary. In addition to case-specific investigative outcomes, cases may result in the development and implementation of new data mining queries to detect similar schemes across other providers.

If a provider appears on a spike report, the SIU will monitor the claims for a period of time to determine if the provider continues to be an outlier. Once a pattern is established, the case moves to the preliminary investigation stage and then on to full investigation if warranted.

If provider education is employed, the education is documented in the SIU's case file and the SIU follows up within a set period of time to review the billing patterns again to

determine if the education had the intended effect. If suspicious billing is identified, the investigation resumes.

Recovery of Medicaid overpayments is pursued if a case does not require referral to BMS and if the requirements of the Service Provider Agreement are met. Pursuant to that Agreement, THP is permitted to recover Medicaid overpayments from providers if:

- The MCO was not required to abstain from collections due to a MFCU or other law enforcement investigation
- BMS has not duplicated the recovery
- The MCO followed proper procedures regarding fraud or abuse referrals to BMS
- The MCO properly and timely disclosed the required information on its monthly FWA report
- The encounter data is properly adjusted to reflect the recovery
- Such recovery is not prohibited by state or federal law

Reporting to BMS

THP submits FWA-related reports to BMS as follows:

- ***FWA Report and Recovery of all Overpayments Report (Monthly):*** Documents all program integrity (PI) activities related to the Medicaid line of business and all overpayments identified and recovered, including those unrelated to program integrity.
- ***Suspension and Adverse Enrollment Action (Monthly):*** Conveys information to BMS related to any healthcare professional, institutional provider or supplier that has been the subject of PI actions related to enrollment/credentialing.
- ***Activities Summary, Analyses, and Results of Provider/Beneficiary Utilization to Detect FWA (Annually):*** Analyzes and summarizes THP's efforts in monitoring provider fraud for underutilization of services and beneficiary and provider fraud for overutilization of services.
- ***FWA Compliance Plan (Annually):*** Includes THP's policies and procedures to prevent, detect, investigate and report potential FWA. Additionally, the Plan addresses the requirements and obligations set forth by CMS and other applicable laws and regulations.

PI003. 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.

PI005. 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.

SIU Team

THP doubled the size of its SIU in 2019, and successfully filled the new director position with a Medicaid fraud subject matter expert who possesses substantial Medicaid and investigations experience, including approximately 20 years with the DHHR's OIG. The SIU currently consists of the director (program integrity lead), a fraud analytics specialist and two investigators. Additionally, the SIU uses a dedicated IT staff member to assist with all Requests for Information (RFIs) from the State.

All the aforementioned personnel are located in West Virginia, all are involved in and capable of responding to RFIs from BMS, MFCU or other State actors, and with the exception of the IT staff member, all are involved in and capable of initiating investigations, developing cases for future action, following up on program integrity leads from BMS, and participating in training, task forces or other meetings. While Program Integrity Lead Trina Crowder is the primary point of contact for program integrity deconfliction, any member of the SIU team can serve in that capacity in her absence.

SIU Experience
Collectively, the SIU team has 70 years of experience in investigations in the state of West Virginia. All SIU team members are Certified Medical Coders (CMCs), or must become CMC-certified within six months of hire.

The team's background consists of prior law enforcement, decades of experience with the OIG and within an SIU, over a decade with the West Virginia MFCU, and advanced degrees in Criminal Justice, Fraud and Forensics and Legal Studies. SIU personnel are required to complete at

least 10 hours of training/continuing education annually. This training may be provided in-house or may be obtained from national organizations such as the National Healthcare Anti-Fraud Association, the Association of Certified Fraud Examiners, the Practice Management Institute, or other relevant, expert sources. The SIU team reports up to the VP of internal audit & quality, who has a master's in Accountancy, is a CPA, and has over 15 years' experience in auditing.

Collaboration with Agencies

Maintaining collaborative relationships is one of the keys to a successful SIU. The entire SIU team is located in West Virginia and enthusiastically participates in all PI-related endeavors undertaken by the State. The SIU meets regularly with members of BMS to discuss fraud schemes, exchange ideas, discuss best practices and identify training topics. This trusted relationship allows for the free exchange of ideas, challenges and solutions. BMS is frequently complimentary of THP's SIU work and presentations, and has used THP's efforts as an example of best practices to share with the other MCOs.

The SIU attends and participates in all training sessions and round-table discussions arranged by the State, including providing case presentations, best practices and other relevant suggestions. These trainings often include MFCU and HHS-OIG, in addition to BMS. SIU staff delivers case studies or training presentations at these events.

Ms. Crowder has a strong working relationship with MFCU. Due to her prior experience in Medicaid fraud, she has a firm understanding of what cases appeal to MFCU and what information must be included in fraud referrals. The SIU works cooperatively with MFCU, responding timely, accurately and fully to requests for information and participating in joint training exercises.

The SIU works cooperatively with CMS's I-MEDIC to detect, prevent and deter FWA. Although the I-MEDIC's focus is on Medicare fraud, bad actors typically operate across all lines of business so information gleaned from this collaboration is relevant to protecting the Medicaid program as well. SIU staff attend CMS trainings and events, including its FWA training.

The compliance department and SIU use CMS's Health Plan Management System (HPMS), a web-enabled information system that CMS uses to facilitate data collection and reporting activities for Medicare Advantage (MA) plans. Though HPMS is used for MA Plan management, HPMS memos and other reports related to fraudulent schemes are applicable across all payers and lines of business. When the SIU receives these HPMS memos or other information regarding suspicious activity, a preliminary investigation is initiated across all relevant Medicaid claims.

Decades of Experience
Not only does our SIU personnel belong to IASIU, one of our investigators actually wrote the by-laws and founded the West Virginia IASIU chapter back in 1996.

As part of its proactive approach to combating FWA, the SIU monitors federal websites, such as CMS and HHS-OIG, for enforcement actions, alerts, work plans, reports and other information to stay abreast of fraud trends and other information used to inform decision-making. Information from these sources is used to conduct a targeted review of claims data to identify exposure to potential fraud schemes that may lead to further investigative or corrective action. The SIU collaborates with the United States Attorney's Offices and the HHS-OIG agents assigned to West Virginia Medicaid fraud cases.

THP is a member of the National Healthcare Anti-Fraud Association (NHCAA), the Healthcare Fraud Prevention Partnership (HFPP), and SIU staff also belong to the

International Association of Special Investigation Units (IASIU) and/or the Association of Certified Fraud Examiners (ACFE). These organizations all contribute to the networking, collaboration and continuing education necessary in fighting fraud. Networking with industry experts enables the SIU to stay abreast of current fraud trends and investigative techniques, ensuring maximum results for the SIU's investigative efforts.

Program Integrity and Medicaid Fraud Control Unit Requests

THP has designated specific personnel as primary and secondary contacts for all BMS program integrity and MFCU requests for data, records or other information. Program Integrity Lead Ms. Crowder serves as the primary point of contact and VP Medicaid Christy Donohue is the secondary contact. Further, as an added assurance that all requests are received and processed timely, the SIU's fraud analytics specialist is an additional contact person for such requests.

All requests from BMS and MFCU are given the highest priority and are acted on immediately. The fraud analytics specialist takes the lead on fulfilling these requests and coordinates efforts with personnel from IT, contracting, credentialing, provider engagement, claims and other staff as necessary to provide a full and complete response in a timely manner and in the required format. In response to **MD017**, THP produces reports in accordance with the MFCU's standardized reporting template.

MFCU Partnership
In the past two years, the SIU has responded to over 400 RFIs from the State, consistently meeting tight deadlines, including urgent requests that require even shorter than usual turn-around times. In CY2019, the average turn-around time for responding to RFIs was less than 4 days, well below the contractually required 14 day time frame.

PI006. The Vendor should provide its compliance plan with clear goals, timelines, assignments, and measurements as outlined by the Department.

PI007. 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.

PI008. The Vendor should describe its disciplinary guidelines and procedures for enforcement of compliance standards.

PI009. The Vendor should describe its procedures for routine internal monitoring, auditing, and remediation of compliance risks and identified issues.

Compliance/FWA Plan

Summarized here for the sake of brevity, THP has developed a written comprehensive Compliance/FWA Plan that meets the requirements of 42 CFR 438.608 and Article III Section 8.1.3 Internal Compliance Plan of the Service Provider Agreement. The Compliance/FWA plan employs goals, timelines, assignments, measurements and milestones that are developed and assessed each year. The Compliance/FWA Plan is reviewed, updated and approved annually by the executive level Corporate Compliance Committee (CCC) and the board level Audit & Corporate Compliance Committee (A&C) with subsequent approval by the full Board of Directors. In addition, the plan is submitted to BMS each October as part of the annual submission process. The plan consists of written policies, procedures and standards of conduct; a compliance officer, compliance committees and high level oversight; a system for training and education; effective lines of communication; well-publicized disciplinary standards; a system for internal auditing and monitoring and procedures and systems for prompt response to compliance issues. These elements are described later in this narrative. This summary focuses on the plan elements identified in Article III Section 8.1.3.2. Required Procedures for the Internal Compliance Plan of the Service

Compliance Program Effectiveness (CPE) Audit Results

"The Health Plan has built a well-functioning compliance department and has demonstrated strong progress since the CPE in 2018."

- *Statement from The Burchfield Group 2019 Audit Report*

Provider Agreement. Examples of the plan's goals, timelines, assignments, measurements and milestones are presented in the following table.

Examples of Goals, Timelines, Assignments, Measurements and Milestones by Compliance Program Elements	
Goals	Policies, Procedures & Standards of Conduct: Timely review/approval of compliance and SIU policies Compliance Officer: Ensure organizational compliance Regulatory Compliance Committee: Provide oversight of the compliance program Training & Education: Ensure a well-trained workforce Lines of Communication: Ensure clear directives and timely implementation Well-Publicized Disciplinary Guidelines: Enforce standards and promote adherence Audits, Monitoring and Corrective Actions: Ensure compliance and continuous improvement
Timelines	Policies, Procedures & Standards of Conduct: Code of Conduct reviewed and approved each November; policies reviewed annually and tracked in PolicyStat Regulatory Compliance Committee: Meetings scheduled in February, April, July and November Training & Education: April: HIPAA training; July: Medicaid contract training; November: Compliance/FWA training Lines of Communication: November: Compliance Week; Quarterly: Compliance newsletter; quarterly reporting to CCC and A&C Well-Publicized Disciplinary Guidelines: Any disciplinary issues addressed timely Audits, Monitoring and Corrective Actions: Planned audits scheduled by month; monitoring metrics scheduled by frequency (e.g., monthly, quarterly), internal CAPs completed in 120 days or less
Assignments	Policies, Procedures & Standards of Conduct: Compliance officer responsible; Code of Conduct approved by board; policies reviewed by CCC Compliance Officer: Responsible for implementation of the compliance plan Regulatory Compliance Committee: Executive-level CCC and Board-level A&C provide oversight Training & Education: Compliance officer and program integrity lead Lines of Communication: Compliance department and SIU Well-Publicized Disciplinary Guidelines: THP directors, managers and SVP of human resources Audits, Monitoring and Corrective Actions: AWP assigns auditing and monitoring activities to designated staff; Compliance/SIU team reviews progress monthly
Measurements	Policies, Procedures & Standards of Conduct: Reviewed during annual CPE audit Compliance Officer: Compliance program audited annually Training & Education: Employee mandatory trainings with a score of at least 80% Lines of Communication: Number of employees who participate in Compliance Week Audits, Monitoring and Corrective Actions: Monitoring metrics with goals set up in OMT; SIU reviews data for outliers and patterns; number of SIU cases opened, closed or referred
Milestones	Regulatory Compliance Committee: Meetings completed as scheduled Training & Education: Mandatory trainings completed Audits, Monitoring and Corrective Actions: Activities identified in AWP as completed, partially completed and not completed.
This table does not provide an exhaustive list of all goals, timelines, assignments, measurements and milestones. Rather it provides examples of how THP integrates these items into its compliance plan.	

Conducting regular reviews and audits of operations to guard against FWA: THP's compliance department conducts regular reviews and audits of Medicaid operational areas based upon contractual requirements. These reviews and audits are tracked in the Compliance and Audit Work Plan (AWP) which is further described in **PI009**.

Verifying, through sampling or other methods, whether services reimbursed were actually furnished to enrollees, including documenting the results of verification activities: Member engagement conducts regular outreach to Medicaid enrollees to confirm that billed services were actually provided to the enrollee. This monitoring is conducted monthly and documented in Gorman's Online Monitoring Tool (OMT).

Assigning and strengthening internal controls to ensure claims are submitted and payments are made properly: Internal Audit conducts annual testing of internal controls to ensure claims are submitted and paid properly. The claims department utilizes editing software and internal edits to identify improperly billed or coded claims. THP's annual SOC 1 audit reviews and tests its system controls that ensure accurate claims payment.

Educating employees, network providers and beneficiaries about FWA and how to report it: Employee education on FWA is described in **PI007**. Network providers are educated about FWA in periodic provider newsletters, information posted on the provider portal and through the provider manual. Beneficiaries are educated about FWA in member newsletters, the Member Handbook and information posted on THP's website.

Effectively organizing resources to respond to complaints of FWA: THP has developed processes to maximize its resources as well as processes to respond to complaints of FWA. See **PI001, PI002** and **PI004**.

Establishing procedures to investigate FWA complaints: THP has written policies and procedures to respond to and investigate suspect FWA. See **PI001 and PI002**.

Establishing procedures for reporting information to BMS: THP has implemented procedures for reporting information to BMS. These procedures are described in **PI002**.

Developing procedures to monitor service patterns of providers, subcontractors and beneficiaries: THP has procedures to monitor the service patterns of members and providers including service underutilization and overutilization. These are described in **PI011**. Subcontractors are monitored in accordance with the Subcontractor monitoring plan described in **PI010**.

Written Policies, Procedures and Standards of Conduct

The compliance department and SIU collaborate on the development of policies and procedures to promote the effectiveness of the compliance program. SIU policies are owned by Ms. Crowder. Compliance policies are owned by Compliance Officer Jill Medley. All policies and procedures are reviewed annually and subject to a structured approval process with a member of the executive management team (EMT) as the final approver. THP uses a contract management software product (PolicyStat) to track review timelines.

PolicyStat
PolicyStat reminds policy owners when policies are due for review. Policies are set to a 365-day renewal cycle. PolicyStat automatically archives prior versions which provides quick retrieval for audit purposes. PolicyStat also documents the approval process and is available to all users through the THP intranet.

THP's Code of Conduct is also maintained in PolicyStat and is reviewed and updated by the compliance officer each November for submission to the CCC and the A&C with subsequent approval by the full Board of Directors. The Code of Conduct is available to all employees and distributed at hire and annually as part of the annual attestation process conducted each January.

Designation of a Compliance Officer

THP's Corporate Compliance Program covers the three primary domains of general compliance, FWA and HIPAA privacy compliance. General compliance and HIPAA privacy compliance are overseen by the compliance officer. The prevention, detection and correction of FWA are overseen by the program integrity lead. Both the compliance officer and program integrity lead have significant experience in their respective roles. The compliance department and SIU collaborate to promote compliance program effectiveness while retaining the subject matter expertise of each discipline.

Compliance Officer Ms. Medley is responsible for the development and implementation of policies, procedures and practices designed to ensure compliance with the requirements of the Service Provider Agreement and all applicable Federal and State requirements. Ms. Medley reports to the CEO/COO, the CCC and the Board of Directors through the provision of reports to the A&C.

Regulatory Compliance Committee

The CCC operates at THP's executive level and provides oversight of the compliance program and the performance of the compliance officer. The A&C operates at the board level and functions as the Regulatory Compliance Committee.

Compliance Reporting to the CCC and the Board

Ms. Medley and Ms. Crowder report to the CCC at least quarterly. CCC agenda items include a summary of program updates/enhancements, departmental reports from compliance, SIU and HIPAA privacy, a summary of internal auditing and monitoring activities and a summary of any external audit activity. Similar reports are presented to the A&C at least quarterly. THP makes the results of any third-party audits, including the results of its SOC 1 audit, available to the Department as required in accordance with **MD025.**

Ms. Medley distributes a monthly Compliance Dashboard to THP's EMT. The Dashboard provides an overview of the prior month's compliance, SIU and HIPAA privacy issues and activities, and the results of scheduled auditing and monitoring activities including any corrective actions. The Dashboard distribution ensures that all THP executives are kept apprised of any new or ongoing compliance-related issues.

System for Training and Education (PI007)

THP's comprehensive employee training covers federal, State and contract requirements. Selected compliance-related training programs are summarized in the following table.

Compliance Related Training		
Name	**Description**	**Frequency and Target Audience**
Medicaid Service Provider Agreement Training	Summarizes the Service Provider Agreement provisions. Updated annually. Ensures CEO/COO, CFO, senior management and employees are trained on contract provisions. Training is documented by the successful completion of a post-training quiz (at least 80%).	Conducted at hire and every July thereafter. Mandatory for all employees of THP.
Medicaid University	Serves as a resource for all things Medicaid. The presentation is posted on THP's intranet (available to all employees) and includes general contract provisions, Medicaid operations, quality, medical management and member outreach.	All employees who work on the Medicaid line of business.

Compliance Related Training		
Name	**Description**	**Frequency and Target Audience**
Compliance & FWA Prevention Training	Covers the seven elements of a compliance program and how to prevent, detect and correct potential non-compliance and FWA. Includes information on relevant healthcare laws such as the Anti-Kickback Statute and the federal False Claims Act (including its qui tam provisions). Training on the federal False Claims Act complies with the requirements of the Deficit Reduction Act of 2005.	Conducted at hire and every November thereafter. Mandatory for all employees of THP and THP board members.
HIPAA Privacy & Security Training	Covers HIPAA requirements, uses and disclosures of PHI and member rights under HIPAA. Training documented by the successful completion of a post-training quiz (at least 80%).	Conducted at hire and every April thereafter. Mandatory for all employees of THP.
Cultural Competency Training	Reviews access for LEP individuals, individuals with disabilities or limited literacy and cultural competency. Training documented by the successful completion of a post-training quiz (at least 80%).	Conducted at hire and every January thereafter. Mandatory for all employees of THP.
Claims Analyst/ Customer Service Department Training	This training program is a hands-on program administered in a classroom setting. The trainees begin learning from day one. New hires begin training with a review of the Medicaid contract.	At hire. All Medicaid claims analysts and CSRs.

Compliance Officer Training

The compliance officer reviews the updated Service Provider Agreement when released and identifies its compliance requirements. This review is used to develop the contract training completed by the CEO/COO, CFO, senior management (EMT) and the organization's employees. The compliance officer also participates in MCO monthly meetings conducted by BMS and various compliance related training seminars including compliance conferences hosted by the Health Care Compliance Association (HCCA).

Additional Training Activities

Compliance/FWA training is augmented by quarterly compliance newsletters distributed to all employees that cover various compliance, HIPAA and FWA topics. The SIU meets periodically with provider engagement, quality management, claims analysts and customer service to provide additional information on how to identify and report potential FWA. The Compliance/FWA training is further enhanced with various activities

conducted during Compliance Week. The SIU participates in specialized training to improve its ability to prevent, detect and correct FWA. Recent training included Billing Basics and Certified Medical Coder training.

Compliance Week Activities

Each November, the Compliance and SIU Departments collaborate to conduct Compliance Week. During the past two years, Compliance Week included a "Spot the Compliance Violation" activity that was presented in person by compliance and SIU staff. Employees reviewed the "Spot the Compliance Violation" scenarios to determine if a potential compliance or FWA issue was present, thus promoting dialog between employees and the compliance/SIU staff. During Compliance Week, the compliance department rolls out annual Compliance/FWA training, distributes daily email blasts on various compliance-related topics and awards prizes for employee participation.

Effective Lines of Communication

THP has several mechanisms to promote prompt reporting of potential compliance and FWA issues including an anonymous hotline, a web form that can be used by all stakeholders including members and providers, and dedicated email addresses to report compliance, HIPAA and SIU concerns. The toll-free hotline and website form both permit anonymous reporting. In addition, employees can report any issue or concern to compliance or SIU staff in person, by phone or by email. THP has a strict non-retaliation policy that ensures there is no retaliation for the good faith reporting of non-compliance or suspected FWA issues. This is communicated during annual training, in quarterly compliance newsletters, provider newsletters, member newsletters, during Compliance Week and in policy format.

THP's lines of communication include reporting to the board as previously described. Communication between the compliance officer and THP's employees is supported through Compliance Week activities, quarterly compliance newsletters, policies and procedures and participation in various organizational workgroups such as the Medicaid Oversight Workgroup.

Well-Publicized Disciplinary Guidelines (PI008)

THP's Compliance/FWA Plan addresses "well publicized disciplinary standards." THP implements its disciplinary standards through its human resources department, which has a documented progressive discipline policy and procedures to promote the enforcement of compliance standards. This policy is available to all employees through the Employee Handbook. New employees must acknowledge review of the Employee Handbook in writing. Progressive discipline means that, with respect to most disciplinary problems, the following steps will be taken although THP reserves the right to bypass one or more steps as the situation warrants:

- First offense: verbal warning
- Second offense: written warning
- Third offense: suspension
- Fourth offense: termination

In addition, THP's Code of Conduct includes an attestation, which states that the employee "understands that any violation of any federal and/or state laws, regulations, the Code of Conduct, the Corporate Compliance Plan or any other The Health Plan compliance policy or procedure is grounds for disciplinary action, up to and including termination of employment or arrangement with The Health Plan." All employees and board members attest to the Code at hire/appointment and annually thereafter.

Internal Auditing and Monitoring and Prompt Correction of Issues (PI009)

THP has a monitoring, auditing and remediation process with dedicated staff including three compliance auditors, an internal auditor, a program integrity lead, two SIU investigators and an SIU fraud analytics specialist. The Audit Work Plan (AWP) includes goals, timelines, assignments, measurements and milestones and is reviewed and

updated monthly to ensure it is a living-breathing document that adapts to new and emerging risks.

Enterprise Risk Management

THP's AWP process begins with its Enterprise Risk Management (ERM) process that includes general and specialized risk assessments. The ERM's principal activity is the annual departmental risk assessment that is coordinated by THP's internal audit and compliance departments and guided by a structured risk assessment questionnaire that identifies and grades departmental risks and associated mitigating activities.

The inclusion of mitigating activities in the risk assessment process transforms the risk assessment from a "simple" identification of organizational risks to an instrument that promotes risk-mitigating activities. A mid-year risk assessment update further promotes the risk assessment as a performance improvement tool.

Mid-Year Risk Assessment Update
To further promote the departmental risk assessment as a performance improvement tool, during the 2019 risk assessment cycle, THP instituted a mid-year update.

"During our 2019 Compliance Program Effectiveness (CPE) assessment with The Health Plan it was noted that their Risk Assessment processes is more in-depth and detailed than a lot of similarly sized health plans we encounter. Additionally, the mid-year re-evaluation of the risk assessment is considered a best practice that many organizations aren't doing."

- *Alexander Henrichs*
The Burchfield Group

Compliance and Audit Work Plan

The Compliance Department and SIU work together each year to draft an AWP that describes the planned auditing and monitoring activities for the upcoming year. The activities are scheduled by frequency or by month due as applicable and assigned to one or more responsible parties. The AWP includes clear goals, timelines, assignments, measurements and milestones. AWP development uses information obtained during the departmental risk assessment as well as information from other sources such as industry trends, the HHS-OIG work plan and requirements in the Service Provider

Agreement. The AWP outlines the compliance audits, monitoring activities and projects planned for the coming year and is documented in an Excel spreadsheet.

Compliance audits are documented in OMT. Monitoring metrics, including SIU metrics, are built into OMT as "indicators." Indicators are set up to repeat on a periodic basis (e.g., monthly, quarterly) and include the responsible submitter and reviewer thus incorporating clear assignments, timelines and measurements. The indicators also include goals as applicable.

Gorman's Online Monitoring Tool
Gorman's Online Monitoring Tool is a compliance software tool used by THP to track monitoring metrics ("indicators"), audits and corrective actions plans. The software allows THP to assign auditing and monitoring activities to specific users, define goals, track timelines and identify patterns of potential non-compliance.

THP's Model Audit Rule (MAR) activities are included in the annual AWP. These activities test internal controls such as those related to claims processing, Medicaid enrollment and provider contracting. Any identified control deficiencies are communicated to the applicable business owner for remediation. The MAR process is overseen by the VP of internal audit & quality. To ensure the AWP covers significant Service Provider Agreement requirements, the compliance department reviews and abstracts it annually to identify compliance requirements and incorporate them into the AWP through appropriate auditing and monitoring activities.

The figure represents THP's AWP process.

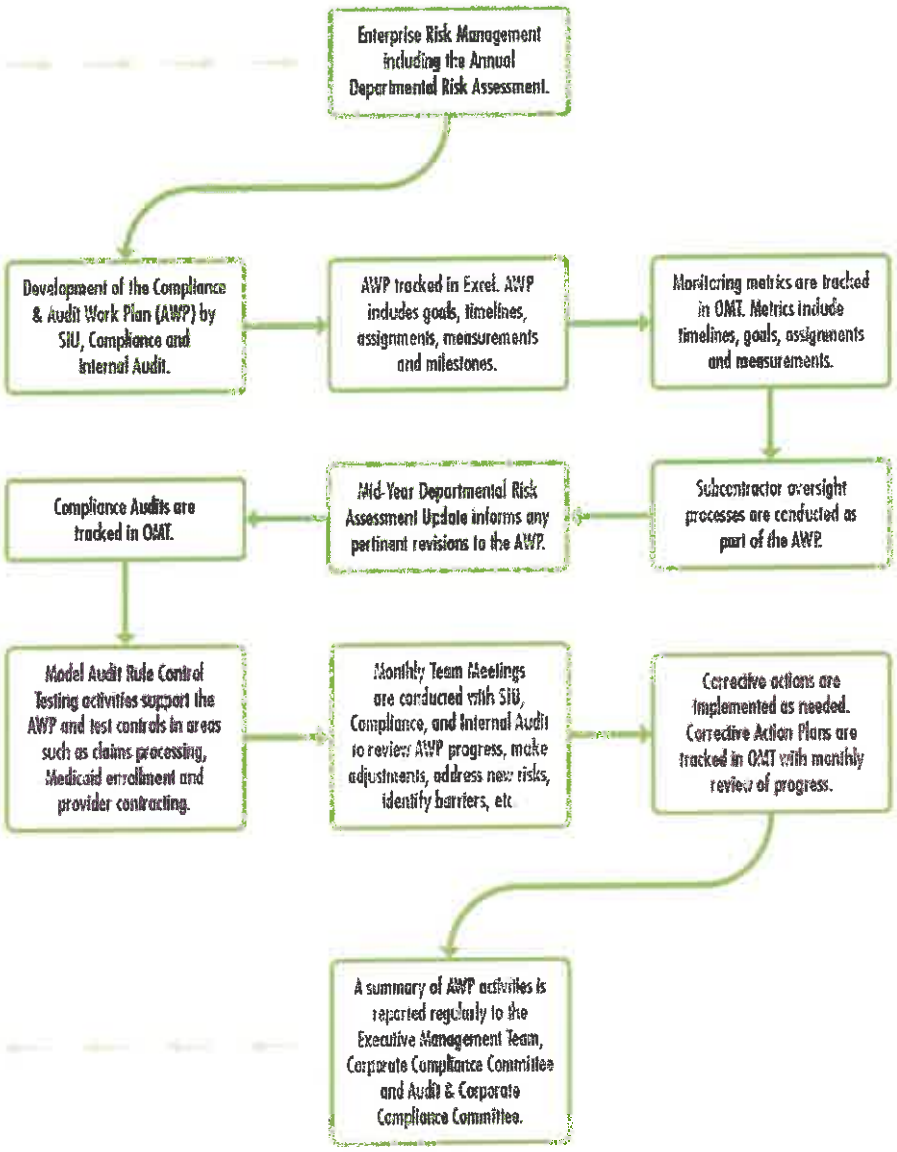


Figure 1: Audit Work Plan Process. The Audit Work Plan Process is a risk-based approach that leverages a number of key inputs across the organization.

Exclusion Screening

THP screens its employees, board members, committee members and providers at initiation of the relationship and on a monthly basis thereafter. Screening at initiation is conducted by the applicable business owner. Monthly screening is conducted through

an automated process with manual review. The following databases are included in the initial and monthly screening:

- Office of Inspector General List of Excluded Individuals and Entities (LEIE)
- Government Services Administration System for Award Management (GSA/SAM, formerly the Excluded Parties List System or EPLS)
- Medicare Sanction/Reinstatement report (practitioners/providers)

Automated monthly screenings are conducted using several data elements such as NPI, name, date of birth and social security number to reduce the risk of false negatives. Potential hits from each month's screenings are reviewed by the business owner and sent to the compliance department. If an exclusion is identified, the employee is terminated. If a provider is excluded, the provider is removed from the Medicaid network, a code is entered into the system to prevent payment for Medicaid claims, the SIU is notified and the program integrity lead notifies BMS (see **PI001)**.

Prompt Response to Compliance Issues

THP has policies and procedures to remediate compliance risks and identified issues including self-reporting to the applicable regulatory authorities when indicated. CAPs are developed internally to ensure that deficiencies identified during THP's internal auditing and monitoring processes are remediated in a timely manner. The development and tracking of corrective actions is consistent with THP's philosophy of continuous improvement. Internal tracking and implementation of corrective actions ensures detected deficiencies are corrected to prevent recurrences.

PI010. 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.

THP has developed a subcontractor oversight process that includes pre-delegation audits, auditing and monitoring processes conducted at various levels of the organization, corrective actions as needed and reporting to a Subcontractor Oversight

Committee, THP executives, the CCC and the A&C. THP's subcontractor monitoring plan includes the requirements found in Article II Section 8.5 Subcontracts of the Service Provider Agreement. THP accepts the financial, legal, ethical and other forms of responsibility for the conduct of all business partners, independent contractors, subcontractors and other entities that support or will support THP in the performance of the Service Provider Agreement and adherence to **MD021**.

The figure demonstrates our subcontractor oversight reporting structure within THP.

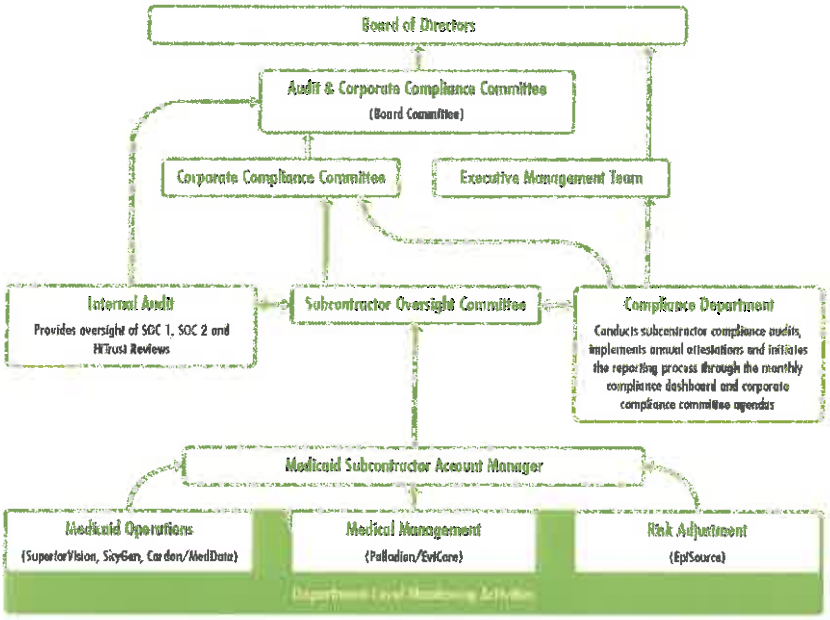


Figure 2: Subcontractor Oversight Reporting Structure. Our subcontractor oversight reporting structure drives visibility to subcontractor performance throughout the organization.

Pre-Delegation Audit

The subcontractor oversight program includes processes to address the continuum of the subcontractor life cycle from pre-delegation audit to termination. The pre-delegation audit is conducted using a team that includes the applicable business owner(s), internal audit and the compliance department. The pre-delegation audit for subcontractors includes an operational readiness review by the applicable business owner, a review of

any applicable SOC 1, SOC 2 or HiTrust reports by Internal Audit, a review of the subcontractor's compliance, privacy and security processes conducted by the compliance department and a list of reports to be received from the subcontractor.

The pre-delegation audit is guided by a checklist and is overseen by the Subcontractor Oversight Committee. The Subcontractor Oversight Committee reviews the findings of the pre-delegation audit of any potential Medicaid subcontractor and makes recommendations based on the results of the audit.

Current THP Subcontractors

THP has experience with its current Medicaid subcontractors through long-standing contractual arrangements as part of its Medicaid program or experience with the subcontractor through THP's other lines of business.

Subcontractor	Services
Superior Vision Benefit Management	Vision benefit administration including network management
SKYGEN USA	Dental benefit administration including network management
Med-Data	Assists Medicaid members in obtaining SSI benefits
eviCore/Palladian	Utilization management including preservice decisions and appeals
Episource	Encounter data submissions

Subcontractor Oversight Committee

The Subcontractor Oversight Committee includes members from Medicaid operations, internal audit, compliance and quality/NCQA. The Subcontractor Oversight Committee receives reports from the subcontractor account manager, Christy Donohue, VP Medicaid, on a form designed to capture all

Regular Monitoring and Auditing Activities
The Subcontractor Oversight Committee regularly reviews the monitoring and auditing activities conducted to ensure the subcontractor performs its delegated duties in a manner consistent with THP's expectations and the requirements of the Service Provider Agreement.

auditing and monitoring activities related to each subcontractor. Ms. Donohue coordinates the monitoring activities associated with all subcontractors.

Subcontractor Auditing and Monitoring

Reporting Requirements and Performance Monitoring

Each subcontractor must submit periodic performance reports to THP. The name, purpose and frequency of each report is documented on the applicable Subcontractor Monitoring Form. The applicable business owner provides the day-to-day oversight of THP's Medicaid subcontractors through a review of these reports and ongoing monitoring activities.

Vision and Dental Benefit Administration

THP receives regular reports from its vision and dental benefit subcontractors. Such reports address, as applicable, provider network including network adequacy, provider credentialing, call volume and call center metrics, appeals and grievances, credible allegations of fraud, utilization management and third party recovery.

Encounter Data Submission and Administration

THP will communicate weekly with its encounter data subcontractor and receive reports related to the percentage and types of encounter data errors. Pertinent information will be captured through documented monitoring metrics that permit the tracking and trending of the subcontractor's performance with respect to the delegated duties.

Utilization Management

Utilization management subcontractors are required to submit performance reports, as applicable, related to standard and expedited pre-service requests, standard and expedited appeals, and grievances. Pertinent information from these reports is captured

through documented monitoring metrics which permits the tracking and trending of the subcontractor's performance with respect to its delegated duties.

SSI Disability Advocate

The SSI disability advocate reports members' SSI status on periodic reports submitted to THP. These reports are reviewed by THP for SSI status accuracy.

All subcontractor monitoring activities, including those described above, are reported to Ms. Donohue using the Subcontractor Monitoring Form and subsequently forwarded to the Subcontractor Oversight Committee for review.

Compliance Audits

Compliance audits augment the ongoing monitoring processes previously described. The compliance department uses a risk-based approach to determine the scheduling and frequency of subcontractor compliance audits. Higher risk subcontractors are audited annually or biennially.

Contract Management
THP has a contract management system called iContracts. iContracts is used to house its Medicaid subcontractor agreements including any applicable delegation agreements and other relevant documents. iContracts provides reminders to the applicable business owner(s) when contracts are coming up for renewal. iContracts is also used to alert business owners when it is time to request updated SOC 1, SOC 2 and/or HiTRUST reports from the subcontractor.

Subcontractor audits are scheduled and tracked in the AWP and documented in OMT. All subcontractor audits are documented in a final report distributed to the applicable executives and summarized in CCC and A&C meeting agendas. If needed, an internal CAP is implemented. CAPs are documented and tracked in OMT.

Control Report Reviews

THP requests and reviews its Medicaid subcontractors' applicable SOC 1, SOC 2 and/or HiTRUST reports annually. The SOC 1 and SOC 2 reports are abstracted by the

business owner using a structured Excel spreadsheet. The abstraction process reviews the auditor's opinion to determine if the opinion is qualified or unqualified and reviews any control testing exceptions. Follow-up is conducted in the event of a qualified auditor opinion, although this has not been necessary to date. Any applicable complementary user entity controls (CUECs) are reviewed with an emphasis on the identification of THP's corresponding controls. Any exceptions in the reports are evaluated by THP to ensure there is no impact on THP's internal control environment.

Annual Compliance Attestations

In addition to periodic audits, all subcontractors must complete an annual compliance attestation. The annual compliance attestation questionnaire requires subcontractors to confirm compliance with the following program elements:

Compliance Attestation Questionnaire - Compliance Program Elements Queried	
Compliance and FWA Training	Code of Conduct (including annual attestation)
OIG LEIE and GSA/SAM Exclusion Screening	Reporting Mechanisms for compliance issues and potential FWA
Downstream Entities (if applicable)	Access Plan for Enrollees with Limited English Proficiency or Disability

Corrective Actions

The Subcontractor Oversight Committee reviews the results of all subcontractor monitoring, auditing and oversight activities including any identified deficiencies to determine if there is the need for an internal CAP. Corrective actions may include:

- Documentation of corrective actions (minor or isolated issues)
- Formal internal CAP (significant or systemic issues)
- Termination of contract (serious deficiencies or no improvement after corrective actions) with notification to BMS within five business days of giving or receiving notice of subcontractor termination or within three business days of a serious breach of contract

Any new subcontractors, including a PBM if applicable, would be subject to the same oversight process as previously described.

Subcontractor Oversight Reporting

Summary reports of these activities will be reported to the EMT through the monthly Compliance Dashboard and to the CCC and the A&C at regularly scheduled meetings. Significant deficiencies are communicated immediately to the CEO/COO and applicable EMT member.

The figure illustrates our Medicaid subcontractor lifecycle.

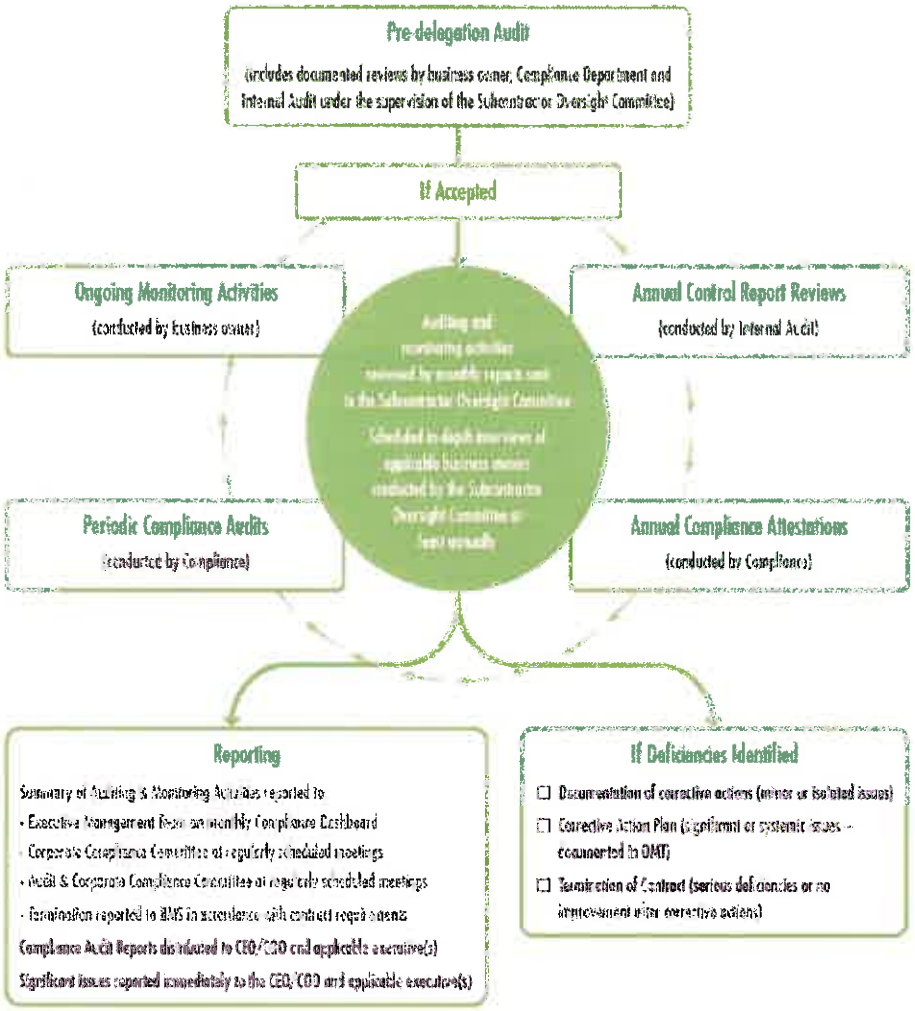


Figure 3: Medicaid Subcontractor Lifecycle. The Medicaid Subcontractor Lifecycle illustrates THP's Subcontractor Monitoring Plan from pre-delegation audit to termination (if applicable). Auditing and monitoring activities are ongoing and subject to the oversight of the Subcontractor Oversight Committee.

PI011. The Vendor should describe its process for monitoring provider fraud for underutilization of services and member/provider fraud for overutilization of services.

THP monitors claims to identify underutilization and overutilization of services to identify potential provider and beneficiary fraud.

Verification Calls
THP conducted 1,080 member service verification calls in 2019. Those calls resulted in four referrals to the SIU.

THP performs service verification calls to a sample of members each month to confirm recently billed services were actually provided. If the member denies receiving such services, or if the conversation indicates other FWA "red flags," a referral is made to the SIU. Additionally, patient EOMBs include a notice asking members to call THP if they did not receive the services itemized on the form.

Members have access to our customer service center and to our grievances and appeals processes should they believe they are a victim of underutilization and a provider is inappropriately denying them care.

THP uses a number of processes to monitor for and deter beneficiary fraud. Methods include providing member education and applying additional scrutiny to emergency room services at the claims review level to identify and prevent payment for inappropriate emergency care, including overutilization. Service verification calls, in addition to identifying potential provider fraud, may also reveal card-sharing.

Claims and Pharmacy Monitoring

Monitoring Results
In CY2019, claims and pharmacy monitoring resulted in the opening of 11 investigations, additional monitoring of seven providers, and one provider fraud referral to BMS.

THP uses a number of system edits and programmatic reviews of data to detect potential FWA. Refer to **PI002** for details. Additionally, the SIU employs various data mining techniques monthly to identify outliers in targeted high-risk areas.

Examples of SIU monitoring to identify suspicious activity:
▪ Top prescribers ▪ Overutilization of controlled substances by members and providers ▪ Change in diagnosis after denial ▪ Duplicate claims ▪ Age-inappropriate procedures ▪ Unbundling ▪ ER services that indicate upcoding; double billing, or billing for services not rendered ▪ Claims violating the National Correct Coding Initiative (NCCI) edits ▪ Billing of comprehensive and individual component procedures ▪ Inappropriate utilization of consultation codes ▪ Inappropriate utilization of Evaluation and Management (E/M) codes ▪ Claims violating Medically Unlikely Edits

Clinical Monitoring

Relevant data is monitored and analyzed annually to identify patterns of under and over utilization. The analysis is performed using established thresholds to detect inappropriate utilization. Contributing causes are identified and effective interventions are developed. THP does not use incentives to issue denials of coverage or service care nor does it encourage decisions that result in inappropriate utilization.

THP's Use of Data Analytics When Assessing Provider Practices

THP uses data analytics to identify provider practice variation patterns using analytical software that builds episodes of care from claims data and ties those episodes to specialty-specific medical conditions. These episodes are analyzed for trends related to cost, utilization, and adherence to evidence-based quality measures.

Clinical monitoring	
Clinical monitoring techniques	▪ Relevant data for each product line is monitored by using clinical analytics software and analyzed as per work plan. ▪ The data is monitored to identify under and overutilization. ▪ Analysis of the data involves appropriate personnel and practitioners/providers having the understanding of healthcare delivery and quality management. ▪ A quantitative analysis includes thresholds used for comparison to detect potential under and overutilization as well as areas for identified improvement. ▪ A qualitative analysis is conducted to determine the cause and effect of all data not within the thresholds as well as the consequences of the issues found in the data. ▪ If the comparative analysis indicates that performance is under or over the threshold, then similar monitoring and analysis is performed at the level of the practice site. ▪ Interventions are developed that address specific circumstances indicated in the analysis and that contribute to a measurable improvement. ▪ The effectiveness of the intervention is measured and compared to previous data in order that it can be determined if the intervention corrected the under or over utilization

Clinical monitoring	
	problem. Sufficient time must elapse before an effectiveness evaluation can be performed.

Monitoring Utilization in Partnership with BMS

Peer Recovery Support Services (H0038) is a new Substance Use Disorder Waiver service put into place by the WVDHHR in 2019 and turned over to the MCOs for management in July of 2019. In August, THP reviewed the initial data on usage of this service. It became evident that three providers were utilization outliers. Subsequent to an onsite chart review, it became clear that one provider did not understand the correct boundaries for the service. After partnering with the program manager at BMS, THP offered feedback to the provider. Additionally, **a work group was formed with BMS at THP's request to clarify the instructions and guidance given to providers regarding this service** so that consistency in interpretation of the manual guidelines could be attained by all three MCOs. The work group includes BMS, all three MCOs and Kepro. The group is clarifying the boundaries of the service and developing a uniform documentation format so that provider education can be expanded, to ensure appropriate utilization.

Driving Utilization Management Amendments in Partnership with BMS

Crisis Stabilization Unit (H0036) is a Medicaid payment for urgent care for members with psychiatric problems that is typically billed in 15 minute units. Maximum utilization for this service is 48 units per day, not to include room and board. When THP reviewed utilization data, it became evident that one provider was using the service at a much higher rate than other providers. This analysis resulted in two actions:

- The deidentified data was presented to BMS and to the West Virginia Behavioral Healthcare Providers Association for review and comment
- **Utilization Management amendments were made** to enable closer monitoring of the use of units per day by providers by authorizing in units of 15 minutes (which is how the provider is typically paid) rather than days. Other **Utilization Management procedures were also adopted, all with proper provider notification and webinar trainings.**

Anonymous Reporting

THP maintains a hotline and a website portal for anonymous reporting. Both options can be used to report both provider and member fraud and are accessible to all stakeholders including members, providers and the general public. THP also provides regular training and notices to employees, members and providers regarding how to report FWA.

PI012. 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.

THP recognizes the importance of monitoring providers to ensure that members receive quality care and that providers are complying with regulations and guidelines. THP's policies and procedures for reviewing and changing the contractual status of a healthcare professional include:

- Regular review of several data sources
- Investigation and due process to verify that we have all the needed information to make a determination
- An appeals process
- A mechanism for reporting serious quality deficiencies to appropriate authorities

Regular Review of Several Data Sources

We continually review federal data sources to verify that contracted providers have not been sanctioned or excluded from participating in Medicare or Medicaid.

Exclusions and Sanctions. A search of the OIG LEIE, GSA/SAM exclusion database, and Medicare Sanction Report is performed on all potential, existing, and reappointed practitioners, Physician Assistants (PA-C), Advanced Practice Registered Nurses (APRN), psychiatrists, non-physician behavioral health practitioners/providers and ancillary practitioners. This screening is repeated and reviewed on a monthly basis for all current practitioners and providers, both contracted and non-contracted.

Any practitioner appearing on the LEIE, GSA/SAM or Medicare Sanction Report is removed from the Medicare and Medicaid lines of business. The provider screen is further flagged with a pend code to assure no claims are paid after the exclusion date, and a referral is made to the SIU.

All new applicants are also screened against the Social Security Death Master File. If a provider is identified as using the social security number of a deceased person, the provider is immediately reported to CMS and BMS.

Suspension or Termination for Risk of Harm. If THP has reason to believe a provider poses a risk of harm to members, the provider is immediately suspended or terminated. Such determinations are made on a case-by-case basis upon recommendation of the Credentials Committee, the Quality Improvement Committee or THP's medical director with the final authorization for termination or suspension made by the EMT. When a provider is terminated or restricted pursuant to a "for cause" provision, the actions are reported to the CEO/COO, the senior VP of provider delivery services, THP's medical director, the director or manager of credentialing and West Virginia Medicaid as applicable.

Provider Termination
On 1/13/20, through its ongoing monitoring of adverse actions, our Credentialing department discovered a psychiatrist's license was suspended effective 1/9/20 after having been accused of an improper sexual relationship with a patient. THP took immediate action to terminate for cause and sent written notification to the provider. The next day, our SIU notified BMS of the termination and provided them with THP's notification letter as well as documentation from the Board of Medicine and the WV Supreme Court of Appeals. The SIU also initiated an investigation to determine if any claims were paid improperly.

Business Reasons for Contract Termination. Non-acceptance, termination or rejection of a practitioner may be instituted for business reasons (i.e., not quality concerns) by the EMT. Business reasons for termination or rejection include, but are not limited to, fraudulent billing practices, discrimination against enrollees, incompatibility with THP's managed care programs, non-compliance with contractual obligations and loss of or failure to maintain credentials. If the practitioner submits a written explanation

of the circumstances leading up to the termination notice that satisfies the medical director or the EMT, the termination action may be withdrawn.

Failure to Maintain Credentialing. The following deficiencies result in a practitioner's failure to maintain credentials without the option to appeal:

Failure to maintain credentials:	
Situation	**THP Action**
Expired professional liability insurance coverage	▪ The provider is sent a letter notifying him/her that participation is terminated immediately, unless the practitioner is a PCP. No appeal is allowed. ▪ If the practitioner is a PCP, termination will be 60 days from the date of the letter to allow for the transition of members. No appeal is allowed.
Revocation or suspension of licensure	▪ The provider's participation is terminated as of the date of the suspension and/or revocation upon receiving notice of such action. No appeal is allowed.
Incomplete recredentialing application	▪ The provider is notified that his/her participation will expire 60 days from receipt of the notice. No appeal is allowed.
All notices are sent certified mail, return receipt requested.	

Suspensions Based on a Credible Allegation of Fraud (CAF). When BMS notifies THP that a provider has been suspended based on a CAF, THP suspends payments within one business day and responds back to BMS within three business days.

If THP initiates the suspension for a provider not enrolled in FFS, THP reports to BMS within one business day the provider name, basis for and date of suspension, amount of payments withheld, the outcome of any appeals, the good cause rationale if imposing only partial suspension, and where applicable, the suspension discontinuance reason and date. Regardless of which entity initiates suspension, notice to the provider is sent within five days, unless requested in writing by a law enforcement agency to temporarily withhold such notice, and then notice is sent within 30 days. The law enforcement delay may be renewed in writing twice, not to exceed a total of 90 days.

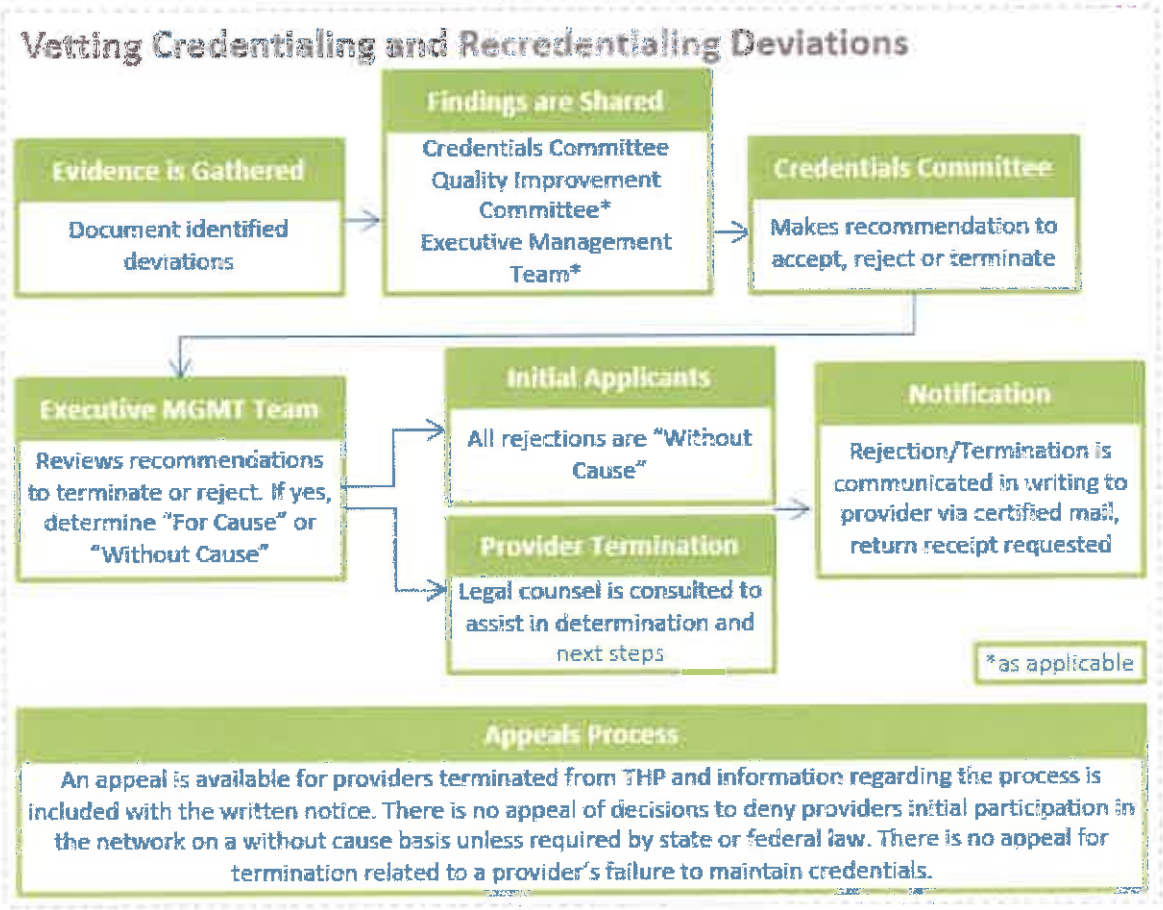
The suspension notice advises the provider that payments are being suspended in accordance with 42 CFR 455.23, and suspension will be discontinued once legal proceedings are completed, or once the state or prosecuting authorities notify THP that there is insufficient evidence of fraud. The notice includes the general allegation, the type of Medicaid claims impacted and information related to the provider's appeal rights.

The payment suspension and the subsequent discontinuance of the suspension are documented in the provider file. THP also reports payment suspension information monthly to BMS on the Suspension & Adverse Enrollment Action report. The internal mechanism for suspending payments based on a CAF is the same, whether initiated by THP or by BMS. See also **PI001**.

Investigation and Due Process

Practitioner anomalies or deviations related to credentialing requirements are reviewed during the initial credentialing period and during recredentialing. Situations do occur when THP is notified of a credentialing deviation during an interim period. In such cases, we review and address these concerns using the same process that we follow during credentialing/recredentialing. Changes, additions or new information regarding a provider's credentials to participate with THP are subject to review at any time.

Our investigation and due process workflow is illustrated in the figure.



Appeals Process

Unless otherwise noted, a provider is entitled to request an appeal/hearing within 30 days of receipt of the notification of termination.

Reapplication Following Denial of Application to Join Network. Practitioners denied acceptance into the provider network are permitted to reapply one year from the date of the non-acceptance notice. The original circumstances regarding non-acceptance are included in the application process and must be presented for evaluation by the Credentials Committee. Practitioners who have been terminated from the network for any of the reasons outlined above may submit a new application upon resolution of the matter causing the termination.

Practitioner Hearing Before a Hearing Committee. The following recommendations or actions entitle the practitioner to a hearing before a hearing committee:

Actions that entitle a practitioner to a hearing
▪ Any circumstance where the event or corrective action is required to be reported to the National Practitioner Data Bank (NPDB) ▪ Any instance where a practitioner's provider contract with THP or the contracting entity is terminated for cause under the terms of the contract, including circumstances concerning quality of care rendered to members ▪ A material adverse determination that affects the practitioner's ability to remain a THP provider in good standing ▪ Any instance where the CEO/COO or medical director, in his or her sole discretion, deems it to be in the best interest of members or THP that the practitioner be granted a hearing

Written notification to the practitioner of the corrective action and/or adverse determination includes the reason(s) for the action and the practitioner's appeal rights which must be filed by the practitioner within 30 days of receipt of notification. Upon receipt of a request for an appeal, THP promptly schedules a hearing date and notifies the practitioner of the scheduled date, time and place for the hearing.

If the adverse determination is based on medical reasons/quality of care, a hearing committee is appointed by the EMT that includes the medical director or a practitioner designated by THP and two other THP practitioners with no previous involvement in the matter under consideration. Practitioners serving on the hearing committee may not be in direct competition with the practitioner and must be qualified to evaluate the issues likely to be presented. At least one member of the hearing committee should practice in the same specialty.

If the adverse determination is based on administrative reasons (e.g., contractual requirements), the hearing will be held before a panel of administrative staff, comprised of selected members of EMT, as determined by THP.

At the hearing, the provider affected by the determination has the following rights:

Affected practitioner has the right:
▪ To be represented by an attorney or other person of the practitioner's choice, with advanced notification to THP ▪ With 5 days advance notice, to have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with their preparation ▪ To call witnesses to testify on his or her behalf with prior notification of the testimony content to THP ▪ To present evidence that is relevant to the hearing committee, regardless of its admissibility in a court of law ▪ To submit a written statement at the close of the hearing

The hearing committee makes a final written recommendation within 30 days of the hearing date and forwards its final recommendation to the EMT. Within 10 days of the final determination by the EMT, the practitioner is notified in writing of the hearing committee's recommendation including the basis for the recommendation and THP's decision and the basis for that decision.

Mechanism to Report Findings to Appropriate Entities

The following actions are reported to the appropriate state licensing board and NPDB:

Reporting to the state licensing board and NPDB	
Process	**Requirements**
Actions to Report	▪ All professional review actions adversely affecting a provider's participation for longer than 30 days based upon the provider's professional conduct or competence including serious quality deficiencies ▪ Acceptance of a voluntary termination of the provider's contract while under investigation for conduct or competence reasons, if that termination is intended to avoid the imposition of reportable sanctions ▪ A summary suspension that remains in effect for longer than 30 days

Report Submission	▪ Reports must be filed with the licensing board and the NPDB within 15 days after the effective date of such action
	▪ Reporting must include:
	  ▪ The name of the provider
	  ▪ A description of the facts and circumstances, which were the basis of the action taken

If the provider satisfies the terms and conditions of a sanction action, a supplemental report is filed with the state licensing agency within 30 days from the date the provider satisfies those terms and conditions. In addition, each month the SIU shares its case list with the credentialing department so it may be reviewed prior to processing the

provider's recredentialing application. For any providers on the list, the case is brought before the Program Integrity Committee for final determination.

PI013. The Vendor should describe its policies regarding identification and recoupment of provider overpayments, and processes to coordinate with the Department.

Identification

THP understands that overpayments may be a result of FWA or may be due to administrative issues or errors such as a processing error or a change in fee schedules. Overpayments are identified through various sources including, but not limited to, notification or complaints from providers or members, internal or external audits, alerts from regulators or law enforcement, investigative activities, eligibility updates, corrected claims submissions, routine monitoring or data mining. As discussed throughout the Program Integrity section, THP leverages multiple methods to identify overpayments:

Methods to identify overpayments		
SIU Activities	Multi-MCO SIU HCF Workgroup	Suspicious Activity Indicators
Claims Xten	Collaboration with gov't actors	Program Integrity Committee
Data Mining	Employees Trained to ID FWA	Utilization Management
Internal Audits	Hotline/Email/Website Reporting	Cost Containment Project
Provider Self-Audits	Targeted Claims Monitoring	High-cost Claim Review

THP has mechanisms in place to identify overpayments unrelated to FWA. For example, if an incorrect fee schedule is loaded, the manager of pricing identifies any overpayments, the specific cause and the affected lines of business. The impacted claims are forwarded to operations for reprocessing. The manager tracks the process to ensure resolution.

THP's cost containment team is tasked with improving payment integrity and executing cost savings initiatives in contracting, clinical, operations and other key areas by leveraging data analytics, clinical analysis, process improvements and technology.

In addition to internal processes to identify any overpayments, THP has a process in place for network providers to report receipt of an overpayment. THP's provider manual informs providers that THP is responsible for the recovery of all overpayments, including those due to fraud, waste and abuse. The provider is required to notify THP in writing of the reason for the overpayment and return the full amount of the overpayment to THP within 60 calendar days of identification. This recovery is administered through the claims system by offsetting against future claims payments or by accepting direct payment from the provider.

The provider manual also includes notice to providers of the State's right to collect THP overpayments directly from the provider pursuant to THP's assignment of this right to BMS. Additionally, in the event the State collects overpayments directly from the provider, the provider's appeal rights are outlined in the BMS policy manual Chapter 800(B), which can be found on the BMS website.

Recoupment

The SIU pursues overpayments related to FWA, while operations pursues administrative recoveries. At the completion of an SIU investigation, recoupment of Medicaid overpayments is pursued if a case does not require referral to BMS and if the requirements of the Service Provider Agreement are met. Pursuant to that agreement, THP is permitted to recover Medicaid overpayments from providers if:

- The MCO was not required to abstain from collections due to a MFCU or other law enforcement investigation
- BMS has not duplicated the recovery
- The MCO followed proper procedures regarding fraud and/or abuse referrals to BMS
- The MCO properly and timely disclosed the required information on its monthly FWA report

- The encounter data is properly adjusted to reflect the recovery
- Such recovery is not prohibited by state or federal law

If the above requirements are met, the SIU contacts the provider to initiate recovery. The provider notice includes the overpaid claims, the amount of the overpayment and related date range, the reason for the overpayment, a description of the federal requirement to refund overpayments within 60 days and the provider's appeal rights.

Once an overpayment has been identified the original claim is reversed/credited. The credited amount is deducted from future payments. If this is not possible, the money is recouped via direct payment from the provider. An adjustment reason and a comment are attached to the claim to explain why it was identified as an overpayment, to assist customer service or other staff if questions arise.

Overpayments
During CY2019, THP identified over $345,000 and collected over $335,000 in Medicaid overpayments related to FWA. During that same time period, THP identified and collected over $4.5 million in Medicaid administrative overpayments.

Coordination with the Department

Each month, THP submits the FWA Monthly Report to BMS. This report includes information on *all* Medicaid overpayments identified or recovered during the previous month, along with the provider's identifying information and the specifics of when and how the overpayment was identified or recovered, and whether the overpayments are related to FWA, or if they are administrative overpayments attributed to errors, incorrect fee schedules and other causes unrelated to fraud. This report also includes all program integrity activities initiated or completed, the target and value of these activities and related outcomes, and all referrals made to BMS, MFCU, and/or licensing boards.

TheHealthPlan

Attachment 6
Information Management Systems

12. Information Management Systems

The Vendor should refer to the business specifications located in ***Appendix 1: Detailed Specifications*** (based on the categorization within Column D: Subject Matter Area) and pertinent narrative in ***Section 4: Project Specifications*** in this RFP, and then describe its approach to Information Management Systems (IM) as part of their bid. The Vendor's narrative response should not exceed 50 pages.

The Health Plan (THP) understands the responsibility it has to protect confidential and proprietary information and to maintain the availability and integrity of its information systems and assets. This commitment is integral to the relationships we have with all of our members, BMS and subcontractors alike.

IM001 The Vendor should describe its written policies and procedures for safeguarding and maintaining the confidentiality of data, including differences for adult and children populations.

IM003 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).

THP does and will continue to comply with all current and future security policies and procedures of the Department and the West Virginia Office of Technology (WVOT) as indicated in the Service Provider Agreement, in accordance with **MD014.**

Safeguarding and maintaining the confidentiality of data

THP's robust privacy and security policies protect the confidentiality of all member data. Policies specific to Medicaid and children are listed below.

Safeguarding Information of Medicaid Enrollees: In accordance with the Service Provider Agreement, THP protects applicable enrollee data in accordance with the confidentiality requirements of §1160 and §1902(a)(7) of the Social Security Act, the information safeguarding requirements of CFR 42, Part 431 Subpart F (Safeguarding Information on Applicants and Beneficiaries), and CFR 45 Parts 160, 162 and 164 (the Health Insurance Portability and Accountability Act or HIPAA) to the extent they apply.

Personal Representatives under HIPAA: In accordance with Section 164.502(g) of the HIPAA Privacy Rule, THP has written policies and procedures related to personal representatives as defined by HIPAA including a personal representative's ability to exercise the individual's rights or authorize disclosures of the individual's protected health information (PHI) unless an exception applies. This policy also addresses the rights of minors in West Virginia with respect to their ability to independently consent to certain services. THP reviews this policy periodically with legal counsel to ensure the rights afforded to minors in the state of West Virginia are accurately reflected in the policy.

In addition, THP receives a list of guardian names from the State. This information is loaded into the system as part of the member's record. When receiving a request for information on a minor, the Customer Service Representative (CSR) validates the guardian's name comparing it with the information provided by the State. The guardian must also provide the member's name and another identifier (e.g., Medicaid ID, THP's assigned ID number or member address) and the member's date of birth before the CSR will release any information.

HIPAA Security Standards: In accordance with HIPAA Security Rule (Security Rule), THP has implemented administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of its electronic protected health information (ePHI). In addition, we undergo an annual SOC 1 audit conducted by an independent third party. During the SOC 1 audit, the auditor conducts an overview of the information technology (IT) department including programming & analysis, PC & decision support, quality assurance and operations. The review also assesses THP's information security

at various levels including application security, mainframe security, LAN based security, email monitoring, anti-virus and wireless networks and THP's physical environment as well as a review of THP's disaster recovery processes. A network penetration test is performed annually by a top-tier security consulting firm. A penetration test is an independent analysis of THP's information systems designed to identify any exposures an attacker could leverage during a targeted attack against THP.

Confidentiality of Personally Identifiable Information (PII) and Protected Health Information (PHI)

Management of Confidential Member Information: In accordance with Sections 164.308(a)(3) and 164.308(a)(4) of HIPAA, THP has implemented policies and procedures to promote appropriate access to electronic protected health information (ePHI), prevent inappropriate access to ePHI and implement appropriate access termination procedures.

Business Associate Arrangements: THP has business associate arrangements with its Medicaid subcontractors if the arrangement involves the creation, use or disclosure of protected health information (PHI). THP has inserted BMS required language in its template business associate agreement (BAA) for use with its Medicaid subcontractors. In addition, THP has initiated an annual business associate attestation process with its subcontractors to ensure that its subcontractors have appropriate administrative, physical and technical safeguards in place. THP's contract tracking software (iContracts) alerts compliance department staff when the annual business associate attestations are due.

Compliance Audits: THP conducts periodic compliance audits of its Medicaid subcontractors that include the review of the subcontractor's privacy and security

policies, procedures and practices. THP uses a risk-based approach to determine the frequency of compliance audits. Subcontractors with direct or substantial impact on member, regulatory compliance or THP financials are prioritized for desk or onsite audit and are audited annually or biennially.

Control Report Reviews: THP requests and reviews its Medicaid subcontractors' applicable SOC 1, SOC 2 and/or HiTRUST reports on an annual basis. HiTrust reports are reviewed by the compliance department. SOC 1 and SOC 2 reports are abstracted by the business owner using a structured Excel spreadsheet. The abstraction process reviews the auditor's opinion to determine if the opinion is qualified or unqualified and reviews any control testing exceptions including any exceptions related to the subcontractor's privacy and security processes. Follow-up is conducted in the event of a qualified auditor opinion, although this has not been necessary to date. Any exceptions in the reports are evaluated by THP to ensure there is no impact on THP's internal control environment.

Contracted Providers: THP requires its contracted providers to comply with established confidentiality requirements including those imposed by HIPAA through the inclusion of confidentiality language in its contracts such as the following:

"Physician shall maintain medical records in an accurate and timely manner and according to normal standards and procedures as stated in 12.1 above, and shall maintain the confidentiality of such medical records (and any information that identifies a particular Member) of Members so as to comply with all federal and state laws and regulations and preserve them for such time periods as are required by applicable law. Such records are subject to all applicable privacy and confidentiality requirements and

Physician shall cooperate with The Health Plan in permitting maximum sharing of medical records and administrative services by Physician providing services to Members. The Physician shall disclose individually identifiable patient health information (PHI) in accordance with the privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA) provisions."

Information related to HIPAA privacy and security is also posted on the provider portal.

Role Based Access: To ensure employees who have access to PHI and PII have appropriate levels of access within the HEART system, supervisors annually review subordinate access levels. Some levels of access are read-only while others allow modification of PHI or PII data. The HEART system consists of multiple modules. Employees are only granted access to the modules necessary to perform their job function.

IM002 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.

Our defined Privacy Plan is based upon the seven elements of an effective compliance program and includes the same robust oversight, documentation and monitoring as our Compliance Program. Regular and ad hoc privacy-related auditing, monitoring and projects are tracked in the Audit Work Plan (AWP) and in Gorman's Online Monitoring Tool (OMT) as applicable.

Privacy Plan Overview: THP's HIPAA Privacy Plan includes written policies and procedures, designated responsibility and high level oversight, effective training and education, effective lines of communication (through the various compliance hotlines and regular reporting to the executive-level Corporate Compliance Committee and

board-level Audit and Corporate Compliance Committee), publicized disciplinary standards, routine monitoring and identification of privacy related issues, and prompt response to identified issues. Privacy and security policies are reviewed at least annually and maintained in an electronic policy management system called PolicyStat. Policies are available to all employees through PolicyStat.

Uses and Disclosures of PHI: THP's HIPAA Privacy Plan requires the use and disclosure of PHI only as permitted by HIPAA and other applicable law. Several policies support this section of the Plan including:

- Employee Security and Confidentiality Agreement
- Disclosing and Requesting Only the Minimum Amount of PHI
- Uses and Disclosures of Protected Health Information for Public Interest and as Required by Law
- Uses and Disclosure Requiring the Opportunity to Agree or Object
- Confidentiality of Substance Use Disorder Records (addresses 42 CFR Part 2)

Member Rights: THP's HIPAA Privacy Plan is cognizant of individual rights under HIPAA. To ensure enrollees are given access to their HIPAA rights, THP has developed and implemented the following policies:

- The Right of Individuals to Access, Inspect and Copy Protected Health Information
- Amending Protected Health Information
- Accounting of Disclosures of PHI
- Confidential Communications for Protected Health Information
- Request for Restriction on Uses and Disclosures of PHI
- Notice of THP Privacy Practices

In addition, THP has developed a written policy and procedure for authorization when required. However, as required by the Office for Civil Rights, THP does not require a completed authorization form when the request for access is made by the member or the member's personal representative. Rather, THP uses the Individual Request for

Access form that reduces any barriers that may otherwise delay or inhibit a member's access to his or her own information consistent with HIPAA and Office for Civil Rights guidance.

Monitoring and Auditing Activities: THP conducts routine and ad hoc auditing and monitoring activities related to the protection of member data. Such activities include:

- Routine access reviews
- Annual capability reviews
- Regular log in monitoring
- Data loss monitoring
- Routine HIPAA walk throughs
- Periodic phish testing
- Regular oversight of shredding vendors
- Vulnerability monitoring
- Monitoring of network/keycard access removal of terminated employees

Periodic phish testing
Realizing the threat of email-related phishing attacks, THP instituted a formal security awareness training system in 2016. An assessment of all employees' susceptibility to a phishing attack was performed.

An initial 25% failure rate was quickly reduced to less than 2% after one month of training. Regular phish testing continues to ensure ongoing employee awareness.

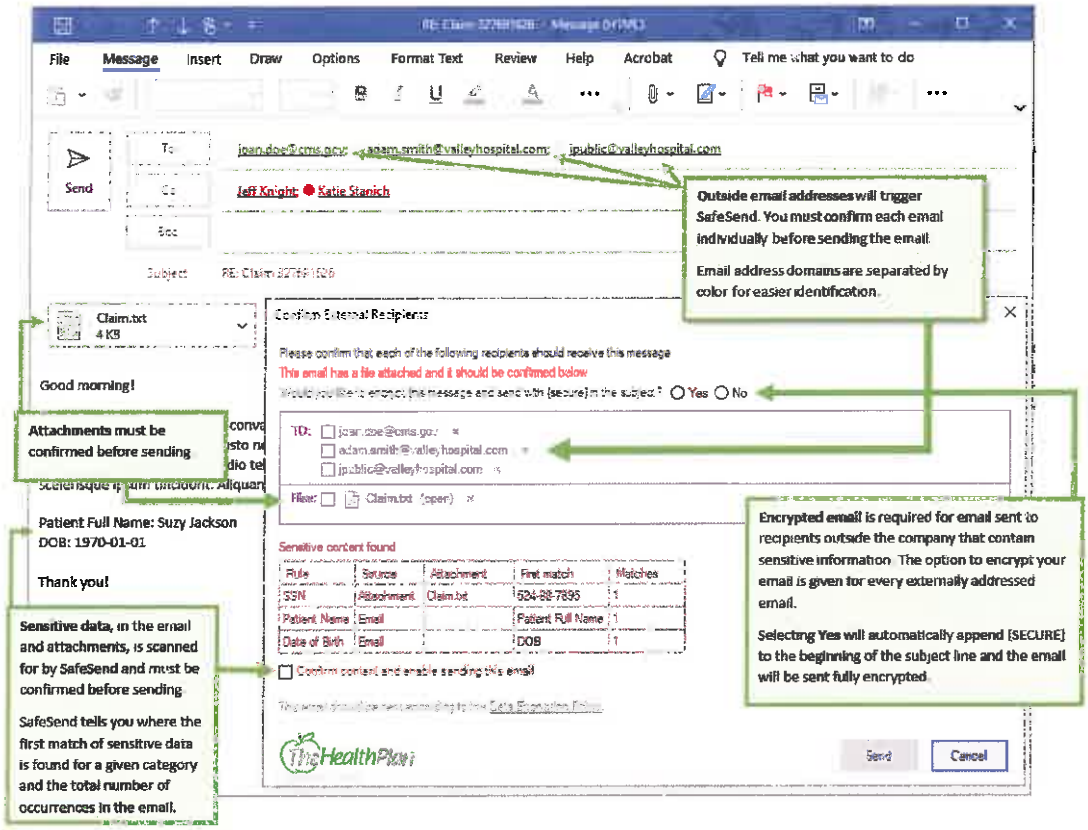
The following table provides additional details on selected monitoring activities:

Item	Activities Performed
Phish monitoring/training	▪ Realizing the threat of email-related phishing attacks, THP instituted a formal security awareness training system in 2016. An assessment of all employees' susceptibility to a phishing attack was performed. ▪ An initial 25% failure rate was quickly reduced to less than 2% after one month of training. Regular phish testing continues to ensure ongoing employee awareness.
Regular Login Monitoring	▪ THP has the following technical controls around its Login Monitoring policy: ▪ THP monitors account lockouts in real-time with alerts sent to the helpdesk. Accounts are locked out for 15 minutes after 3 failed attempts. ▪ THP reviews a daily report of logins outside normal business hours of 7 pm and 5 am. Deviations are investigated next day. ▪ THP reviews a daily report of all successful and unsuccessful logins. ▪ THP reviews a daily inactive user account report showing any account that has not been logged in to for 14 days. Deviations are reported to human resources.
Vulnerability Monitoring	▪ All internet-facing servers are scanned for vulnerabilities on a weekly basis by a well-known scanning vendor. These same servers are tested annually by a 3rd party penetration testing vendor. The director of network operations has a certification in enterprise vulnerability assessment (GIAC GEVA).
Monitoring of keycard access & removal	▪ THP conducts ongoing monitoring of its network access termination and keycard access removal on a monthly basis. These metrics are tracked

Item	Activities Performed
	OMT. Termination of network access is tracked to ensure that access is terminated within 24 hours of employee termination. Keycard termination is tracked to ensure that keycard access is terminated by the end of business on the employee's last day of work. Tracking in OMT permits THP to identify and remediate any deficiencies in the event they occur. Access removal is also tested during the annual SOC 1 audit conducted by an independent third party

Collaboration with Information Systems: THP's compliance department works hand-in-hand with its IT department to develop and review HIPAA security policies and procedures, review security incidents (including "near miss" incidents), conduct periodic access and capability reviews, develop staff training, review and implement National Institute of Standards and Technology (NIST) framework standards and conduct periodic HIPAA privacy and security risk assessments. To ensure appropriate collaboration between the compliance department and IT, THP created a Privacy-Security Workgroup that meets on a monthly basis (more often as needed) to review and discuss items to enhance the effectiveness of THP's privacy and security processes. Regular communication between the departments promotes the best use of THP resources, enhances the effectiveness of the privacy and security functions, prevents program gaps through the collaborative nature of both distinct disciplines, and promotes THP's continuous improvement philosophy. Examples of projects/items implemented based upon this collaboration include:

- Completion of annual HIPAA Security Risk Assessments (THP uses a software program called HIPAAOne to guide and document the annual assessment)
- Participation in annual training provided by the Office for Civil Rights and NIST
- Ongoing review and updating of THP's role-based access definitions
- Implementation of an email data loss prevention technology (alerts users when sending email outside the network, when email contains sensitive information and prior to sending unsecure email) called SafeSend (below screenshot)



Future projects include an enhanced review of the NIST cybersecurity framework and the implementation of the NIST privacy framework once finalized (the NIST privacy framework is currently under development by the National Institute of Standards and Technology).

Business Associate Arrangements: THP has business associate arrangements with various vendors and entities and has developed template BAAs to govern these arrangements. THP inserted BMS required language in its template business associate agreement for use with its Medicaid subcontractors. THP maintains records of its business associate arrangements including copies of the signed business associate agreements. In addition, THP has initiated an annual business associate attestation process with its subcontractors to ensure that the subcontractor has appropriate

administrative, physical and technical safeguards in place. THP's contract tracking software (iContracts) alerts compliance department staff when the annual business associate attestation is due.

Privacy Breaches: In the event of a potential privacy breach, THP has policies and procedures in place for reporting, documenting and investigating inappropriate uses or disclosures of PHI. When a privacy or security incident occurs, the privacy officer, or appropriate designee, evaluates the occurrence to determine if the incident resulted in a privacy breach as defined by HIPAA. THP abides by the reporting and notification requirements as required by the HIPAA Breach Notification Rule and other applicable statutes. In addition, if the breach relates to THP's role as a business associate of an outside entity, THP will make notification to that entity as required in the applicable business associate agreement including the business associate agreement between THP and BMS.

Corrective Actions: Corrective actions are implemented to correct and prevent non-compliance with HIPAA privacy and security standards or other privacy-related regulations. Such corrective actions may include one or more of the following:

- Additional training
- Revision of existing, or development of new, policies and procedures
- Implementation of additional controls
- Internal monitoring
- Disciplinary action, including termination, when required
- Other actions as deemed appropriate by THP's privacy officer or security officer

IM004 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.

We collect and integrate multiple data sources and powerful analytic system mechanisms to support our Quality Assessment and Performance Improvement (QAPI) program. Our open interface architecture allows us to consume data in any HIPAA EDI, HL-7 or proprietary formats. Listed below are our key data sources to implement and maintain our QAPI program.

- Member data including demographics, claims, referrals
- Provider data
- Lab data
- West Virginia Health Information System Data
- WV and Ohio State immunization registries
- Care management assessments
- Health risk assessment (HRA)

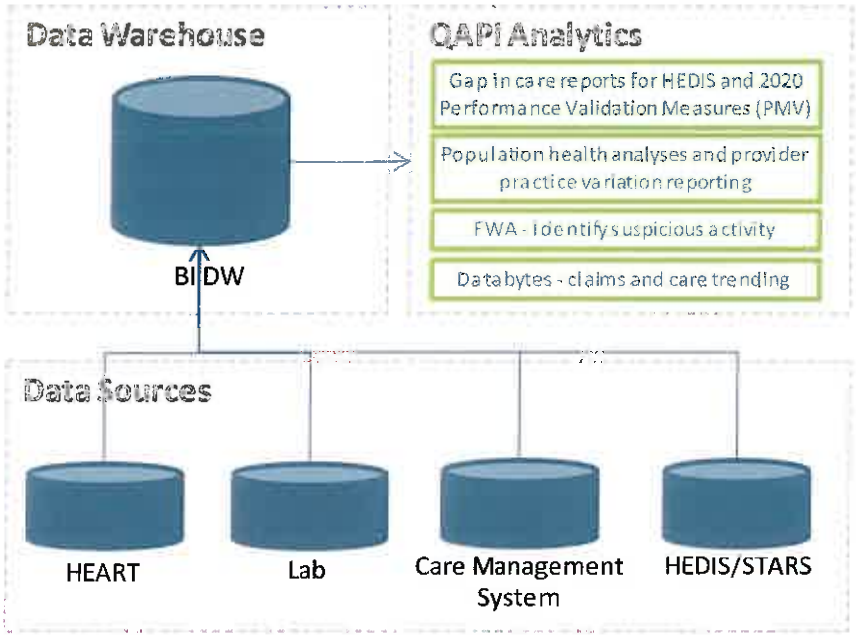


Figure 1: QAPI data sources and analytics.

Our Business Intelligence Data Warehouse allows us to store all data at one place to produce report or analytics needed to implement and maintain our QAPI program. The data is used to feed our analytical processes including:

- Cotiviti, our NCQA certified software, to build gap in care reports for HEDIS and 2020 Performance Validation Measures (PMV)
- CCGroup Marketbasket and Impact Pro, our population health and provider analytics software tools, to build population health analyses and provider practice variation reporting
- STARSSolutions, our FWA software used by SIU to identify suspicious activity

- Databytes, our internal report builder that permits queries from the data based upon claims and care trending

IM005 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

Through our work over the past several years, we have evolved a best-in-class information systems platform that we continually invest in to meet the evolving needs of improving the health of our members. THP's claims payment process uses a proprietary system owned, advanced, and maintained by our in-house IT team. We originally used the COMPRECARE software system, which was a turnkey system specifically designed for HMO processing. THP began advancing the software to incorporate a more user-friendly interface several years ago, and this has evolved into what is now known as the HEART system. All core claims business functions are processed through HEART.

Our approach to managing our information systems includes:

- ***Multi-year roadmaps*** that guide investments to the platforms and technology that enable business capabilities serving our members.
- ***Use of process automation*** to ensure quality of business processes, data and member experience is optimized, investments such as end-to-end enrollment file automation, claims automation and robots have been deployed to strengthen the Medicaid deployment.
- ***Systems lifecycle management*** to inform the THP information systems roadmap of assets requiring replacement to maintain the needed service level agreement (SLA) and capability.
- ***Technology pilots and adoption processes*** used to identify, test and bring to use new technologies, such as code editing solutions, in a structured and secure manner as business capabilities are introduced, launched and optimized. We will ensure compatibility with the most current WVOT supported versions and standards as indicated in the Service Provider Agreement, in accordance with **MD015.**
- ***Information security architecture*** embedded within all aspects of the business, including investments in penetration testing and email phishing campaigns and training.

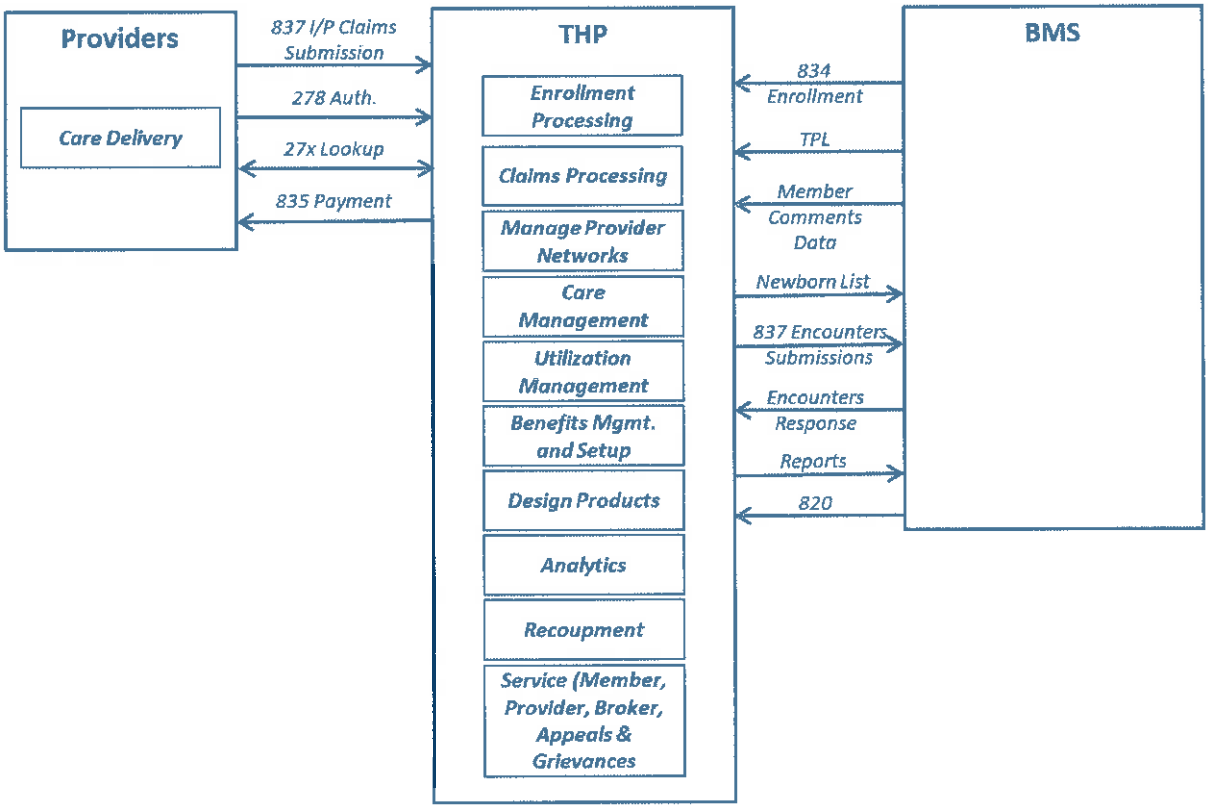
Our modular management information system (MIS) enables the day-to-day management of key operations including, but not limited to, the following:

- Eligibility, enrollment and disenrollment management and data reconciliation
- Provider network management, ongoing access and availability and credentialing
- Member and provider information access through secure online portals
- Claims processing, edits, benefit coding, automation and adjustments
- Claims adjudication, payment, FWA edits and coordination of benefits (COB) for claims with third-party liability (TPL)
- Care coordination and case management for physical health, behavioral health, integration of pharmacy data and social determinants of health (SDOH)
- Financial management and accounting
- Encounters data submission
- Reporting and analytics to facilitate standard and ad hoc reporting

We will be responsible for all expenses required to obtain and maintain access to the Department systems as indicated in the Service Provider Agreement, in accordance with **MD023**. Additionally, THP is 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, per **MD024**.

Flexible Architecture and Data Aggregation

Our flexible integrations architecture allows us to accept and produce a variety of electronic data formats, including HL7, XML, JSON, custom file formats and HIPAA standard formats such as 820, 834, 835, 837I, 837P, 837D, 270/271, NCPDP, 276/277 and 278 file formats for electronic transactions. We will adhere to all State-defined file formats and templates including, but not limited to, 820 payment advice, 834 enrollment and 837 encounter files as indicated in the Service Provider Agreement, in accordance with **MD018**. Our current data exchanges with the Department are depicted in the figure.



Data can be exchanged through multiple protocols, including file-based through synchronous Secure File Transmission Protocols (FTP), secure web services and asynchronous exchange mechanisms such as message queue-based solutions for guaranteed delivery of data. All data exchange is robustly monitored through our information systems alerting and monitoring controls. We escalate exceptions to the proper technical and business partners for timely resolution to ensure continuity of business.

We leverage a robust Enterprise Data Warehouse (EDW) where all member data is integrated as it is received from internal and external data partners. The EDW enables accurate, high quality, timely, analysis and reporting. We collect a significant amount data to use in healthcare operations. We will ensure that our health information system accepts the Medical Assistance Identification (MAID) generated by the Department for

all members for data collection and billing purposes as indicated in the Service Provider Agreement, in accordance with **MD016**.

Requirements Development Process

We have a disciplined approach for accepting changes as per new or modified contract requirements. Our Software Development Life Cycle (SDLC) process consists of six phases, presented below, with each phase including review steps, approval steps and required approvals. The following exhibit presents the phases and a few key activities/deliverables within each phase.

- ***Define phase*** translates business information into a formal project and includes completion of an impact analysis, development of high level requirements and identification of resources needed. A review of existing system/product documentation is completed to identify the scope of changes.
- ***Plan phase*** creates comprehensive project documents and plans for project review/approval, including development of a Business Requirements Document, test case scenarios and measurement criteria.
- ***Design phase*** develops detailed systems and process designs to satisfy requirements, including a SDP deployment (project) plan, development of system design and system test conditions and environment preparation (such as development, test and production).
- ***Build phase*** develops and tests system changes to ensure all requirements are satisfied, including user acceptance testing documentation, an updated SDP deployment plan and installation and testing of system/changes.
- ***Deploy phase*** moves the system/changes and all associated processes to production, including a MIS change ticket with back-out plan and completed system testing.
- ***Close (Control) phase*** measures and reports results, including implementation of a support plan, finalization and archiving of all documents and development feedback, lessons learned and closure meeting.

System Configuration Process

To change or implement new requirements, we produce a configuration assessment that walks through the HEART configuration options and defines those configuration options based on BMS requirements. The assessment verifies or information system processes data according to BMS requirements, calling out any custom requirements

and data or reporting needs. Once the assessment is completed, we perform the configuration work to confirm HEART meets BMS requirements.

Additionally, all key subsystems follow formal SDLC process to modify their systems to accommodate HEART configuration changes, such as new data extracts, to support the MHT and WVCHIP programs.

System Testing Process

Our Testing Center of Excellence (TCoE) develops and implements consistent and repeatable quality assurance (QA) processes across THP IT enterprise applications to identify and remove critical defect before time of release. The TCoE focuses on the following areas of development to instill quality within our applications:

- ***Metrics:*** Defining and implementing common metrics across the QA domain to enable a consistent perspective on quality throughout the organization.
- ***Testing Standards/Best Practices:*** As a core capability of the TCoE, we define the optimum methodologies and approaches for quality assurance in a manner that can adapt to multiple technologies and implementation approaches. We also look to capture and communicate successful approaches that can be better leveraged throughout the organization.
- ***QA Training and Development:*** Enhances the capabilities of QA within THP IT by developing a career map to show the possible paths within the QA realm.

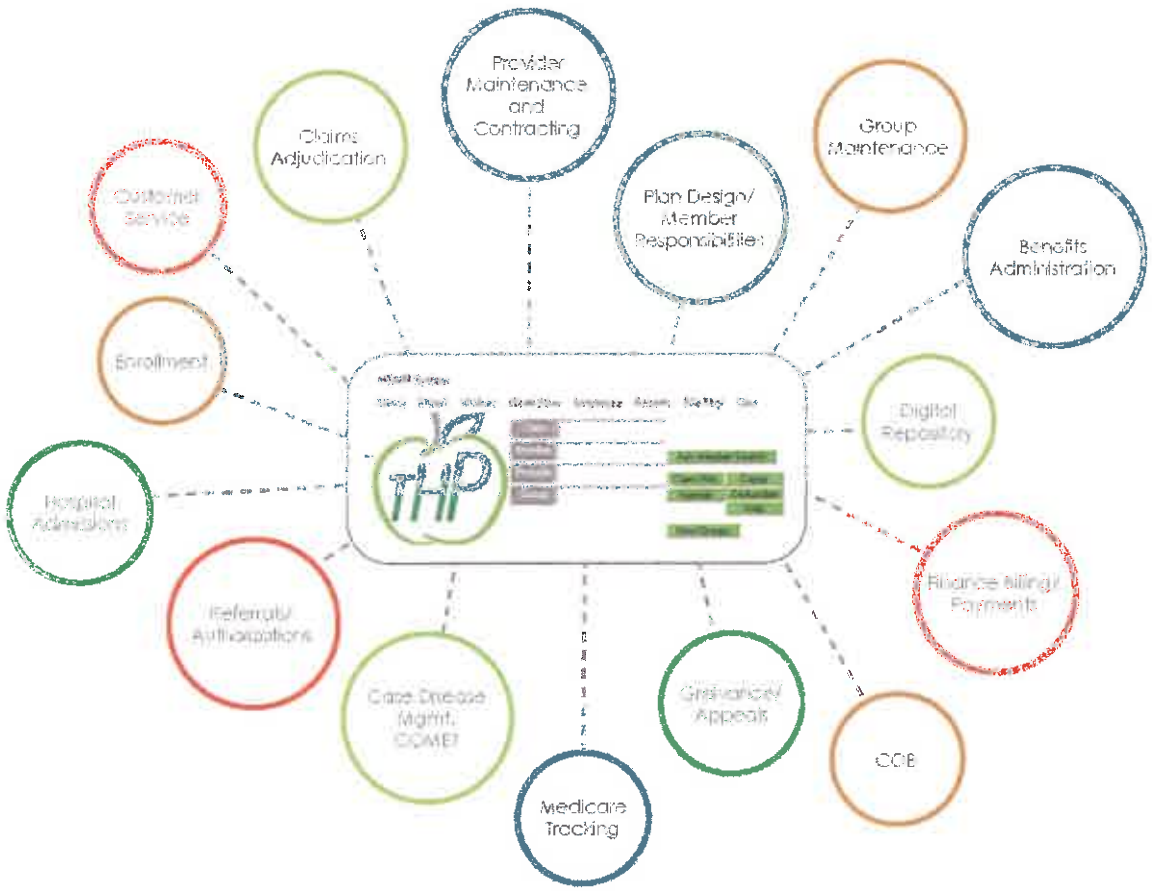
Our development teams test system changes based upon metrics, standards and methodologies developed by the TCoE. The test environment attempts to reproduce the production environment as closely as possible. However, we physically separate development, test and production environments to reduce the risk of accidental change or unauthorized access to production software and data. The separation of these environments is paramount to ensure software developers do not have access to source code after it is migrated from the development environment and test data are sanitized whenever possible. In the event actual production data are needed in the test

environment, only authorized individuals have access to such data, and the data are destroyed when testing is complete.

System changes go through a number of testing phases to verify that the change is ready for a production environment, including:

- ***Unit testing:*** Testing just the component
- ***System testing:*** Testing the component with all other components/processes it touches
- ***Regression testing:*** To confirm that new software does not cause problems with existing processes
- ***User acceptance testing:*** To validate that the change satisfies user expectation

The following diagram presents the components of our managed care information system, HEART.



The following is an overview of several of our key system modules:

System Module	Functions Supported by System
Claims Adjudication	▪ Physician, Hospital, Dental, Pharmacy and Member Reimbursements. ▪ Ability to view original claim and/or paper documents sent along with claim. ▪ View all information sent on an electronic claim. ▪ Real-time pricing when modifying. ▪ Integrated with WorkFlow that allows us to assign and create work queues based on various claim criteria and allows monitoring of claim flow to ensure time requirements are met. ▪ Managers have the capability to design queues so that they can focus review on new groups, lines of business or specific providers as just a few examples. ▪ On-line edit review system that records all areas claim was flagged and released. ▪ System is integrated with the member's claim history to make claim review more efficient. ▪ Track and log all claim activity. ▪ Provider vouchers are viewable on-line. ▪ Integrated with ClaimsXten for coding information and review. ▪ Integrated to use third-party pricers.
Provider Maintenance and Contracting	▪ Capture all basic demographics. ▪ Ability to exclude/include from various lines of business. ▪ Maintain separate payment arrangements based on lines of business or group numbers. ▪ Tie together unlimited number of addresses associated with: locations, billing and tax information. ▪ Apply numerous restrictions. ▪ Customize which directories provider will be listed and how. ▪ In-office/lab procedures approved for. ▪ Track all licensing, education and credentialing information. ▪ Provider sanctions history. ▪ Ability to add detailed remarks that are public or private. ▪ Complete maintenance history. ▪ Imaging system that can be tied to Tax ID, NPI, Provider ID, contract type or delegation code for online information.
Plan Design/Member Responsibilities	▪ Plans can be designed to apply copay, coinsurance, deductibles, member responsibilities and pre-cert penalties. ▪ All amounts can be set to track in-network, out-of-network and special network. ▪ Ability to have the same amount applied to numerous networks if required. ▪ Ability to require at least one or more family members to reach the individual limit before the family limit can be satisfied. ▪ Plan can be designed to accumulate based on calendar year, group contract year or specific date range. ▪ Attachment and maximum levels can be set differently for each area. ▪ Plan managers have the ability to design benefits based on various criteria, such as age, gender, place of service and provider specialty for just a few. ▪ Copays and coinsurance can be applied at various levels, all the way to

System Module	Functions Supported by System
	specific procedures. ▪ Flexibility to set design new plans without any recoding. ▪ Deductible carryover. ▪ Ability to carry amounts applied across different group numbers. ▪ On-line SBC design and archival.
Customer Service	▪ Member summary screen that ties information from various modules in order to give a quick snapshot of current information. ▪ All information is displayed based on cross reference logic. This allows members under more than one policy to have all their information pulled together when warranted regardless of the ID they give. ▪ One Click design to get to detail information from various modules such as enrollment, group and provider information. ▪ On-line access to member documents: Explanation of Coverage, Schedule of Benefits, Pharmacy Benefits, Chiropractic Benefits, Vision Benefits, Dental Benefits, Privacy Information and Group Card Specifications. ▪ Access to all copay and deductible information, including current amounts applied. ▪ Any special programs or management member is flagged for. ▪ Order new ID cards or generate a temporary card that can be immediately emailed or faxed to the member. ▪ Unlimited number of alternate addresses for each member. ▪ Select various letters to be sent. ▪ Advance directive information. ▪ View all digital folder information. ▪ Sign member up for MyPlan secure portal. ▪ Ability to view information from member portal as if logged in as the member.
Enrollment	▪ Accept unlimited alternate addresses for members. ▪ Flag members for special programs or management that follows them to other modules. ▪ Work with several HR services to receive electronic enrollment information in various formats. ▪ Employer Module that allows group administrators to submit their own enrollment changes and view their census information in real- time. ▪ Detailed audit logs of all changes. ▪ Select various letters to be sent.
Group Maintenance	▪ Ability to rate groups using community or age/band rating. ▪ Ability to administer cafeteria plan design. ▪ All benefits can be set at group level or a consolidated group. ▪ Track and price unlimited number of rented networks per group. ▪ Plan documents are set at group level and viewable on-line. ▪ Premium Estimator for small groups and individuals.
Hospital Admissions	▪ Integrated with a DRG grouper. ▪ Integrated with hospital contracting module to generate an estimate for the stay. ▪ Perform detailed admission reviews and document all changes. ▪ Integrated with Interqual criteria for reviews. ▪ Attach supporting documentation directly to the census.

System Module	Functions Supported by System
	▪ Ability to view all active admissions and filter based on numerous criteria, such as: line of business, facility, facility type, days admitted, admission type, etc. ▪ Capture detailed newborn information that is integrated into HEDIS reports.
Authorizations	▪ Ability to Gold Card certain providers so they don't need authorizations. ▪ Integrated with our claims editing process. ▪ Multiple review levels can be performed at nurse and medical director level, with reviewer and date information logged. ▪ Integrated with Interqual. ▪ Pending screen for nurses and medical directors to perform reviews. ▪ Authorizations that are sent out are also in the member's digital folder for online access. ▪ Ability to submit certain specialty authorizations through a secure provider portal. ▪ Attach supporting documentation directly to the referral.
Case/Disease Management	▪ Health risk assessments. ▪ Set goals and track progress. ▪ Capture meeting/progress notes. ▪ Create correspondence. ▪ Interfaces with all other modules of HEART, such as enrollment, claims, authorizations and admissions. ▪ Trigger system generated alerts when specific actions occur, such as admissions and authorizations. ▪ Attach supporting documentation directly to the case.
Benefits Administration	▪ Coordinates enrollment and benefit packages for several clients. ▪ Customized benefits and reporting for each client's requirements. ▪ Web interface for members to verify/select their coverage levels during open enrollment periods. ▪ Inbound/Outbound automated file transfers with several third-party vendors.

HR System	▪ Capture all the basic employee demographics.
	▪ Track job history within company.
	▪ Custom built Time Off module tracks:
	▪ All scheduled and unscheduled leave time.
	  ▪ Employees can view their own status and submit time off for review.
	  ▪ Apply carry over hours from the previous year.
	  ▪ Generates reports for quarterly review and approval.
	  ▪ View department coverage for specific time spans.
	▪ Integrated with our system security capabilities.

Fax/PDF Management	▪ All of our incoming faxes are saved as PDF'
	▪ Capability to file PDFs as:
	  ▪ Document Repository folders.
	  ▪ Attachment in HEART.
	  ▪ Re-route to various work queues.
	  ▪ Email as attachments.
	  ▪ Other functions specific to the fax line being worked.
	▪ Users can file any PDF straight into Document Repository folders as if it was WinScanned.

System Module	Functions Supported by System
Finance	▪ Generate all group/individual billings and payments. ▪ Group bills are available for online viewing. ▪ Ability to prorate members and groups. ▪ Claim lag reports for calculating IBNR and other financial reports. ▪ Provider credit balance history. ▪ Module for tracking West Virginia Medicaid billing reconciliation. ▪ ACH Workflow module

COB	▪ COB demographic information.
	  ▪ Insurance carrier information
	  ▪ Employer information
	  ▪ Medical and Rx information for complete family
	▪ COB confirmation letters
	▪ Part D information

Medicaid	▪ Accept the West Virginia Medicaid's 834, and the complete record of information is viewable. ▪ Quarterly report package required by the state. ▪ Prenatal outreach tracking. ▪ EPSDT outreach tracking. ▪ Generate monthly maternity billing.
Medicare Tracking	▪ Submit directly to CMS's MARX any of our enrollments we receive by paper, electronic files from HR Services or from our on-line WEB form. ▪ Accept the Medicare on-line enrollment file from CMS. ▪ Process all inbound files from the MARX and distribute to the various departments. ▪ Ability to track and follow-up on paper applications. ▪ Module to track compliance to ensure enrollment is sent within contracted timeframes. ▪ Create HCC and RAP files. ▪ Integrated with a third-party vendor to perform chart review for missing claim information. ▪ Part C Quarterly Summary.
Grievance/Appeals	▪ Detailed tracking for Appeals, Complaints, Grievances, IRO Information, DOI Information, Administrative Review, Maximus Information and ALJ information. ▪ All levels are date stamped. ▪ Ability to tie to claims. ▪ Automated reports are sent based on system triggers and timeframes. ▪ Customized user generated reports. ▪ System generated letters.

Marketing	▪ User requested profit/loss reports based on group numbers and emailed in an electronic format.
	▪ Custom report packages for ASO clients
	▪ SBC system
	  ▪ Generated from existing plan structure or from scratch.
	  ▪ Dollar amounts are totally customizable by the user.
	  ▪ Stored on-line as a PDF.
	▪ Capability to place a final product in the group's digital folder.

IM006: The Vendor should provide its business continuity and disaster recovery plan for the technology and infrastructure components of business operations with its bid.

We are providing a summary of our current business continuity and disaster recovery plan in accordance with the instructions in Addendum #5. THP will provide the entire plan upon award. Our plan is reviewed annually during the third-party SOC 1 audit as well as internally by THP's safety committee and other key stakeholders. This approach ensures our ability to continue operations in the event of a downtime or service interruption.

Business Contingency and Disaster Recovery Plan

The purpose of the business contingency and disaster recovery plan is to establish a streamlined and clearly defined emergency response procedure to assist the company's normal operations when responding to a severe emergency for an extended period of time.

THP maintains a comprehensive business contingency and disaster recovery plan using an online hosted software application – KingsBridge. This cloud-based application addresses all facets of business continuity and specifically identifies tasks for management, administration and operational teams. The business contingency and disaster recovery plan is reviewed at least annually and updated as necessary. The plan includes detailed roles, responsibilities, preparation and response tasks specific to each functional area in the organization with extensive coverage of information technology requirements. The plan is securely hosted online and accessible anywhere with internet connectivity.

The 2019 plan update was initiated by the completion of a business impact analysis in order to determine the criticality of defined THP processes in the event of a downtime or

other service interruption. During the business impact analysis, key members of the various THP processes, including but not limited to claims processing, appeals and grievances, case management, utilization management, enrollment, credentialing and finance, were asked to grade the degree of impact a system interruption would have to THP's members, finances, operations, personnel, suppliers and regulatory compliance. The analysis also identified the minimum and maximum downtime durations that could be tolerated before it would be difficult for THP to recover. This information was compiled and used to prioritize resources within the business contingency and disaster recovery plan so that in the event of a system downtime or other service interruption, the most critical systems and processes are addressed first. Information systems also used this data to prioritize its system recovery processes.

This plan maximizes our capacity to prepare for, respond to and recover from all types of system emergencies and disruptions.

- Ensures an established organizational structure is in place to respond to any emergency.
- Ensures that regular communication channels between response teams and customers, the media, governments and regulatory agencies operate effectively in order to exchange accurate and timely information.
- Establishes an emergency command center which is designed to assist in the communication and coordination process during an emergency or downtime.
- Provides for personnel training, emergency drills, evaluations and critiques to continually refine procedures and improve performance.
- Establishes an organizational structure that supports centralized oversight of emergency response activities.
- Establishes a concept of operations that provides a business unit coordination mechanism to facilitate emergency response activities.
- Establishes incident action plans that each business unit will take in the overall corporate emergency response.
- Establishes an architecture for a systematic and coordinated corporate response.

The Health Plan's Facilities and Systems

In late 2017, THP moved its headquarters to a brand new 4-story building in Wheeling, WV. The new facility houses THP's primary data center along with redundant, state of the art cooling and backup power systems, including a full facility diesel generator with several days of fuel on hand.

The computing infrastructure is architected in a way that allows for the continuation of mission critical business processes should the loss of an entire data center occur. A smaller secondary data center located at THP's office in Charleston, WV, houses an almost identical infrastructure as the Wheeling data center. Mission critical systems such as mainframe and database servers are kept synchronized in real-time between data centers. Other critical file and application servers are backed up multiple times each day (as frequently as every 30 minutes) and that backup data is replicated from Wheeling to Charleston within minutes of the backup's completion. Redundant SD-WAN internet fiber optic connections service each data center for resiliency.

A complete disaster recovery test of the HP3000 mainframe system is performed biennially with the assistance from Beechglen Development, Inc – the vendor contracted by THP for hardware and software support and maintenance – which also maintains hot-standby hardware in Cincinnati, OH – three hours away. A claims processing job is performed to test system integrity during the biennial testing. Additionally, weekly restores (back-ups) are made as part of development operations processes in order to keep the development HP3000 system one week behind the production system.

Restores of mission critical file and application servers are performed regularly as part of day-to-day IT operations. Restoration of a complete server is performed (in an offline fashion) when a user requests the restoration of a file or folder.

Disaster testing of the primary database server is performed during its patch cycle. The primary server is "failed over" to the secondary backup server over a period of a weekend while software patches are applied. During this time, the backup server processes all data requests. Network failover testing is performed annually to verify proper cutover of Internet service.

Redundant Infrastructure & Data Replication

THP has redundant hardware in Wheeling and Charleston data centers. Data is replicated to back-up sites for recovery purposes. THP has three key mechanisms to replicate and back-up data to maintain the integrity and availability of information and information processing systems in the event of hardware or software failure, disaster or human error.

Mainframe replication

- Exact duplicate of data in Charleston
- Replicated in real time
- Backups taken in Wheeling and replicated to Charleston nightly
- Emergency disaster recovery site in Cincinnati at Beechglen Development

San-to-San replication (Nimble replication to Charleston)

- Volume level replication
- Near instant restore and recovery
- Direct copy of data in Wheeling is replicated to Charleston
- Ability to run virtual machines (VMs) off enterprise-class Nimble hardware

Traditional Incremental Backups

- Rapid recovery replication to Charleston
- Replaced cumbersome tape backups
- Long term retention options
- Flexible snapshot schedule
- File level restores
- Bare metal restores and standby VMs
- Data replicates immediately

TheHealthPlan

Attachment 6
Value-Added Services

13. Value-Added Services

In addition to the above subject matter areas from ***Appendix 1: Detailed Specifications***, the Vendor should include any Value-Added Services to be offered in this section, as well as any eligibility requirements and potential limits for these services. Vendors are not required to propose value-added benefits, but inclusion of such services may impact the Vendor's overall evaluation. The Vendor's narrative response should not exceed 10 pages.

The Health Plan's (THP's) value-added services are innovative and were thoughtfully selected to reflect the Department's RFP goal to improve health outcomes for Medicaid and WVCHIP members. In addition to our current value-added services, we are pleased to offer Teladoc, our 24/7 telehealth services for members to access medical, behavioral health and dermatology care via phone, video or app. We also are adding the following new value-added services:

- Boy Scout memberships
- Girl Scout memberships
- Boys & Girls Clubs memberships
- Member Advisory Committee participation
- Jobs & Hope West Virginia training and education classes

Our value-added services are available statewide to all MHT members that we serve, and will include the newly added WVCHIP members. Our value-added services are offered at no cost to the member. We will continually monitor value-added service utilization to verify that members do not exceed the $250 maximum annual limit. And, through our Member Advisory Committee, we will seek member feedback and recommendations on current and future value-added services to ensure that we are providing value-added services that are important to members.

Value-added Services – Currently Offered

The following table provides the description, eligibility criteria, and limits and restrictions of each of our current value-added services. We will continue to offer these value-added services under the new MHT contract.

Value-added Service	Description, Eligibility Criteria, Limits and Restrictions
24-hour Nurse Line	Members may call our 24-Hour nurse line to reach a nurse. The phone number is 1-800-624-6961. Our 24-Hour nurse line is staffed by local THP employees. Eligibility Criteria: Members statewide. Limits and Restrictions: None.
Asthma Care Program	This program offers telephonic education with asthma nurse educator; materials are mailed if requested Eligibility Criteria: Members statewide with a diagnosis of asthma. Limits and Restrictions: None.
Diabetes Care Program	Our diabetes care program provides: ▪ Diabetes education by care managers ▪ One-on-one education by diabetes educators on glucometer and insulin pump use and general diabetes education ▪ Journey for Control month-long interactive diabetes class led by certified educator ▪ Scholarships to Camp Kno Koma for children ages 7-15 ▪ $50 gift card for HbA1C blood test, nephropathy exam and a diabetic eye exam for diabetics ages 18-75 Eligibility Criteria: Members statewide. Camp Kno Koma scholarships for children ages 7-15. Incentive available to members with diabetes ages 18-75. Limits and Restrictions: None.
Gifts for Good Health Practices	This initiative includes: ▪ $25 gift card for yearly well visit for ages 3-6 and 12-21 ▪ $25 gift card for women ages 21-64 for Pap smear every 3 years Eligibility Criteria: Members statewide. The yearly well visit is for children and youth ages 3-6 and 12-21. The Pap smear incentive is for women ages 21-64. Limits and Restrictions: None.
Phone Services	Our phone services provide members with a free cell phone with free minutes for text and voice, unlimited calls to customer service, and free wellness and appointment reminder text messages. This phone allows providers and our outreach staff and care managers to reach members to address health issues and schedule provider appointments. Eligibility Criteria: MHT Medicaid members statewide who are age 18 and older. WVCHIP members are not eligible for this service. Limits and Restrictions: This benefit is available to one member per household. All THP Medicaid members are eligible. THP members who are under 18 require parents or guardian to enroll on their behalf.

Pregnancy Care Program	Our pregnancy care program offers value-added services for pregnant women:
	▪ Text4Baby messages to keep mom and baby healthy
	▪ Preventive dental for those over the age of 21 – up to 2 visits
	▪ Maternity outreach programs:
	  ▪ $50 gift card for 2 visits in 1st trimester
	  ▪ $50 gift card for 4 visits in 3rd trimester
	  ▪ $50 gift card for post-partum visit between 7-84 days after delivery
	▪ Care coordination through baby's first year for mothers with:

Value-added Service	Description, Eligibility Criteria, Limits and Restrictions
	▪ High-risk pregnancies ▪ Substance use disorder during pregnancy ▪ NICU babies or babies with complex conditions Eligibility Criteria: Members statewide who are pregnant or have a newborn (up to 1 year old) and had at least one of the following: 1) high-risk pregnancy, 2) SUD during pregnancy or 3) NICU babies or babies with complex conditions. The preventive dental initiative is for pregnant women ages 21 and over. Limits and Restrictions: The preventive dental initiative is limited to 2 visits up to 84 days after delivery.
Health and Wellness	Our health and wellness value-added services include: ▪ Quit smoking packets, managed internally by our certified smoking cessation coordinators, for all members ages 12 and older, with workbook, relaxation exercises CD, and quit smoking survival kit ▪ Access to our CoreWellness online tool that helps members learn ways to get and stay healthy ▪ Care managers to help members manage medications, disease and improve overall health ▪ Health risk assessments ▪ Specialized care managers: ▪ Neonatal Abstinence Syndrome (NAS) ▪ NICU ▪ High-risk OB ▪ Hepatitis ▪ Behavioral health ▪ Case management with high-risk members ▪ One-on-one help for tobacco cessation with certified coordinator Eligibility Criteria: Members statewide. The Quit Smoking packet is available for members ages 12 and older. Limits and Restrictions: None.
Dental Care Program	Our dental care program includes a $25 gift card for dental exam for children ages 2-3. Eligibility Criteria: Members statewide who are 2-3 years old. Limits and Restrictions: None.
Supplemental Security Income (SSI) Application Assistance	Personal help applying for SSI for Medicaid members who may qualify. We review diagnosis codes to identify members who may qualify for SSI. Once identified, we outreach to them and offer assistance to help them apply for SSI coverage. Eligibility Criteria: MHT Medicaid members statewide. WVCHIP members are not eligible. Limits and Restrictions: None.

Proposed Value-added Services – New

The following table provides the description, eligibility criteria, and limits and restrictions of each of our new value-added services. We will offer these value-added services under the new MHT contract.

Value-added Service	Description, Eligibility Criteria, Limits and Restrictions
Boy Scouts Membership	Provides annual membership for members ages 5-18 to join the Boy Scouts. Eligibility Criteria: Members statewide ages 5-18. Limits and Restrictions: None
Girl Scouts Membership	Provides annual membership for members ages 5-18 and also for members over the age of 18 who wish to volunteer and mentor to join the Girl Scouts. 5 ways Girl Scouts build girl leaders: ▪ Strong sense of self ▪ Positive values ▪ Challenge seeking ▪ Healthy relationships ▪ Community problem-solving Eligibility Criteria: Members statewide ages 5-18. Limits and Restrictions: One annual membership per child.
Boys & Girls Clubs Membership	Provides an annual donation to each of the eight West Virginia Boys & Girls Clubs to be used for membership dues for children and youth in need. Boys & Girls Clubs provide a safe place for children and youth ages 6-18 to learn and grow while having fun. While at the Club, children and youth can connect with working adults and their communities, gain education and career development, leadership, health and life skills and build character. Eligibility Criteria: Boys & Girls Club membership is available statewide to all members aged 6-18. Limits and Restrictions: None.
Member Advisory Committee Participation	$25 gift card to participate in our newly formed Member Advisory Committee. Meeting quarterly, we ask Committee members to make recommendations or provide feedback on initiatives, programs, services and even materials and other educational items. Our Member Advisory Committee will include a diverse representation of MHT and WVCHIP members and provide us with a fresh perspective on programmatic issues. Eligibility Criteria: Members statewide who are age 18 and older. Limits and Restrictions: Limited reimbursement for up to five members at one time to participate in our Member Advisory Committee.
Jobs & Hope West Virginia	Jobs & Hope West Virginia is the state's comprehensive response to the substance use disorder crisis. Established by Governor Jim Justice and the West Virginia Legislature, this program offers support through a statewide collaboration of agencies that provide West Virginians in recovery the opportunity to obtain career training and to ultimately secure meaningful employment. Free job training and financial education classes. THP care management staff will refer members to the program who meet the eligibility criteria, including having employment as one of their goals in their treatment plan.

Value-added Service	Description, Eligibility Criteria, Limits and Restrictions
	Eligibility Criteria: West Virginia residence; member has employment as their goal; member has an obstacle to obtaining employment, is stable and agrees to random drug testing throughout the program and will provide the results to the Transition Agent. Limits and Restrictions: See eligibility requirements.
Teladoc	Teladoc is the first telehealth provider to receive certification from the NCQA for its physician credentialing process. Teladoc is the only telehealth provider to receive NCQA certification twice and to pass both certifications with a perfect score of 100%. Teladoc physicians are board-certified and state-licensed with an average of 25 years of practice. **Medical Consult** Teladoc's general medical program provides 24/7/365 access to consult with a physician for common uncomplicated conditions. Teladoc is the nation's first and largest telehealth company, delivering on-demand healthcare anytime, anywhere, via mobile devices, the internet, video and telephone. Our solution connects members with Teladoc's national network of board-certified physicians that are living and working in each state within a median time of 10 minutes. Teladoc's NCQA certified physician network treats a wide range of conditions and cases from acute diagnoses such as upper respiratory infection, urinary tract infection and sinusitis to dermatological conditions and mental health disorders. Teladoc uses the following providers to deliver our general medical program: emergency physicians, primary care physicians, family practice physicians and pediatricians. **Behavioral Health** The Teladoc behavioral health program provides ongoing access to diagnosis, talk therapy, and prescription/medication management when appropriate as well as a best-in-class clinical intake assessment with continuous monitoring measurements. Their behavioral health services are for complete episodes of care, or for medication management with a psychiatrist. The patient experience typically begins with a non-MD therapist or psychologist (patients are not required to begin with a psychiatrist) and the therapist can refer to a psychiatrist if the therapist feels an evaluation for medication is appropriate. Currently psychiatrists conduct approximately 28–30% of sessions for either an initial evaluation or follow-up medication management. Should a patient begin with a psychiatrist, the psychiatrist may refer the patient to a provider for talk therapy if appropriate. A patient may also work with a personal therapist and use Teladoc's service for medication management only. A patient may direct an electronic summary (CCR) of a Teladoc provider's visit to a personal therapist or physician. Teladoc has recently added a "Matching Tool" that asks the patient five questions to assist in determining which providers would be a good match to their needs. The Teladoc behavioral health platform then displays providers that are the best fit. Program includes a network of psychiatrists, psychologists, clinical social workers, licensed professional counselors, mental health counselors, certified drug and alcohol abuse counselors, and marital and family therapists. Common behavioral health conditions treated include: ▪ Depressive disorders ▪ Anxiety disorders and phobias ▪ Bipolar and related disorders ▪ Schizophrenia and psychotic disorders

Value-added Service	Description, Eligibility Criteria, Limits and Restrictions
	▪ Attention disorders ▪ Addiction and substance-related disorders and alcoholism ▪ Eating disorders ▪ Obsessive compulsive and related disorders ▪ Personality disorders ▪ Sleep/Wake disorders ▪ Neurocognitive disorders and dementia ▪ Dissociative disorders **Dermatology** Our program includes a customized, comprehensive clinical intake assessment for multiple dermatologic issues, a national provider network, asynchronous dermatology consults and follow-up consults with the same dermatologist. Program includes a credentialed network of dermatologists (with provider profiles), protocols and guidelines tailored to telehealth, permission-based ability to share information with other providers, and "asynchronous" image and text upload ("Store and Forward"). Common dermatological conditions treated include: ▪ Skin infections ▪ Skin rash ▪ Acne ▪ Abrasions ▪ Moles ▪ Warts ▪ Eczema ▪ Ringworm ▪ Shingles ▪ Nail fungus **Prescription** Teladoc physicians are licensed to practice medicine in the states they provide services in. They are allowed to prescribe if they feel that would benefit the member in their treatment plan. Teladoc allows the member to choose the pharmacy of their choice. Teladoc physicians can issue prescriptions in all states where they perform consults. However, regulations in Georgia limit prescriptions to a 3-day supply, or a 30-day supply if the prescription is a refill. Teladoc physicians prescribe short-term, traditional antibiotics, antihistamines, cough suppressants, and anti-bacterial agents. Nearly 99% are generic, which is the system default when prescribing a medication. Teladoc does not prescribe DEA controlled substances, lifestyle drugs, pain medications or psychotropic drugs. Our behavioral health solution has some non-controlled behavioral health medications. Eligibility Criteria: Members statewide. Limits and Restrictions: None.

Promoting Value-added Services

Members receive information about value-added services in several ways. In addition to the enrollment broker providing a list of each MCO's value-added services to members in their enrollment packet, our comprehensive communication strategy provides our members with information about value-added services through many channels:

- Member Handbook
- Member portal, available at healthplan.org
- Member newsletter, HealthySense, published and sent to members twice annually
- Postcard reminders (e.g., postcards for dental exams for 2-3 year olds)
- Letters advising members they have qualified for value-added services, based upon claims data (e.g., pregnancy, well-child exam)
- Local community events (e.g., schools, health fairs)
- Customer service representatives (CSRs) through our customer service center, available Monday-Friday from 8 am – 5 pm EST
- Outreach staff and care managers share value-added services information with members during their discussions

Figure 1: Value-added services flyer. Our printed flyer helps members and providers better understand our value-added services.

We also communicate our value-added services to the provider community through our Provider Practitioner Manual and provider portal. Our provider engagement specialists share value-added services information with providers and their staff during meetings and other opportunities.

If a member has a question about any of our value-added services, they can simply call our customer service and talk with one of our highly trained CSRs. Alternatively,

members can contact our member advocates. Each CSR and member advocate receives training on available value-added services that helps assure all member inquiries are addressed immediately. Our CSRs and member advocates have access to value-added services information, including detailed descriptions, eligibility, limits and member access requirements. When value-added services are changed, we train our staff on the changes.

Monitoring Use of Value-added Services
We continually monitor member usage of our value-added services to verify that the services are being used and that members stay within the $250 annual maximum limit. For example, from March 1, 2019 through January 1, 2020, we realized the following utilization:

- 501 members received a $50 gift card for a diabetes screening
- 691 members received a $25 gift card for a pediatric dental visit
- 121 members received a $50 gift card for a prenatal visit in their first trimester
- 678 members received a $50 gift card for a prenatal visit in their third trimester
- 1,310 members received a $50 gift card for a postpartum screening
- 1,444 members received a $25 gift card for a well visit

Per the Service Provider Agreement, we will notify the member if a request for a value-added service is not approved. To date, THP has always approved requests for value-added services and we anticipate continuing this practice.

Specifications				Vendor Response	
Req ID #	Hierarchy Level	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	General	P. 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	General	P. 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	Benefit Administration	P. 2
BA002	2	Medical Services (includes Physical, Behavioral Health, Dental, and Vision)	Benefit Administration	Benefit Administration	P. 2
BA003	2	Pharmacy Services	Benefit Administration	Benefit Administration	P. 2
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	Benefit Administration	P. 5
BA005	1	The Vendor should provide its training curriculum for Utilization Management (UM) and clinical staff.	Benefit Administration	Benefit Administration	P. 8
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	Benefit Administration	P. 17
BA007	2	Ongoing monitoring of Emergency Room (ER) utilization	Benefit Administration	Benefit Administration	P. 17
BA008	2	Ongoing monitoring of potential abuse or inappropriate utilization of controlled prescription medications	Benefit Administration	Benefit Administration	P. 17
BA009	2	Reports and other tools that will be used to monitor and manage service utilization	Benefit Administration	Benefit Administration	P. 17
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	Benefit Administration	P. 17

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
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	Benefit Administration	P. 39
BA012	2	Standing referrals	Benefit Administration	Benefit Administration	P. 42
BA013	2	Expedited utilization review processes	Benefit Administration	Benefit Administration	P. 43
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	Benefit Administration	P. 39
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	Benefit Administration	P. 39
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	Benefit Administration	P. 44
BA017	2	Medical Services (includes Physical, Behavioral Health, Dental, and Vision)	Benefit Administration	Benefit Administration	P. 44
BA018	2	Pharmacy	Benefit Administration	Benefit Administration	P. 44
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	Benefit Administration	P. 46

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
BA020	1	The Vendor should describe its process for authorizing out-of-network access including, but not limited to, the following:	Benefit Administration	Benefit Administration	P. 48
BA021	2	Emergency Services, including transportation	Benefit Administration	Benefit Administration	P. 51
BA022	2	Medically Necessary Travel, for the West Virginia Children's Health Insurance Program (WVCHIP)	Benefit Administration	Benefit Administration	P. 51
BA023	2	Medical Necessity	Benefit Administration	Benefit Administration	P. 51
BA024	2	Out-of-State Providers (for example, members who are students, live in proximity to State borders, etc.)	Benefit Administration	Benefit Administration	P. 53
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	Benefit Administration	P. 54
BA026	1	The Vendor should describe the extent to which a specialist provider may refer services.	Benefit Administration	Benefit Administration	P. 55
BA027	1	The Vendor should describe its process for out-of-network referrals, including, but not limited to, the following:	Benefit Administration	Benefit Administration	P. 55
BA028	2	Members and/or providers requesting out-of-network referrals	Benefit Administration	Benefit Administration	P. 55
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	Benefit Administration	P. 56
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	Benefit Administration	P. 56
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	Benefit Administration	P. 56
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	Benefit Administration	P. 59

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	Benefit Administration	P. 60
BA034	1	The Vendor should describe its process for member access and coverage of Family Planning services.	Benefit Administration	Benefit Administration	P. 60
BA035	1	The Vendor should describe its process for accessing crisis stabilization services.	Benefit Administration	Benefit Administration	P. 61
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.	Benefit Administration	Benefit Administration	P. 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	Benefit Administration	P. 66
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	Benefit Administration	P. 67
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	Benefit Administration	P. 67
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	Benefit Administration	P. 69
BA041	2	What constitutes a change in behavioral health status	Benefit Administration	Benefit Administration	P. 70
BA042	2	How the member will be assisted to access additional services as a result of a change in behavioral health status	Benefit Administration	Benefit Administration	P. 70

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
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	Benefit Administration	P. 72
BA044	1	The Vendor should describe its mechanisms to remind members of upcoming appointments, including, but not limited to, the following:	Benefit Administration	Benefit Administration	P. 74
BA045	2	Medical Appointments and Screenings	Benefit Administration	Benefit Administration	P. 74
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	Benefit Administration	P. 74
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	Benefit Administration	P. 64
CM001	1	The Vendor should describe its Care Management program, including, but not limited to, the following:	Care Management	Care Management	P. 5
CM002	2	Processes to organize its care management department by disease or problem type	Care Management	Care Management	P. 5
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	Care Management	P. 9
CM004	2	Processes and timeframes for assigning members to a care manager	Care Management	Care Management	P. 22
CM005	2	Processes for identifying candidates for care management, or those receiving high-cost care, who would benefit from care management	Care Management	Care Management	P. 9
CM006	2	Processes for how care managers will establish relationships with members, including frequency and timeliness standards after the initial health assessment	Care Management	Care Management	P. 23

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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	Care Management	P. 25
CM008	2	Processes to ensure continuity and coordination of care	Care Management	Care Management	P. 27
CM009	2	Processes to identify pregnant women at enrollment and on an ongoing basis	Care Management	Care Management	P. 35
CM010	2	Processes to promote "early and often" prenatal care for women identified as being pregnant	Care Management	Care Management	P. 35
CM011	2	Processes for Supplemental Security Income (SSI) members, if different	Care Management	Care Management	P. 39
CM012	2	Processes for administering care management for both adults and children	Care Management	Care Management	P. 41
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	Care Management	P. 42
CM014	2	Processes for administering care management for children with special health care needs (CSHCN)	Care Management	Care Management	P. 45
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	Care Management	P. 46
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	Care Management	P. 51
CM017	2	Members with special health care needs, defined as individuals with complex or serious medical conditions	Care Management	Care Management	P. 52
CM018	2	Children with special health care needs (CSHCN)	Care Management	Care Management	P. 53
CM019	2	Clinical, social, or other criteria used to determine which members require care management and assignment to care managers	Care Management	Care Management	P. 53
CM020	2	Performance of health assessments	Care Management	Care Management	P. 51
CM021	2	Implementation of targeted education programs	Care Management	Care Management	P. 54

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CM022	1	The Vendor should describe its process for creating educational materials and educating members and care management staff.	Care Management	Care Management	P. 56
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	Care Management	P. 56
CM024	1	The Vendor should describe its process for hiring care management staff including, but not limited to, the following:	Care Management	Care Management	P. 64
CM025	2	Staff qualifications	Care Management	Care Management	P. 56
CM026	2	Plan for hiring	Care Management	Care Management	P. 64
CM027	2	Timeframe for hiring	Care Management	Care Management	P. 64
CM028	2	Total number of care managers to be hired	Care Management	Care Management	P. 64
CM029	2	Maximum case loads and ratios per care manager for Vendor-defined risk tiers	Care Management	Care Management	P. 65
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	Care Management	P. 65
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	Care Management	P. 66
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	Care Management	P. 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	Care Management	P. 68
CM034	2	Including Primary Care Providers (PCPs) in the development of treatment plans	Care Management	Care Management	P. 71

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CM035	2	Sharing treatment plans with the member's PCP or other providers, as applicable	Care Management	Care Management	P. 71
CM036	2	Staff responsible for sharing treatment plans with the member's PCP	Care Management	Care Management	P. 71
CM037	2	Tracking of completion of treatment plans	Care Management	Care Management	P. 72
CM038	2	Identification, tracking, and remediation of gaps in care	Care Management	Care Management	P. 73
CM039	2	Processes for episodic and/or catastrophic care management interventions	Care Management	Care Management	P. 76
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	Care Management	P. 78
CM041	2	Identification	Care Management	Care Management	P. 78
CM042	2	Actions taken to improve coordination	Care Management	Care Management	P. 79
CM043	1	The Vendor should describe its programs for coordination of care with community resources and social services for members.	Care Management	Care Management	P. 81
CM044	1	The Vendor should describe its approach to address Social Determinants of Health (SDOH).	Care Management	Care Management	P. 85
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	Care Management	P. 88
CM046	2	Employment	Care Management	Care Management	P. 89
CM047	2	Food security	Care Management	Care Management	P. 89
CM048	2	Housing stability	Care Management	Care Management	P. 89
CM049	2	Education	Care Management	Care Management	P. 89
CM050	2	Social cohesion	Care Management	Care Management	P. 89
CM051	2	Resources that connect members to social supports and healthcare	Care Management	Care Management	P. 89
CM052	2	Environmental needs	Care Management	Care Management	P. 89
CM053	1	The Vendor should describe its plan to develop additional programs for Social Determinants of Health (SDOH).	Care Management	Care Management	P. 90
CM054	1	The Vendor should describe its population health approach including, but not limited to, the following:	Care Management	Care Management	P. 95
CM055	2	Engaging members across the entire care continuum	Care Management	Care Management	P. 95

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CM056	2	Promoting and incentivizing healthy behaviors and disease self-management	Care Management	Care Management	P. 102
CM057	2	Integrating care management	Care Management	Care Management	P. 103
CM058	2	Advancing evidence-based practices	Care Management	Care Management	P. 106
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	Care Management	P. 95
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	Care Management	P. 108
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	Care Management	P. 110
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	Care Management	P. 111
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	Care Management	P. 112
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	Care Management	P. 112

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CS001	1	The Vendor should describe its approach to establishing and maintaining relationships with associated Department agencies and State advocacy groups.	Community/Stakeholder Engagement	Community/ Stakeholder Engagement	P. 3
CS002	1	The Vendor should describe its approach to establishing and maintaining relationships with applicable provider and medical associations.	Community/Stakeholder Engagement	Community/ Stakeholder Engagement	P. 6
CS003	1	The Vendor should describe its approach to establishing and maintaining relationships with applicable professional boards.	Community/Stakeholder Engagement	Community/ Stakeholder Engagement	P. 11
CS004	1	The Vendor should describe its process to coordinate with agencies providing complimentary services to the member.	Community/Stakeholder Engagement	Community/ Stakeholder Engagement	P. 12
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	Member Services	P. 3
MS002	1	The Vendor should describe how they will leverage information technology (IT) solutions to improve access to member information.	Member Services	Member Services	P. 5
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	Member Services	P. 15
MS004	1	The Vendor should describe how they will develop protocols to notify members of Primary Care Provider (PCP) assignment.	Member Services	Member Services	P. 16
MS005	1	The Vendor should describe how they will educate members of the right to change Primary Care Providers (PCPs).	Member Services	Member Services	P. 16
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	Member Services	P. 20
MS007	2	Methods utilized to complete assessments, and variances by risk level	Member Services	Member Services	P. 20
MS008	2	Timeline to complete assessments, and variances by risk level	Member Services	Member Services	P. 20

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MS009	2	Identification of the trigger(s) for completion of a comprehensive assessment	Member Services	Member Services	P. 20
MS010	2	How assessments will be used to develop and update treatment plans and confirm the risk stratification level for each member	Member Services	Member Services	P. 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	Member Services	P. 20
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	Member Services	P. 20
MS013	2	How assessment data will be stored and made available to members of the care team in order to coordinate care	Member Services	Member Services	P. 20
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	Member Services	P. 21
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	Member Services	P. 32
MS016	2	Updates to the member handbook	Member Services	Member Services	P. 33
MS017	2	Handbooks requested ad hoc by a member	Member Services	Member Services	P. 33
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	Member Services	P. 34
MS019	1	The Vendor should describe how they will train member services representatives.	Member Services	Member Services	P. 34
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	Member Services	P. 38
MS021	2	Member-to-representative ratios	Member Services	Member Services	P. 38
MS022	2	Call answering time, with a minimum of 83% of calls answered in thirty (30) seconds	Member Services	Member Services	P. 38
MS023	2	Call abandonment rate not to exceed five percent (5%)	Member Services	Member Services	P. 38

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Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
MS024	2	Single contact resolution	Member Services	Member Services	P. 38
MS025	2	Turnaround time for member requests	Member Services	Member Services	P. 38
MS026	2	Remediation strategies for performance issues	Member Services	Member Services	P. 38
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	Member Services	P. 40
MS028	2	Member contact, including welcome calls, welcome letters, and/or home visits	Member Services	Member Services	P. 40
MS029	2	Outreach to members who are difficult to contact, including disabled members and members without telephones	Member Services	Member Services	P. 40
MS030	2	Processing and issuing identification cards	Member Services	Member Services	P. 40
MS031	2	Distributing member handbooks	Member Services	Member Services	P. 33
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	Member Services	P. 40
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	Member Services	P. 45
MS034	2	Medical records	Member Services	Member Services	P. 45
MS035	2	Authorization status	Member Services	Member Services	P. 45
MS036	2	Cost sharing information	Member Services	Member Services	P. 45
MS037	2	Temporary identification (ID) cards	Member Services	Member Services	P. 45
MS038	2	Confirmation of Primary Care Provider (PCP)	Member Services	Member Services	P. 45
MS039	2	Provision of access to guardians	Member Services	Member Services	P. 45
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	Member Services	P. 47

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
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	Member Services	P. 47
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	Member Services	P. 47
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	Member Services	P. 47
MS044	1	The Vendor should describe its policies and procedures related to issuance of member identification cards within contractually defined timeframes.	Member Services	Member Services	P. 40
MS045	1	The Vendor should describe how they will administer a health education program for disease and injury prevention and identification.	Member Services	Member Services	P. 49
MS046	1	The Vendor should describe its tobacco-cessation program.	Member Services	Member Services	P. 49
MS047	1	The Vendor should describe how they will leverage community events/resources to help improve the health of its member population.	Member Services	Member Services	P. 52
MS048	1	The Vendor should describe how they will foster cultural competency among staff.	Member Services	Member Services	P. 58

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
ED001	1	The Vendor should describe its policies and procedures regarding enrollment of members, including the processing of 834 enrollment files.	Enrollment and Disenrollment	Enrollment and Disenrollment	P. 2
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	Enrollment and Disenrollment	P. 9
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	Enrollment and Disenrollment	P. 12
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	Enrollment and Disenrollment	P. 14
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	Enrollment and Disenrollment	P. 14
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	Network Development	P. 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	Network Development	P. 7
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	Network Development	P. 8

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
ND004	2	The anticipated MHT enrollment and the appropriate PCP provider-to-member ratios for adult and pediatric members	Network Development	Network Development	P. 8
ND005	2	The expected utilization of services for the anticipated MHT populations assigned to the Vendor for care	Network Development	Network Development	P. 8
ND006	2	The number of providers not accepting new patients	Network Development	Network Development	P. 8
ND007	2	The geographic location of providers and members, considering time and distance, and transportation needs	Network Development	Network Development	P. 8
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	Network Development	P. 8
ND009	1	The Vendor should describe how they ensure its provider network will provide culturally competent care to members.	Network Development	Network Development	P. 11
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	Network Development	P. 13
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	Network Development	P. 17
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	Network Development	P. 20
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	Network Development	P. 21

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
ND014	1	The Vendor should describe its guidelines and monitoring processes that ensure members have timely access to care per contractual requirements.	Network Development	Network Development	P. 24
ND015	1	The Vendor should describe its process for the selection, credentialing, retention, and maintaining of qualified providers.	Network Development	Network Development	P. 26
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-medicaid-managed-care-chip-delivered).	Network Development	Network Development	P. 32
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	Network Development	P. 34
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	Network Development	P. 35
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	Network Development	P. 37

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
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	Network Development	P. 37
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	Network Development	P. 37
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	Network Development	P. 37
ND023	2	Immediate notification of a hospital termination to the Department	Network Development	Network Development	P. 37
PS001	1	The Vendor should provide a description of its Provider Services operating model.	Provider Services	Provider Services	P. 1
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	Provider Services	P. 12
PS003	1	The Vendor should describe its process for specialists serving as Primary Care Providers (PCPs), and related monitoring activities.	Provider Services	Provider Services	P. 15
PS004	1	The Vendor should describe how its Provider Services Department will provide training to its provider network regarding culturally competent care.	Provider Services	Provider Services	P. 17
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	Provider Services	P. 19
PS006	1	The Vendor should describe how members are held harmless and protected from balance billing for covered services.	Provider Services	Provider Services	P. 21
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	Provider Services	P. 23

Specifications				Vendor Response	
Req ID #	Hierarchy Level	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	Provider Services	P. 31
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	Claims and Encounters	P. 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	Claims and Encounters	P. 12
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	Claims and Encounters	P. 13
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	Claims and Encounters	P. 12

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/nationalcorrectcodinited/index.html).	Claims and Encounters	Claims and Encounters	P. 14
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	Claims and Encounters	P. 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	Claims and Encounters	P. 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	Claims and Encounters	P. 28
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	Claims and Encounters	P. 18
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	Claims and Encounters	P. 18
CE011	1	The Vendor should provide its annual encounter data accuracy and completeness plan with its bid.	Claims and Encounters	Claims and Encounters	P. 18
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	Claims and Encounters	P. 29

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
CE013	2	A detailed summary of the file submission that includes total claims and dollars by service category	Claims and Encounters	Claims and Encounters	P. 29
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	Claims and Encounters	P. 29
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	Claims and Encounters	P. 30
QU001	1	The Vendor should describe its Quality Assessment and Performance Improvement (QAPI) Program.	Quality	Quality	P. 2
QU002	1	The Vendor should describe how they will coordinate Quality Assessment and Performance Improvement (QAPI) activities with other performance monitoring activities.	Quality	Quality	P. 6
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	Quality	P. 11
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	Quality	P. 6
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	Quality	P. 17
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	Quality	P. 19

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
QU007	1	The Vendor should describe how they will administer the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey.	Quality	Quality	P. 22
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	Quality	P. 22
QU009	1	The Vendor should describe how they will gather, report, and utilize audited Healthcare Effectiveness Data and Information Set (HEDIS) measures.	Quality	Quality	P. 25
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	Quality	P. 25
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	Quality	P. 32

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
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	Quality	P. 33
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	Quality	P. 40
QU014	1	The Vendor should describe how they will use data to identify barriers to care for individuals with special health care needs.	Quality	Quality	Removed Add. 5
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	Quality	P. 46
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	Program Integrity	P. 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	Program Integrity	P. 7

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
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	Program Integrity	P. 14
PI004	1	The Vendor should describe how they will maximize resources for fraud, waste and abuse (FWA) issues.	Program Integrity	Program Integrity	P. 1
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	Program Integrity	P. 14
PI006	1	The Vendor should provide its compliance plan with clear goals, timelines, assignments, and measurements as outlined by the Department.	Program Integrity	Program Integrity	P. 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	Program Integrity	P. 18
PI008	1	The Vendor should describe its disciplinary guidelines and procedures for enforcement of compliance standards.	Program Integrity	Program Integrity	P. 18
PI009	1	The Vendor should describe its procedures for routine internal monitoring, auditing, and remediation of compliance risks and identified issues.	Program Integrity	Program Integrity	P. 18
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	Program Integrity	P. 30
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	Program Integrity	P. 37

Specifications				Vendor Response	
Req ID #	Hierarchy Level	Specification Text	Subject Matter Area	Section	Page #
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	Program Integrity	P. 40
PI013	1	The Vendor should describe its policies regarding identification and recoupment of provider overpayments, and processes to coordinate with the Department.	Program Integrity	Program Integrity	P. 47
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	Information Management Systems	P. 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	Information Management Systems	P. 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	Information Management Systems	P. 1
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	Information Management Systems	P. 11
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	Information Management Systems	P. 12

Specifications				Vendor Response	
Req ID #	Hierarchy Level	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	Information Management Systems	P. 22

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.

Jeff M. Knight, CEO/COO — 2/4/2020

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.

Jeff M. Knight, CEO/COO — 2/4/2020

Printed Name / Signature of Authorized Personnel — Date

If the Vendor is <u>not taking exceptions</u> to any of the State Customary Terms and Conditions, then the Vendor needs to provide a binding signature stipulating its acceptance of these documents.

Jeff M. Knight, CEO/COO — 2/4/2020

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 5, 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.

Jeff M. Knight, CEO/COO — 2/4/2020

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.

The Health Plan of West Virginia, Inc. has not identified exceptions to the State's Terms and Conditions. Therefore, according to the instructions provided in the paragraph above, we are not required to complete the West Virginia Addendum to Vendor's Standard Contractual Form (WV-96) and have not submitted it as part of our response.

West Virginia
Offices of the Insurance Commissioner

Certificate of Authority

Whereas, **THE HEALTH PLAN OF WEST VIRGINIA, INC.**, a HMO of **WEST VIRGINIA**, has complied with all the necessary requirements of the laws of this State so as to entitle it to transact its appropriate business in **Barbour, Berkeley, Boone, Braxton, Brooke, Cabell, Calhoun, Clay, Doddridge, Fayette, Gilmer, Grant, Greenbrier, Hampshire, Hancock, Hardy, Harrison, Jackson, Jefferson, Kanawha, Lewis, Lincoln, Logan, Marion, Marshall, Mason, McDowell, Mercer, Mineral, Mingo, Monongalia, Morgan, Monroe, Nicholas, Ohio, Pleasants, Pendleton, Pocahontas, Preston, Putnam, Raleigh, Randolph, Ritchie, Roane, Summers, Taylor, Tucker, Tyler, Upshur, Wayne, Webster, Wetzel, Wirt, Wood and Wyoming** counties, in the State of West Virginia.

Therefore, I the undersigned, Insurance Commissioner of the State of West Virginia, pursuant to the authority vested in me by the laws of this State, do hereby authorize it to operate in the aforementioned counties in the State of West Virginia as defined in Chapter 33

HEALTH MAINTENANCE ORGANIZATION - ARTICLE 25A

of the 1931 Code of West Virginia as amended, in the State of West Virginia in accordance with the laws thereof until midnight on the 31st day of May, 2020, unless this license may be sooner suspended or revoked.

In Testimony Whereof, I have hereunto set my hand and affixed my seal of office at the City of Charleston this 1st day of June, 2019.

James A. Dodrill
Insurance Commissioner

NAIC # 95677

Legacy State ID # D030

dun & bradstreet

CreditBuilder™

HEALTH PLAN OF WEST VIRGINIA, INC., THE - Full Company View | Saved by **Jeremy Piergallini** | 01-17-2020

Report as of: 01-17-2020

HEALTH PLAN OF WEST VIRGINIA, INC., THE

Tradestyle(s): HEALTH PLAN

ACTIVE | GLOBAL ULTIMATE

Address: 1110 Main St. Wheeling, WV, 26003, UNITED STATES

Alerts:

Risk Assessment

D&B Guidance

Overall Business Risk

LOW | LOW-MODERATE | MODERATE | MODERATE-HIGH | HIGH

Maximum Credit Recommendation

US$ 600,000

The recommended limit is based on a low probability of severe delinquency.

Dun & Bradstreet Thinks...

- Overall assessment of this company: **VERY STABLE CONDITION**
- Based on the perceived sustainability of this company: **HIGH LIKELIHOOD OF CONTINUED OPERATIONS**
- Based on the payment behavior of this company: **VERY-LOW-POTENTIAL-FOR-SEVERELY-DELINQUENT-PAYMENTS**

PAYDEX® Score

Based on 24 months of data

73

Low Risk (100) High Risk (1)

Based on a D&B PAYDEX® Score of 73

Risk of Slow Pay
Low

Payment Behavior
11 Days Beyond Terms

Business and Industry Trends

Understand My Score

Payment History

Total Last 24 Months: 33

View All

Date of Experience	Payment Status	Selling Terms	High Credit (US$)	Now Owes (US$)	Past Due (US$)	Months Since Last Sale
12/19	Pays Promptly	-	50	0	0	Between 2 and 3 Months
12/19	Pays Promptly	-	250	0	0	1
12/19	Pays Promptly	N30	2,500	0	0	Between 6 and 12 Months
12/19	Pays Promptly	-	2,500	0	0	1
12/19	Pays Promptly	N30	2,500	0	0	1

Keys

PAYDEX®	Payment Practices
100	Anticipate
90	Discount
80	Prompt
70	15 Days Beyond Terms
60	22 Days Beyond Terms
50	30 Days Beyond Terms
40	60 Days Beyond Terms
30	90 Days Beyond Terms
20	120 Days Beyond Terms
1-19	Over 120 Days Beyond Terms
UN	Unavailable

Delinquency Predictor Score

94

Low Risk (100) High Risk (1)

Based on a D&B Delinquency Predictor Percentile of 94

Score
593

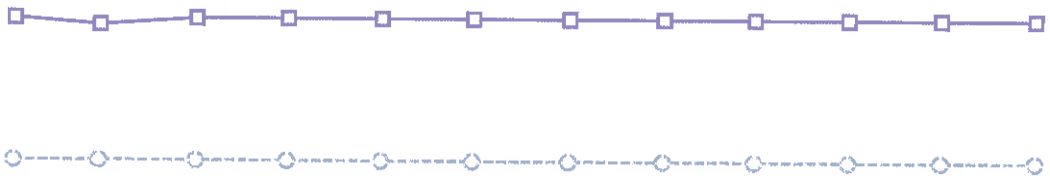
Class
1

Factors Affecting Your Score:

- Higher risk industry based on delinquency rates for this industry

Level of risk	Probability of Delinquency	Compared to Businesses in D&B Database
Low	1.25%	10.2%

Business and Industry Trends



Financial Stress Score

71

Low Risk (100) High Risk (1)

Based on a D&B Financial Stress Percentile of 71

Score	Class
1514	2

Factors Affecting Your Score:

- UCC Filings reported
- High proportion of past due balances to total amount owing

Level of risk	Probability of Failure	Average Probability of Failure for Businesses in D&B Database
Low-Moderate	0.13%	0.48%

Business and Industry Trends

Supplier Evaluation Risk Rating

Based on 24 months of data

1

Low Risk (1) High Risk (9)

Factors Affecting Your Score:

Business and Industry Trends

D&B Rating

Current Rating as of 01-15-2020

Employee Size

ER2 :

500 to 999 employees

Previous Rating

Employee Size

ER2 :

500 to 999 employees

Risk Indicator

3 : Moderate Risk

D&B Viability Rating

Portfolio Comparison Score

1

Low Risk (1) High Risk (9)

Level of risk

Low

Rating Confidence Level

Robust Predictions

Probability of becoming no longer viable

2%

Percentage of businesses ranked with this score

11%

Average probability of becoming no longer viable

5%

Viability Score

2

Low Risk(1) High Risk (9)

Level of risk

Low

Probability of becoming no longer viable

2%

Percentage of businesses ranked with this score

14%

Average probability of becoming no longer viable

4%

Data Depth Indicator

A

Predictive (A)

Descriptive (G)

- Rich Firmographics
- Extensive Commercial Trading Activity
- Comprehensive Financial Attributes

Company Profile

	Financial Data	Trade Payments	Company Size	Years in Business
G	Not Available	Available	Large	Established

Compared to ALL US Businesses within the D&B Database:

- Financial Data : Not Available
- Trade Payments : Available: 3+Trade
- Company Size : Large: Employees:50+ or Sales: $500K+
- Years in Business : Established: 5+

Trade Payments

Trade Payments Summary

Overall Payment Behavior

11

Days Beyond Terms

% of Trade Within Terms

96%

Highest Past Due

US$ 0

Highest Now Owing:

US$ 1,000

Total Trade Experiences:

33

Largest High Credit:
US$ 70,000

Average High Credit:
US$ 4,288

Total Unfavorable Comments :

0

Largest High Credit:
US$ 0

Total Placed in Collections:

0

Largest High Credit:
US$ 0

Trade Payments By Credit Extended

Dispute Payments

Range of Credit Extended (US$)	Number of Payment Experiences	% Within Terms
100,000 -	0	0
50,000 - 99,999	1	100
15,000 - 49,999	1	0

5,000 - 14,999	1	100
1,000 - 4,999	6	100
- 999	17	100

Trade Payments By Industry

Industry Category	Number of Payment Experiences	Largest High Credit (US$)	% Within Terms (Expand to View)
35 - Industrial and Commercial Machinery and Computer Equipment	2	2,500	
3534 - Mfg elevator/escaltrs	1	2,500	100
3572 - Mfg computer storage	1	2,500	100
48 - Communications	4	500	
4812 - Radiotelephone commun	1	500	100
4813 - Telephone communictns	3	250	100
49 - Electric, Gas and Sanitary Services	2	50	
4911 - Electric services	2	50	100
50 - Wholesale Trade - Durable Goods	2	20,000	
5044 - Whol office equipment	1	50	100
5084 - Whol industrial equip	1	20,000	0
51 - Wholesale Trade - Nondurable Goods	2	2,500	
5112 - Whol office supplies	1	2,500	100
5113 - Whol service paper	1	50	100
59 - Miscellaneous Retail	1	50	
5961 - Ret mail-order house	1	50	100
60 - Depository Institutions	1	2,500	
6021 - Natnl commercial bank	1	2,500	100
61 - Nondepository Credit Institutions	6	50	
6159 - Misc business credit	6	50	100

62 - Security and Commodity Brokers Dealers Exchanges and Services	2	1,000	
6282 - Investment advice	2	1,000	100
73 - Business Services	2	750	
7363 - Help supply service	1	750	100
7389 - Misc business service	1	0	0
91 - Executive Legislative and General Government except Finance	2	5,000	
9111 - Executive office	2	5,000	100
93 - Public Finance Taxation and Monetary Policy	1	70,000	
9311 - Public finance	1	70,000	100

Trade Lines

Date of Experience	Payment Status	Selling Terms	High Credit (US$)	Now Owes (US$)	Past Due (US$)	Months Since Last Sale
12/19	Pays Promptly	-	50	0	0	Between 2 and 3 Months
12/19	Pays Promptly	-	250	0	0	1
12/19	Pays Promptly	N30	2,500	0	0	Between 6 and 12 Months
12/19	Pays Promptly	-	2,500	0	0	1
12/19	Pays Promptly	N30	2,500	0	0	1
12/19	Pays Promptly	-	-	1,000	0	1
12/19	Pays Promptly	-	-	750	0	1
12/19	Pays Promptly	-	-	100	0	1
12/19	Pays Promptly	-	-	250	0	1
12/19	Pays Promptly	-	-	500	0	1

11/19	Pays Promptly	Lease Agreemnt	50	50	0	1
11/19	Pays Promptly	-	50	0	0	1
11/19	Pays Promptly	-	750	0	0	Between 6 and 12 Months
11/19	Pays Promptly	-	2,500	0	0	Between 6 and 12 Months
09/19	Pays Promptly	-	500	0	0	Between 2 and 3 Months
09/19	Pays Promptly	-	1,000	0	0	Between 4 and 5 Months
08/19	Pays Promptly	-	0	0	0	Between 6 and 12 Months
06/19	-	Cash account	50	-	-	Between 4 and 5 Months
05/19	-	Cash account	50	-	-	1
04/19	-	Cash account	50	-	-	1
04/19	Pays Promptly	-	50	50	0	1
04/19	Pays Promptly	-	50	50	0	1
04/19	Pays Promptly	-	70,000	-	-	1
11/18	Pays Promptly	N30	50	0	0	Between 6 and 12 Months
06/18	-	Sales COD	-	-	-	1
06/18	Pays Promptly	N30	50	0	0	Between 6 and 12 Months
04/18	-	Cash account	250	0	0	Between 6 and 12 Months
04/18	Pays Promptly	-	500	-	-	1
04/18	Pays Promptly	-	5,000	-	-	1
03/18	Pays Slow 30-90+	N30	20,000	0	0	Between 6 and 12 Months
12/17	cash own option	-	50	-	-	1

12/17	Pays Promptly	-	50	0	0	Between 6 and 12 Months
12/17	Pays Promptly	-	500	500	0	1

Legal Events

The following Public Filing data is for information purposes only and is not the official record. Certified copies can only be obtained from the official source.

Judgments	Liens	Suits	UCC Filings
0	0	0	10
Latest Filing: -	Latest Filing: -	Latest Filing: -	Latest Filing: 11-19-2010

Events

UCC Filing - Original

Dispute UCC Filing

Filing Date	11-19-2010
Filing Number	201038362626
Received Date	01-18-2011
Collateral	Business machinery/equipment
Secured Party	IKON FINANCIAL SVCS, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO
Filing Office	UCC DIVISION, CHARLESTON, WV

UCC Filing - Original

Filing Date	04-09-2010
Filing Number	201038272411
Received Date	06-22-2010
Collateral	Leased Business machinery/equipment including proceeds and products

Secured Party	IKON FINANCIAL SVCS, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO
Filing Office	UCC DIVISION, CHARLESTON, WV

UCC Filing - Original

Filing Date	08-12-2009
Filing Number	200938185402
Received Date	08-31-2009
Collateral	Leased Equipment including proceeds and products
Secured Party	IKON FINANCIAL SVCS, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO
Filing Office	UCC DIVISION, CHARLESTON, WV

UCC Filing - Original

Filing Date	07-23-2009
Filing Number	200938178027
Received Date	08-31-2009
Collateral	Leased Equipment including proceeds and products
Secured Party	IKON FINANCIAL SVCS, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO
Filing Office	UCC DIVISION, CHARLESTON, WV

UCC Filing - Original

Filing Date	12-13-2007
Filing Number	200700135021
Received Date	01-15-2008
Collateral	Leased Equipment including proceeds and products
Secured Party	IKON FINANCIAL SVCS, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO

Filing Office	UCC DIVISION, CHARLESTON, WV

UCC Filing - Original

Filing Date	12-12-2007
Filing Number	200700134853
Received Date	01-15-2008
Collateral	Leased Equipment including proceeds and products
Secured Party	IKON FINANCIAL SVCS, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO
Filing Office	UCC DIVISION, CHARLESTON, WV

UCC Filing - Original

Filing Date	01-19-2007
Filing Number	200701014254
Received Date	02-16-2007
Collateral	Leased Business machinery/equipment including proceeds and products
Secured Party	IOS CAPITAL, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO
Filing Office	UCC DIVISION, CHARLESTON, WV

UCC Filing - Original

Filing Date	02-23-2006
Filing Number	200600841991
Received Date	03-10-2006
Collateral	Leased Equipment including proceeds and products
Secured Party	IOS CAPITAL, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO
Filing Office	UCC DIVISION, CHARLESTON, WV

UCC Filing - Original

Filing Date	01-10-2006
Filing Number	200600820391
Received Date	02-17-2006
Collateral	Leased Equipment including proceeds and products
Secured Party	IOS CAPITAL, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO
Filing Office	UCC DIVISION, CHARLESTON, WV

UCC Filing - Original

Filing Date	01-09-2006
Filing Number	200600819728
Received Date	02-17-2006
Collateral	Leased Business machinery/equipment including proceeds and products
Secured Party	IOS CAPITAL, MACON, GA
Debtors	HEALTH PLAN OF THE UPPER OHIO
Filing Office	UCC DIVISION, CHARLESTON, WV

Special Events

07-23-2019
The Chief Executive Officer is now James M Pennington, CEO.

01-09-2018
Business address has changed from 52160 National Rd E, Saint Clairsville, OH, 43950 to 1110 Main Street, Wheeling, WV, 26003.

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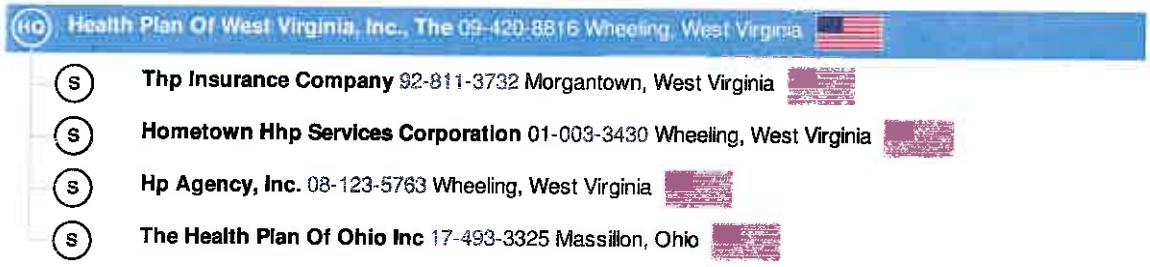
Ownership

Family Tree

Members in the Tree	Subsidiaries of this Company	Branches of this Company
5	4	0

Exclude Branches



Company Profile

Company Overview

D-U-N-S
09-420-8816

Mailing Address
United States

Annual Sales
US$ 710,433,854

Legal Form
Corporation (US)

Telephone
(740) 695-3585

Employees
550 (260 here)

Date Incorporated
August 8, 1978

Website
www.healthplan.org

Age (Year Started)
41 years (1979)

State of Incorporation
West Virginia

Named Principal
JEFFREY M KNIGHT, COO

Ownership
Not publicly traded

Line of Business
Hospital/medical service plan

Business Registration

Corporate and business registrations reported by the secretary of state or other official source as of: 01-15-2020
This data is for informational purposes only, certification can only be obtained through the Office of the Secretary of State.

Registered Name	HEALTH PLAN OF WEST VIRGINIA, INC., THE
Corporation Type	Corporation (US)
Business Commenced On	1979
State of Incorporation	WEST VIRGINIA
Date Incorporated	08-08-1978
Registration ID	13078
Registration Status	ACTIVE
Filing Date	08-08-1978

Where Filed	CORPORATIONS DIVISION

Registered Agent

Name	JAMES M. PENNINGTON, PRES./CEO
Address	1110 MAIN STREET, WHEELING, WV, 260030000

Registered Principal

Name	KAREN T. BONNIE
Title	
Address	6318 UTAH AVE., WASHINGTON, DC, 200010000
Name	JAMES M. PENNINGTON
Title	President
Address	4 HAWTHORNE COURT, WHEELING, WV, 260030000
Name	JEFFREY KNIGHT
Title	Treasurer
Address	145 TIERRA ROAD, WHEELING, WV, 260030000

Principals

Officers

JEFFREY M KNIGHT, COO
RYAN RALSTON, CFO
SUSAN BUCHANAN, SEC

Directors

DIRECTOR(S): THE OFFICER(S)

Company Events

The following information was reported on: 01-15-2020

The West Virginia Secretary of State's business registrations file showed that The Health Plan Of West Virginia, Inc. was registered as a Corporation on August 8, 1978, under the registration file number 13078.

Business started Nov 1 1979 by a group of local doctors.

PHILLIP D WRIGHT. Antecedents are undetermined.

JAMES NEWTON. Antecedents are undetermined.

JOHN J YEAGER. Antecedents are undetermined.

DONALD MOLTER. Antecedents are undetermined.

JERRY FISHER. Antecedents are unknown.

ROLAND L HOBBS. Antecedents are unknown.

Business address has changed from 52160 National Rd E, Saint Clairsville, OH, 43950 to 1110 Main Street, Wheeling, WV, 26003.

Business Activities And Employees

The following information was reported on: 01-15-2020

Business Information

Trade Names	HEALTH PLAN
Description	Operates as a hospital or medical insurance plan carrier, specializing in health maintenance organization (HMO) coverage. Provides home health care services. Terms are on a fee basis from members subscriptions. Sells to general public. Territory : Local Including 25 Counties.
Employees	550 which includes officer(s) and 79 part-time. 260 employed here.
Financing Status	Unsecured
Seasonality	Nonseasonal.

SIC/NAICS Information

SIC Codes	SIC Description	Percentage of Business
6324	Hospital/medical service plan	-
63249903	Health Maintenance Organization (HMO), insurance only	-
80820000	Home health care services	-

NAICS Codes	NAICS Description
524114	Direct Health and Medical Insurance Carriers
621610	Home Health Care Services

Government Activity

Dispute Government Activity

Activity Summary

Borrower(Dir/Guar)	No

Administrative Debt	No
Contractor	No
Grantee	No
Party excluded from federal program(s)	No

Possible candidate for socio-economic program consideration

8(A) Firm	Yes
Labor Surplus Area	Yes
Small Business	Yes

Source: D&B | Currency: All figures shown in USD unless otherwise stated

Financials

Key Business Ratios

	Ratio for the business	Industry Median	Industry Quartile
Profitability			
Short Term Solvency			
Efficiency			
Utilization			

Inquiries

Inquiries-Summary - 12 Month

Total number of Inquiries	Unique Customers
44	32

Inquiries-Summary

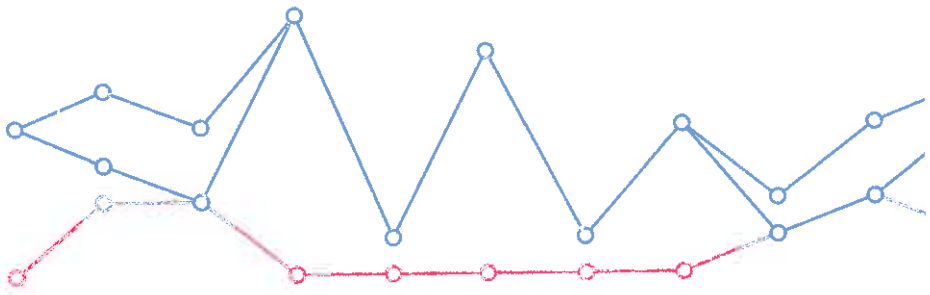
Over the past 12 months ending 1-2020, 44 individual requests for information on your company were received. The 44 inquiries were made by 32 unique customers indicating that some companies have inquired on your business multiple times and may be monitoring you. Of the total products purchased, 16, or 36 % came from the Finance, Insurance and Real Estate; 15, or 34 % came

from the Services; 5, or 11 % came from the Manufacturing; 4, or 9 % came from the Retail Trade; 1, or 2 % came from the Mining;

SIC/Sector	Type	Date
MANUF - Manufacturing		
- Electronic computers	Sales & Marketing Solution	2020-01-09
- Electronic computers	Sales & Marketing Solution	2019-12-15
- Radio and t.v. communications equipment	D&B Risk Solution	2019-05-06
- Office machines, nec	D&B Risk Solution	2019-03-12
- Office machines, nec	D&B Risk Solution	2019-03-12
SERV - Services		
- Business services, nec	D&B Risk Solution	2019-12-19
- Accounting, auditing, and bookkeeping	Sales & Marketing Solution	2019-11-04
- Custom computer programming services	D&B Risk Solution	2019-07-19
- Help supply services	D&B Risk Solution	2019-07-12
- Help supply services	D&B Risk Solution	2019-07-12
- Help supply services	D&B Risk Solution	2019-07-12
- Employment agencies	D&B Risk Solution	2019-05-21
- Custom computer programming services	D&B Risk Solution	2019-05-20
- Data processing and preparation	D&B Risk Solution	2019-05-15
- Data processing and preparation	D&B Risk Solution	2019-05-15
- Employment agencies	General Data Request	2019-04-01
- Home health care services	D&B Risk Solution	2019-03-04
- Employment agencies	General Data Request	2019-03-04
- Passenger car rental	D&B Risk Solution	2019-02-06
- Passenger car rental	D&B Risk Solution	2019-02-06
OTHER - Other		
- Other	D&B Risk Solution	2019-07-22
RETLTRD - Retail Trade		
- Miscellaneous retail stores, nec	D&B Risk Solution	2019-11-21
- Miscellaneous retail stores, nec	D&B Risk Solution	2019-11-21
- Catalog and mail-order houses	D&B Risk Solution	2019-07-18
- Computer and software stores	D&B Risk Solution	2019-06-19
TCEGS - Transportation, Communications, Electric, Gas and Sanitary Services		
- Radio broadcasting stations	D&B Risk Solution	2019-04-15
FIR - Finance, Insurance and Real Estate		
- Surety insurance	D&B Risk Solution	2019-12-22
- Surety insurance	D&B Risk Solution	2019-12-22
- Miscellaneous business credit institutions	D&B Risk Solution	2019-12-09
- Short-term business credit institutions, except agricultural	Corporate Linkage Request	2019-11-22
- Insurance agents, brokers, and service	D&B Risk Solution	2019-10-08
- Investment advice	Corporate Linkage Request	2019-10-07
- Insurance agents, brokers, and service	D&B Risk Solution	2019-09-26
- Life insurance	D&B Risk Solution	2019-09-26
- Hospital and medical service plans	D&B Risk Solution	2019-09-24
- Miscellaneous business credit institutions	D&B Risk Solution	2019-08-05
- Accident and health insurance	D&B Risk Solution	2019-05-07
- Miscellaneous business credit institutions	D&B Risk Solution	2019-04-25

- Miscellaneous business credit institutions	Corporate Linkage Request	2019-04-25
- Surety insurance	General Data Request	2019-03-19
- National commercial banks	D&B Risk Solution	2019-02-06
- National commercial banks	D&B Risk Solution	2019-02-06
MINING - Mining		
- Crude petroleum and natural gas	D&B Risk Solution	2019-09-05
WHLSLTRD - Wholesale Trade		
- Industrial and personal service paper	D&B Risk Solution	2019-05-10

Inquiries Trends - 12 Month



Top-Five-Inquiries

By SIC Sector

Finance, Insurance and Real Estate	16
Services	15
Manufacturing	5
Retail Trade	4
Mining	1

By Report Type

D&B Risk Solution	35
Corporate Linkage Request	3
General Data Request	3
Sales & Marketing Solution	3

All-Inquiries

Industry	Total Inquiries	Last 30 Days	Last 90 Days	Last 180 Days	Last 365 Days
Mining	1	0	0	1	1
Manufacturing	5	1	2	2	5
Transportation, Communications, Electric, Gas and Sanitary Services	1	0	0	0	1
Wholesale Trade	1	0	0	0	1
Retail Trade	4	0	2	2	4
Finance, Insurance and Real Estate	16	2	4	10	16
Services	15	1	2	2	15
Other	1	0	0	1	1

Peers Inquiries

Please add a peer from peers page to start the comparison.

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INSTRUCTIONS TO VENDORS SUBMITTING BIDS

1. REVIEW DOCUMENTS THOROUGHLY: The attached documents contain a solicitation for bids. Please read these instructions and all documents attached in their entirety. These instructions provide critical information about requirements that if overlooked could lead to disqualification of a Vendor's bid. All bids must be submitted in accordance with the provisions contained in these instructions and the Solicitation. Failure to do so may result in disqualification of Vendor's bid.

2. MANDATORY TERMS: The Solicitation may contain mandatory provisions identified by the use of the words "must," "will," and "shall." Failure to comply with a mandatory term in the Solicitation will result in bid disqualification.

3. PREBID MEETING: The item identified below shall apply to this Solicitation.

☐ A pre-bid meeting will not be held prior to bid opening

☑ A **MANDATORY PRE-BID** meeting will be held at the following place and time:

One Davis Square
Suite 100E, CR134
Charleston, WV 25301

January 8, 2020 at 10:00 PM EST

All Vendors submitting a bid must attend the mandatory pre-bid meeting. Failure to attend the mandatory pre-bid meeting shall result in disqualification of the Vendor's bid. No one individual is permitted to represent more than one vendor at the pre-bid meeting. Any individual that does attempt to represent two or more vendors will be required to select one vendor to which the individual's attendance will be attributed. The vendors not selected will be deemed to have not attended the pre-bid meeting unless another individual attended on their behalf.

An attendance sheet provided at the pre-bid meeting shall serve as the official document verifying attendance. Any person attending the pre-bid meeting on behalf of a Vendor must list on the attendance sheet his or her name and the name of the Vendor he or she is representing.

Additionally, the person attending the pre-bid meeting should include the Vendor's E-Mail address, phone number, and Fax number on the attendance sheet. It is the Vendor's responsibility to locate the attendance sheet and provide the required information. Failure to complete the attendance sheet as required may result in disqualification of Vendor's bid.

All Vendors should arrive prior to the starting time for the pre-bid. Vendors who arrive after the starting time but prior to the end of the pre-bid will be permitted to sign in, but are charged with knowing all matters discussed at the pre-bid.

Questions submitted at least five business days prior to a scheduled pre-bid will be discussed at the pre-bid meeting if possible. Any discussions or answers to questions at the pre-bid meeting

are preliminary in nature and are non-binding. Official and binding answers to questions will be published in a written addendum to the Solicitation prior to bid opening.

4. VENDOR QUESTION DEADLINE: Vendors may submit questions relating to this Solicitation to the Purchasing Division. Questions must be submitted in writing. All questions must be submitted on or before the date listed below and to the address listed below in order to be considered. A written response will be published in a Solicitation addendum if a response is possible and appropriate. Non-written discussions, conversations, or questions and answers regarding this Solicitation are preliminary in nature and are nonbinding.

Submitted e-mails should have solicitation number in the subject line.

Question Submission Deadline: January 17, 2020, at 3:00 PM EST

Submit Questions to: April Battle, File #22
2019 Washington Street, East
Charleston, WV 25305
Fax: (304) 558-4115 (Vendors should not use this fax number for bid submission)
Email: april.e.battle@wv.gov

5. VERBAL COMMUNICATION: Any verbal communication between the Vendor and any State personnel is not binding, including verbal communication at the mandatory pre-bid conference. Only information issued in writing and added to the Solicitation by an official written addendum by the Purchasing Division is binding.

6. BID SUBMISSION: All bids must be submitted electronically through wvOASIS or signed and delivered by the Vendor to the Purchasing Division at the address listed below on or before the date and time of the bid opening. Any bid received by the Purchasing Division staff is considered to be in the possession of the Purchasing Division and will not be returned for any reason. The Purchasing Division will not accept bids, modification of bids, or addendum acknowledgment forms via e-mail. Acceptable delivery methods include electronic submission via wvOASIS, hand delivery, delivery by courier, or facsimile.

The bid delivery address is:
Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

A bid that is not submitted electronically through wvOASIS should contain the information listed below on the face of the envelope or the bid may be rejected by the Purchasing Division.:

SEALED BID: RFP for Mountain Health Trust (MHT) Managed Care
BUYER: April Battle, File #22
SOLICITATION NO.: CRFP 0511 BMS2000000002
BID OPENING DATE: February 12, 2020
BID OPENING TIME: 1:30 PM EST
FAX NUMBER: N/A

The Purchasing Division may prohibit the submission of bids electronically through wvOASIS at its sole discretion. Such a prohibition will be contained and communicated in the wvOASIS system resulting in the Vendor's inability to submit bids through wvOASIS. Submission of a response to an Expression or Interest or Request for Proposal is not permitted in wvOASIS.

For Request For Proposal ("RFP") Responses Only: In the event that Vendor is responding to a request for proposal, the Vendor shall submit one original technical and one original cost proposal plus ten (10) convenience copies of each to the Purchasing Division at the address shown above. Additionally, the Vendor should identify the bid type as either a technical or cost proposal on the face of each bid envelope submitted in response to a request for proposal as follows:

BID TYPE: (This only applies to CRFP)
☑ Technical
☑ Cost

7. BID OPENING: Bids submitted in response to this Solicitation will be opened at the location identified below on the date and time listed below. Delivery of a bid after the bid opening date and time will result in bid disqualification. For purposes of this Solicitation, a bid is considered delivered when confirmation of delivery is provided by wvOASIS (in the case of electronic submission) or when the bid is time stamped by the official Purchasing Division time clock (in the case of hand delivery).

Bid Opening Date and Time: February 12, 2020, at 1:30 PM EST

Bid Opening Location: Department of Administration, Purchasing Division
2019 Washington Street East
Charleston, WV 25305-0130

8. ADDENDUM ACKNOWLEDGEMENT: Changes or revisions to this Solicitation will be made by an official written addendum issued by the Purchasing Division. Vendor should acknowledge receipt of all addenda issued with this Solicitation by completing an Addendum Acknowledgment Form, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

9. BID FORMATTING: Vendor should type or electronically enter the information onto its bid to prevent errors in the evaluation. Failure to type or electronically enter the information may result in bid disqualification.

10. ALTERNATE MODEL OR BRAND: Unless the box below is checked, any model, brand, or specification listed in this Solicitation establishes the acceptable level of quality only and is not intended to reflect a preference for, or in any way favor, a particular brand or vendor. Vendors may bid alternates to a listed model or brand provided that the alternate is at least equal to the model or brand and complies with the required specifications. The equality of any alternate being bid shall be determined by the State at its sole discretion. Any Vendor bidding an alternate model or brand should clearly identify the alternate items in its bid and should include manufacturer's specifications, industry literature, and/or any other relevant documentation demonstrating the

equality of the alternate items. Failure to provide information for alternate items may be grounds for rejection of a Vendor's bid.

☐ This Solicitation is based upon a standardized commodity established under W. Va. Code § 5A-3-61. Vendors are expected to bid the standardized commodity identified. Failure to bid the standardized commodity will result in your firm's bid being rejected.

11. EXCEPTIONS AND CLARIFICATIONS: The Solicitation contains the specifications that shall form the basis of a contractual agreement. Vendor shall clearly mark any exceptions, clarifications, or other proposed modifications in its bid. Exceptions to, clarifications of, or modifications of a requirement or term and condition of the Solicitation may result in bid disqualification.

12. COMMUNICATION LIMITATIONS: In accordance with West Virginia Code of State Rules §148-1-6.6, communication with the State of West Virginia or any of its employees regarding this Solicitation during the solicitation, bid, evaluation or award periods, except through the Purchasing Division, is strictly prohibited without prior Purchasing Division approval. Purchasing Division approval for such communication is implied for all agency delegated and exempt purchases.

13. REGISTRATION: Prior to Contract award, the apparent successful Vendor must be properly registered with the West Virginia Purchasing Division and must have paid the $125 fee, if applicable.

14. UNIT PRICE: Unit prices shall prevail in cases of a discrepancy in the Vendor's bid.

15. PREFERENCE: Vendor Preference may be requested in purchases of motor vehicles or construction and maintenance equipment and machinery used in highway and other infrastructure projects. Any request for preference must be submitted in writing with the bid, must specifically identify the preference requested with reference to the applicable subsection of West Virginia Code § 5A-3-37, and should include with the bid any information necessary to evaluate and confirm the applicability of the requested preference. A request form to help facilitate the request can be found at:
http://www.state.wv.us/admin/purchase/vrc/Venpref.pdf.

15A. RECIPROCAL PREFERENCE: The State of West Virginia applies a reciprocal preference to all solicitations for commodities and printing in accordance with W. Va. Code § 5A-3-37(b). In effect, non-resident vendors receiving a preference in their home states, will see that same preference granted to West Virginia resident vendors bidding against them in West Virginia. A request form to help facilitate the request can be found at:
http://www.state.wv.us/admin/purchase/vrc/Venpref.pdf.

16. SMALL, WOMEN-OWNED, OR MINORITY-OWNED BUSINESSES: For any solicitations publicly advertised for bid, in accordance with West Virginia Code §5A-3-37(a)(7) and W. Va. CSR § 148-22-9, any non-resident vendor certified as a small, women-owned, or minority-owned business under W. Va. CSR § 148-22-9 shall be provided the same preference made available to any resident vendor. Any non-resident small, women-owned, or minority-owned business must identify itself as such in writing, must submit that writing to the

Purchasing Division with its bid, and must be properly certified under W. Va. CSR § 148-22-9 prior to contract award to receive the preferences made available to resident vendors. Preference for a non-resident small, women-owned, or minority owned business shall be applied in accordance with W. Va. CSR § 148-22-9.

17. WAIVER OF MINOR IRREGULARITIES: The Director reserves the right to waive minor irregularities in bids or specifications in accordance with West Virginia Code of State Rules § 148-1-4.6.

18. ELECTRONIC FILE ACCESS RESTRICTIONS: Vendor must ensure that its submission in wvOASIS can be accessed and viewed by the Purchasing Division staff immediately upon bid opening. The Purchasing Division will consider any file that cannot be immediately accessed and viewed at the time of the bid opening (such as, encrypted files, password protected files, or incompatible files) to be blank or incomplete as context requires, and are therefore unacceptable. A vendor will not be permitted to unencrypt files, remove password protections, or resubmit documents after bid opening to make a file viewable if those documents are required with the bid. A Vendor may be required to provide document passwords or remove access restrictions to allow the Purchasing Division to print or electronically save documents provided that those documents are viewable by the Purchasing Division prior to obtaining the password or removing the access restriction.

19. NON-RESPONSIBLE: The Purchasing Division Director reserves the right to reject the bid of any vendor as Non-Responsible in accordance with W. Va. Code of State Rules § 148-1-5.3, when the Director determines that the vendor submitting the bid does not have the capability to fully perform, or lacks the integrity and reliability to assure good-faith performance."

20. ACCEPTANCE/REJECTION: The State may accept or reject any bid in whole, or in part in accordance with W. Va. Code of State Rules § 148-1-4.5. and § 148-1-6.4.b."

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

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

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

22. INTERESTED PARTY DISCLOSURE: West Virginia Code § 6D-1-2 requires that the vendor submit to the Purchasing Division a disclosure of interested parties to the contract for all contracts with an actual or estimated value of at least $1 Million. That disclosure must occur on the form prescribed and approved by the WV Ethics Commission prior to contract award. A copy of that form is included with this solicitation or can be obtained from the WV Ethics Commission. This requirement does not apply to publicly traded companies listed on a national or international stock exchange. A more detailed definition of interested parties can be obtained from the form referenced above.

23. WITH THE BID REQUIREMENTS: In instances where these specifications require documentation or other information with the bid, and a vendor fails to provide it with the bid, the Director of the Purchasing Division reserves the right to request those items after bid opening and prior to contract award pursuant to the authority to waive minor irregularities in bids or specifications under W. Va. CSR § 148-1-4.6. This authority does not apply to instances where state law mandates receipt with the bid.

GENERAL TERMS AND CONDITIONS:

1. CONTRACTUAL AGREEMENT: Issuance of a Award Document signed by the Purchasing Division Director, or his designee, and approved as to form by the Attorney General's office constitutes acceptance of this Contract made by and between the State of West Virginia and the Vendor. Vendor's signature on its bid signifies Vendor's agreement to be bound by and accept the terms and conditions contained in this Contract.

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

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

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

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

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

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

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

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

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

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

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

☑ **Term Contract**

Initial Contract Term: Initial Contract Term: This Contract becomes effective on _____ and extends for a period of One (1) year(s).

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

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

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

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

☐ **Fixed Period Contract with Renewals:** This Contract becomes effective upon Vendor's receipt of the notice to proceed and part of the Contract more fully described in the attached specifications must be completed within _____ days. Upon completion of the work covered by the preceding sentence, the vendor agrees that maintenance, monitoring, or warranty services will be provided for _____ year(s) thereafter.

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

☑ **Other:** See attached.

4. NOTICE TO PROCEED: Vendor shall begin performance of this Contract immediately upon receiving notice to proceed unless otherwise instructed by the Agency. Unless otherwise specified, the fully executed Award Document will be considered notice to proceed.

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

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

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

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

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

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

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

☐ **BID BOND (Construction Only):** Pursuant to the requirements contained in W. Va. Code § 5-22-1(c), All Vendors submitting a bid on a construction project shall furnish a valid bid bond in the amount of five percent (5%) of the total amount of the bid protecting the State of West Virginia. The bid bond must be submitted with the bid.

☐ **PERFORMANCE BOND:** The apparent successful Vendor shall provide a performance bond in the amount of 100% of the contract. The performance bond must be received by the Purchasing Division prior to Contract award.

☐ **LABOR/MATERIAL PAYMENT BOND:** The apparent successful Vendor shall provide a labor/material payment bond in the amount of 100% of the Contract value. The labor/material payment bond must be delivered to the Purchasing Division prior to Contract award.

In lieu of the Bid Bond, Performance Bond, and Labor/Material Payment Bond, the Vendor may provide certified checks, cashier's checks, or irrevocable letters of credit. Any certified check, cashier's check, or irrevocable letter of credit provided in lieu of a bond must be of the same amount and delivered on the same schedule as the bond it replaces. A letter of credit submitted in lieu of a performance and labor/material payment bond will only be allowed for projects under $100,000. Personal or business checks are not acceptable. Notwithstanding the foregoing, West Virginia Code § 5-22-1 (d) mandates that a vendor provide a performance and labor/material payment bond for construction projects. Accordingly, substitutions for the performance and labor/material payment bonds for construction projects is not permitted.

☐ **MAINTENANCE BOND:** The apparent successful Vendor shall provide a two (2) year maintenance bond covering the roofing system. The maintenance bond must be issued and delivered to the Purchasing Division prior to Contract award.

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

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

☑ NCQA Accreditation (prior to contract start date)

☑ Provider Network Certification (prior to contract start date)

☑ Other documents as defined within the Service Provider Agreement and/or RFP

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

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

Vendor must maintain:

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

☐ **Automobile Liability Insurance** in at least an amount of: _____ per occurrence.

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

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

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

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

☐ **Pollution Insurance** in an amount of: _____ per occurrence.

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

☑ Workers Compensation, $2,000,000.00 per accident.

☐

☐

☐

Notwithstanding anything contained in this section to the contrary, the Director of the Purchasing Division reserves the right to waive the requirement that the State be named as an additional insured on one or more of the Vendor's insurance policies if the Director finds that doing so is in the State's best interest.

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

10. [Reserved]

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

☐ _____ for _____

☑ Liquidated Damages Contained in the Specifications

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

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

14. PAYMENT IN ARREARS: Payment in advance is prohibited under this Contract. Payment may only be made after the delivery and acceptance of goods or services. The Vendor shall submit invoices, in arrears.

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

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

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

18. FUNDING: This Contract shall continue for the term stated herein, contingent upon funds being appropriated by the Legislature or otherwise being made available. In the event funds are not appropriated or otherwise made available, this Contract becomes void and of no effect beginning on July 1 of the fiscal year for which funding has not been appropriated or otherwise made available.

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

20. TIME: Time is of the essence with regard to all matters of time and performance in this Contract.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

34. VENDOR CERTIFICATIONS: By signing its bid or entering into this Contract, Vendor certifies (1) that its bid or offer was made without prior understanding, agreement, or connection with any corporation, firm, limited liability company, partnership, person or entity submitting a bid or offer for the same material, supplies, equipment or services; (2) that its bid or offer is in all respects fair and without collusion or fraud; (3) that this Contract is accepted or entered into without any prior understanding, agreement, or connection to any other entity that could be considered a violation of law; and (4) that it has reviewed this Solicitation in its entirety; understands the requirements, terms and conditions, and other information contained herein.

Vendor's signature on its bid or offer also affirms that neither it nor its representatives have any interest, nor shall acquire any interest, direct or indirect, which would compromise the performance of its services hereunder. Any such interests shall be promptly presented in detail to the Agency. The individual signing this bid or offer on behalf of Vendor certifies that he or she is authorized by the Vendor to execute this bid or offer or any documents related thereto on Vendor's behalf; that he or she is authorized to bind the Vendor in a contractual relationship; and that, to the best of his or her knowledge, the Vendor has properly registered with any State agency that may require registration.

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

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

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

37. PURCHASING AFFIDAVIT: In accordance with West Virginia Code §§ 5A-3-10a and 5-22-1(i), the State is prohibited from awarding a contract to any bidder that owes a debt to the State or a political subdivision of the State, Vendors are required to sign, notarize, and submit the Purchasing Affidavit to the Purchasing Division affirming under oath that it is not in default on any monetary obligation owed to the state or a political subdivision of the state.

38. ADDITIONAL AGENCY AND LOCAL GOVERNMENT USE: This Contract may be utilized by other agencies, spending units, and political subdivisions of the State of West Virginia; county, municipal, and other local government bodies; and school districts ("Other Government Entities"), provided that both the Other Government Entity and the Vendor agree. Any extension of this Contract to the aforementioned Other Government Entities must be on the same prices, terms, and conditions as those offered and agreed to in this Contract, provided that such extension is in compliance with the applicable laws, rules, and ordinances of the Other Government Entity. A refusal to extend this Contract to the Other Government Entities shall not impact or influence the award of this Contract in any manner.

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

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

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

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

41. BACKGROUND CHECK: In accordance with W. Va. Code § 15-2D-3, the Director of the Division of Protective Services shall require any service provider whose employees are regularly employed on the grounds or in the buildings of the Capitol complex or who have access to sensitive or critical information to submit to a fingerprint-based state and federal background inquiry through the state repository. The service provider is responsible for any costs associated with the fingerprint-based state and federal background inquiry.

After the contract for such services has been approved, but before any such employees are permitted to be on the grounds or in the buildings of the Capitol complex or have access to sensitive or critical information, the service provider shall submit a list of all persons who will be physically present and working at the Capitol complex to the Director of the Division of Protective Services for purposes of verifying compliance with this provision. The State reserves the right to prohibit a service provider's employees from accessing sensitive or critical information or to be present at the Capitol complex based upon results addressed from a criminal background check.

Service providers should contact the West Virginia Division of Protective Services by phone at (304) 558-9911 for more information.

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

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

b. "Steel Products" means products rolled, formed, shaped, drawn, extruded, forged, cast, fabricated or otherwise similarly processed, or processed by a combination of two or more or such operations, from steel made by the open heath, basic oxygen, electric furnace, Bessemer or other steel making process. The Purchasing Division Director may, in writing, authorize the use of foreign steel products if:

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

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

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

The cost of domestic aluminum, glass, or steel products may be unreasonable if the cost is more than twenty percent (20%) of the bid or offered price for foreign made aluminum, glass, or steel products. If the domestic aluminum, glass or steel products to be supplied or produced in a

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

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

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

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

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.

SVP Medicaid & Provider

(Name, Title)

Jason Landers, SVP Medicaid & Provider Services (Contract Liaison)

(Printed Name and Title) 1110 Main Street Wheeling, WV 26003

(Address)

304-907-6606 (Phone) 304-347-3643

(Phone Number) / (Fax Number)

jlanders@healthplan.org

(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.

The Health Plan of West Virginia, Inc.

(Company)

CEO/COO

(Authorized Signature) (Representative Name, Title)

Jeff M. Knight, CEO/COO

(Printed Name and Title of Authorized Representative)

2-11-2020

(Date)

740-698-7585 (Phone) 740-695-8103 (Fax)

(Phone Number) (Fax Number)

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)

- [x] Addendum No. 1
- [x] Addendum No. 2
- [x] Addendum No. 3
- [x] Addendum No. 4
- [x] Addendum No. 5
- [x] Addendum No. 6
- [ ] Addendum No. 7
- [ ] Addendum No. 8
- [ ] Addendum No. 9
- [ ] 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 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.

The Health Plan of West Virginia, Inc.
Company

Authorized Signature

2/11/2020
Date

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

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: RFP for Mountain Health Trust (MHT) Managed Care

Proc Type: Central Master Agreement

Date Issued	Solicitation Closes	Solicitation No	Version
2019-12-17	2020-02-12 13:30:00	CRFP 0511 BMS2000000002	1

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:

The Health Plan of West Virginia, Inc
1110 Main Street
Wheeling, WV 26003
740-695-7585

FOR INFORMATION CONTACT THE BUYER
April E Battle
(304) 558-0067
april.e.battle@wv.gov

Signature X [signature] **FEIN #** 55-0585592 **DATE** 2/11/2020

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

ADDITIONAL INFORMATION:

The West Virginia Purchasing Division is soliciting proposals on behalf of the West Virginia Department of Health and Human Resources to provide statewide physical and behavioral health managed care services to individuals enrolled in West Virginia's Medicaid Managed Care Programs, including the program currently designated as the "Mountain Health Trust" (MHT).

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

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 #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:

The Health Plan of West Virginia, Inc
1110 Main Street
Wheeling, WV 26003
740-695-7585

FOR INFORMATION CONTACT THE BUYER

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

Signature X FEIN # 55-0585592 DATE 2/11/2020

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 6, 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

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

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP 0511 BMS2000000002
Addendum Number: 1

The purpose of this addendum is to modify the solicitation identified as ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[X] Correction of error

[ ] Other

Description of Modification to Solicitation:

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, CR134
CHARLESTON WV 25301

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

No other changes.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith as Attachment A and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

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.

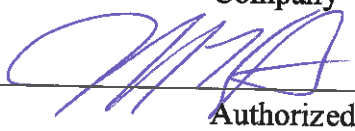
Addendum Numbers Received:
(Check the box next to each addendum received)

[✓] 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.

The Health Plan of West Virginia, Inc.

Company



Authorized Signature

2/4/2020

Date

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

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:

The Health Plan of West Virginia, Inc.
1110 Main Street
Wheeling, WV 26003
740-695-7585

FOR INFORMATION CONTACT THE BUYER

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

Signature X [signature] FEIN # 55-0585592 DATE 2/4/2020

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	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

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	0.00000			

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	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

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP BMS2000000002
Addendum Number: 2

The purpose of this addendum is to modify the solicitation identified as CRFP MCH200000001 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[X] Other

Additional Documentation:

To change the buyer and contact information on the CRFP.

Brittany Ingraham, Senior Buyer, will now be the assigned buyer to the CRFP.
Email: Brittany.E.Ingraham@wv.gov
Phone number: 304-558-0067

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
~~SOLICITATION NO.: CRFP 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
[X]	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.

The Health Plan of West Virginia, Inc.

Company

Authorized Signature

2/4/2020

Date

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

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 #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:

The Health Plan of West Virginia, Inc.
1110 Main Street
Wheeling, WV 26003
740-695-7585

FOR INFORMATION CONTACT THE BUYER

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

Signature X [signature] FEIN # 55-0585592 DATE 2/4/2020

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	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

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	0.00000			

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	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

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP BMS2000000002
Addendum Number: 3

The purpose of this addendum is to modify the solicitation identified as CRFP BMS2000000002 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[X] Other

Additional Documentation:

1. This addendum is issued to correct the documentation previously provided on Addendum No. 2 since the wrong solicitation number was listed at the top of the page.

2. Buyer and contact information on the CRFP.

   Brittany Ingraham, Senior Buyer, will now be the assigned buyer to the CRFP.
   Email: Brittany.E.Ingraham@wv.gov
   Phone number: 304-558-0067

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP BMS200000002

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
[X]	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.

The Health Plan of West Virginia, Inc.
Company

Authorized Signature

2/4/2020
Date

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

Purchasing Divison
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:

The Health Plan of West Virginia, Inc.
1110 Main Street
Wheeling, WV 26003
740-695-7585

FOR INFORMATION CONTACT THE BUYER

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

Signature X FEIN # 55-0585592 DATE 2/4/2020

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

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP BMS2000000002
Addendum Number: 4

The purpose of this addendum is to modify the solicitation identified as CRFP BMS2000000002 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[ ] Attachment of vendor questions and responses

[X] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[ ] Other

Description of Modification to Solicitation:

To provide the pre-bid meeting sign-in sheets.

No other changes.

Additional Documentation: Documentation related to this Addendum (if any) has been included herewith and is specifically incorporated herein by reference.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: CRFP 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
[X]	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.

The Health Plan of West Virginia, Inc.
Company

Authorized Signature

2/4/2020
Date

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

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
2020-02-05	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:

The Health Plan of West Virginia, Inc.
1110 Main Street
Wheeling, WV 26003
740-695-7585

FOR INFORMATION CONTACT THE BUYER

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

Signature X _____ **FEIN #** 55-0585592 **DATE** 2/11/2020

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:

1 opening WAS 02/12/2020 at 1:30 PM ET
J 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_SFY21 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 :
HT 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

SOLICITATION NUMBER: CRFP 0511 BMS2000000002
Addendum Number: 5

The purpose of this addendum is to modify the solicitation identified as CRFP 0511 BMS2000000002 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[X] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[X] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[X] Other

Additional Documentation: This 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_SFY21 Service Provider Agreement
5. Attach Appendix 8_CHIP Provider Listing

No other changes.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

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)

[X]	Addendum No. 1	[ ]	Addendum No. 6
[X]	Addendum No. 2	[ ]	Addendum No. 7
[X]	Addendum No. 3	[ ]	Addendum No. 8
[X]	Addendum No. 4	[ ]	Addendum No. 9
[X]	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.

THE HEALTH PLAN OF WEST VIRGINIA, INC.
Company

Authorized Signature

2/4/2020
Date

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

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:

The Health Plan of West Virginia, Inc
1110 Main Street
Wheeling, WV 26003
740-695-7585

FOR INFORMATION CONTACT THE BUYER

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

Signature X _____ **FEIN #** 55-0585592 **DATE** 2/11/2020

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

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	0.00000			

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	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

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

SOLICITATION NUMBER: CRFP 0511 BMS2000000002
Addendum Number: 6

The purpose of this addendum is to modify the solicitation identified as CRFP 0511 BMS2000000002 ("Solicitation") to reflect the change(s) identified and described below.

Applicable Addendum Category:

[ ] Modify bid opening date and time

[ ] Modify specifications of product or service being sought

[X] Attachment of vendor questions and responses

[ ] Attachment of pre-bid sign-in sheet

[ ] Correction of error

[ ] Other

Additional Documentation: This 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.

Terms and Conditions:

1. All provisions of the Solicitation and other addenda not modified herein shall remain in full force and effect.

2. Vendor should acknowledge receipt of all addenda issued for this Solicitation by completing an Addendum Acknowledgment, a copy of which is included herewith. Failure to acknowledge addenda may result in bid disqualification. The addendum acknowledgement should be submitted with the bid to expedite document processing.

CRFP 0511 BMS2000000002
Agency responses to additional Vendor questions

1.) **Is it the State's intent that Attachment 4: Project Organization and Staffing Approach (25 pages) and Attachment 5: Mandatory Requirements (10 pages) be double-spaced? We want to ensure we have interpreted this correctly and all bidders will be held to this requirement under the same page limits.**

Answer: Yes, this is the State's intent. However, as noted in prior responses, this requirement is not applicable to resumes and bulleted lists which may be single spaced.

2.) **Can the state confirm that required supplemental documentation previously excluded from page counts (organizational charts, resumes, forms, descriptions of roles associated with organizational charts) do not count towards applicable page counts?**

Answer: Attachments should correspond to the page limits defined by the applicable section. The vendor is permitted 2 pages per resume, as outlined within Attachment 4. Please note that no documents referenced within Appendix 4 is due at time of bid, and thus should not impact page availability. For any plans requested as part of the specifications, the vendor may provide narrative describing their plans, should the plan itself exceed the allotted number of pages.

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)

[X]	Addendum No. 1	[X]	Addendum No. 6
[X]	Addendum No. 2	[ ]	Addendum No. 7
[X]	Addendum No. 3	[ ]	Addendum No. 8
[X]	Addendum No. 4	[ ]	Addendum No. 9
[X]	Addendum No. 5	[ ]	Addendum No. 10

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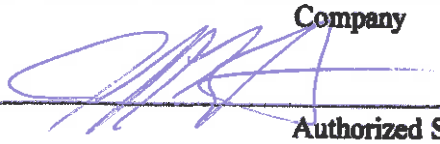
The Health Plan of West Virginia, Inc.

Company



Authorized Signature

2/11/2020

Date

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

WV STATE GOVERNMENT

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Health Insurance Portability and Accountability Act of 1996 (hereafter, HIPAA) Business Associate Addendum ("Addendum") is made a part of the Agreement ("Agreement") by and between the State of West Virginia ("Agency"), and Business Associate ("Associate"), and is effective as of the date of execution of the Addendum.

The Associate performs certain services on behalf of or for the Agency pursuant to the underlying Agreement that requires the exchange of information including protected health information protected by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the American Recovery and Reinvestment Act of 2009 (Pub. L. No. 111-5) (the "HITECH Act"), any associated regulations and the federal regulations published at 45 CFR parts 160 and 164 (sometimes collectively referred to as "HIPAA"). The Agency is a "Covered Entity" as that term is defined in HIPAA, and the parties to the underlying Agreement are entering into this Addendum to establish the responsibilities of both parties regarding HIPAA-covered information and to bring the underlying Agreement into compliance with HIPAA.

Whereas it is desirable, in order to further the continued efficient operations of Agency to disclose to its Associate certain information which may contain confidential individually identifiable health information (hereafter, Protected Health Information or PHI); and

Whereas, it is the desire of both parties that the confidentiality of the PHI disclosed hereunder be maintained and treated in accordance with all applicable laws relating to confidentiality, including the Privacy and Security Rules, the HITECH Act and its associated regulations, and the parties do agree to at all times treat the PHI and interpret this Addendum consistent with that desire.

NOW THEREFORE: the parties agree that in consideration of the mutual promises herein, in the Agreement, and of the exchange of PHI hereunder that:

1. **Definitions.** Terms used, but not otherwise defined, in this Addendum shall have the same meaning as those terms in the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

   a. **Agency Procurement Officer** shall mean the appropriate Agency individual listed at: http://www.state.wv.us/admin/purchase/vrc/agencyll.html.

   b. **Agent** shall mean those person(s) who are agent(s) of the Business Associate, in accordance with the Federal common law of agency, as referenced in 45 CFR § 160.402(c).

   c. **Breach** shall mean the acquisition, access, use or disclosure of protected health information which compromises the security or privacy of such information, except as excluded in the definition of Breach in 45 CFR § 164.402.

   d. **Business Associate** shall have the meaning given to such term in 45 CFR § 160.103.

   e. **HITECH Act** shall mean the Health Information Technology for Economic and Clinical Health Act. Public Law No. 111-05. 111th Congress (2009).

f. **Privacy Rule** means the Standards for Privacy of Individually Identifiable Health Information found at 45 CFR Parts 160 and 164.

g. **Protected Health Information or PHI** shall have the meaning given to such term in 45 CFR § 160.103, limited to the information created or received by Associate from or on behalf of Agency.

h. **Security Incident** means any known successful or unsuccessful attempt by an authorized or unauthorized individual to inappropriately use, disclose, modify, access, or destroy any information or interference with system operations in an information system.

i. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information found at 45 CFR Parts 160 and 164.

j. **Subcontractor** means a person to whom a business associate delegates a function, activity, or service, other than in the capacity of a member of the workforce of such business associate.

2. **Permitted Uses and Disclosures.**

a. **PHI Described.** This means PHI created, received, maintained or transmitted on behalf of the Agency by the Associate. This PHI is governed by this Addendum and is limited to the minimum necessary, to complete the tasks or to provide the services associated with the terms of the original Agreement, and is described in Appendix A.

b. **Purposes.** Except as otherwise limited in this Addendum, Associate may use or disclose the PHI on behalf of, or to provide services to, Agency for the purposes necessary to complete the tasks, or provide the services, associated with, and required by the terms of the original Agreement, or as required by law, if such use or disclosure of the PHI would not violate the Privacy or Security Rules or applicable state law if done by Agency or Associate, or violate the minimum necessary and related Privacy and Security policies and procedures of the Agency. The Associate is directly liable under HIPAA for impermissible uses and disclosures of the PHI it handles on behalf of Agency.

c. **Further Uses and Disclosures.** Except as otherwise limited in this Addendum, the Associate may disclose PHI to third parties for the purpose of its own proper management and administration, or as required by law, provided that (i) the disclosure is required by law, or (ii) the Associate has obtained from the third party reasonable assurances that the PHI will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the third party by the Associate; and, (iii) an agreement to notify the Associate and Agency of any instances of which it (the third party) is aware in which the confidentiality of the information has been breached. To the extent practical, the information should be in a limited data set or the minimum necessary information pursuant to 45 CFR § 164.502, or take other measures as necessary to satisfy the Agency's obligations under 45 CFR § 164.502.

f. **Support of Individual Rights.**

i. **Access to PHI.** Associate shall make the PHI maintained by Associate or its agents or subcontractors in Designated Record Sets available to Agency for inspection and copying, and in electronic format, if requested, within ten (10) days of a request by Agency to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.524 and consistent with Section 13405 of the HITECH Act.

ii. **Amendment of PHI.** Within ten (10) days of receipt of a request from Agency for an amendment of the PHI or a record about an individual contained in a Designated Record Set, Associate or its agents or subcontractors shall make such PHI available to Agency for amendment and incorporate any such amendment to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR § 164.526.

iii. **Accounting Rights.** Within ten (10) days of notice of a request for an accounting of disclosures of the PHI, Associate and its agents or subcontractors shall make available to Agency the documentation required to provide an accounting of disclosures to enable Agency to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR §164.528 and consistent with Section 13405 of the HITECH Act. Associate agrees to document disclosures of the PHI and information related to such disclosures as would be required for Agency to respond to a request by an individual for an accounting of disclosures of PHI in accordance with 45 CFR § 164.528. This should include a process that allows for an accounting to be collected and maintained by Associate and its agents or subcontractors for at least six (6) years from the date of disclosure, or longer if required by state law. At a minimum, such documentation shall include:

- the date of disclosure;
- the name of the entity or person who received the PHI, and if known, the address of the entity or person;
- a brief description of the PHI disclosed; and
- a brief statement of purposes of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure.

iv. **Request for Restriction.** Under the direction of the Agency, abide by any individual's request to restrict the disclosure of PHI, consistent with the requirements of Section 13405 of the HITECH Act and 45 CFR § 164.522, when the Agency determines to do so (except as required by law) and if the disclosure is to a health plan for payment or health care operations and it pertains to a health care item or service for which the health care provider was paid in full "out-of-pocket."

v. **Immediate Discontinuance of Use or Disclosure.** The Associate will immediately discontinue use or disclosure of Agency PHI pertaining to any individual when so requested by Agency. This includes, but is not limited to, cases in which an individual has withdrawn or modified an authorization to use or disclose PHI.

g. **Retention of PHI.** Notwithstanding section 4.a. of this Addendum, Associate and its subcontractors or agents shall retain all PHI pursuant to state and federal law and shall continue to maintain the PHI required under Section 3.f. of this Addendum for a period of six (6) years after termination of the Agreement, or longer if required under state law.

h. **Agent's, Subcontractor's Compliance.** The Associate shall notify the Agency of all subcontracts and agreements relating to the Agreement, where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum. Such notification shall occur within 30 (thirty) calendar days of the execution of the subcontract and shall be delivered to the Agency Procurement Officer. The Associate will ensure that any of its subcontractors, to whom it provides any of the PHI it receives hereunder, or to whom it provides any PHI which the Associate creates or receives on behalf of the Agency, agree to the restrictions and conditions which apply to the Associate hereunder. The Agency may request copies of downstream subcontracts and agreements to determine whether all restrictions, terms and conditions have been flowed down. Failure to ensure that downstream contracts, subcontracts and agreements contain the required restrictions, terms and conditions may result in termination of the Agreement.

j. **Federal and Agency Access.** The Associate shall make its internal practices, books, and records relating to the use and disclosure of PHI, as well as the PHI, received from, or created or received by the Associate on behalf of the Agency available to the U.S. Secretary of Health and Human Services consistent with 45 CFR § 164.504. The Associate shall also make these records available to Agency, or Agency's contractor, for periodic audit of Associate's compliance with the Privacy and Security Rules. Upon Agency's request, the Associate shall provide proof of compliance with HIPAA and HITECH data privacy/protection guidelines, certification of a secure network and other assurance relative to compliance with the Privacy and Security Rules. This section shall also apply to Associate's subcontractors, if any.

k. **Security.** The Associate shall take all steps necessary to ensure the continuous security of all PHI and data systems containing PHI. In addition, compliance with 74 FR 19006 Guidance Specifying the Technologies and Methodologies That Render PHI Unusable, Unreadable, or Indecipherable to Unauthorized Individuals for Purposes of the Breach Notification Requirements under Section 13402 of Title XIII is required, to the extent practicable. If Associate chooses not to adopt such methodologies as defined in 74 FR 19006 to secure the PHI governed by this Addendum, it must submit such written rationale, including its Security Risk Analysis, to the Agency Procurement Officer for review prior to the execution of the Addendum. This review may take up to ten (10) days.

l. **Notification of Breach.** During the term of this Addendum, the Associate shall notify the Agency and, unless otherwise directed by the Agency in writing, the WV Office of Technology immediately by e-mail or web form upon the discovery of any Breach of unsecured PHI; or within 24 hours by e-mail or web form of any suspected Security Incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the Agency Procurement Officer at www.state.wv.us/admin/purchase/vrc/agencyli.htm and,

unless otherwise directed by the Agency in writing, the Office of Technology at incident@wv.gov or https://apps.wv.gov/ot/ir/Default.aspx.

The Associate shall immediately investigate such Security Incident, Breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, the Associate shall notify the Agency Procurement Officer, and, unless otherwise directed by the Agency in writing, the Office of Technology of: (a) Date of discovery; (b) What data elements were involved and the extent of the data involved in the Breach; (c) A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data; (d) A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized; (e) A description of the probable causes of the improper use or disclosure; and (f) Whether any federal or state laws requiring individual notifications of Breaches are triggered.

Agency will coordinate with Associate to determine additional specific actions that will be required of the Associate for mitigation of the Breach, which may include notification to the individual or other authorities.

All associated costs shall be borne by the Associate. This may include, but not be limited to costs associated with notifying affected individuals.

If the Associate enters into a subcontract relating to the Agreement where the subcontractor or agent receives PHI as described in section 2.a. of this Addendum, all such subcontracts or downstream agreements shall contain the same incident notification requirements as contained herein, with reporting directly to the Agency Procurement Officer. Failure to include such requirement in any subcontract or agreement may result in the Agency's termination of the Agreement.

m. **Assistance in Litigation or Administrative Proceedings.** The Associate shall make itself and any subcontractors, workforce or agents assisting Associate in the performance of its obligations under this Agreement, available to the Agency at no cost to the Agency to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against the Agency, its officers or employees based upon claimed violations of HIPAA, the HIPAA regulations or other laws relating to security and privacy, which involves inaction or actions by the Associate, except where Associate or its subcontractor, workforce or agent is a named as an adverse party.

4. **Addendum Administration.**

a. Term. This Addendum shall terminate on termination of the underlying Agreement or on the date the Agency terminates for cause as authorized in paragraph (c) of this Section, whichever is sooner.

b. **Duties at Termination.** Upon any termination of the underlying Agreement, the Associate shall return or destroy, at the Agency's option, all PHI received from, or created or received by the Associate on behalf of the Agency that the Associate still maintains in any form and retain no copies of such PHI or, if such return or destruction is not feasible, the Associate shall extend the protections of this Addendum to the PHI and limit further uses and disclosures to the purposes that make the return or destruction of the PHI infeasible. This shall also apply to all agents and subcontractors of Associate. The duty of the Associate and its agents

and subcontractors to assist the Agency with any HIPAA required accounting of disclosures survives the termination of the underlying Agreement.

c. **Termination for Cause.** Associate authorizes termination of this Agreement by Agency, if Agency determines Associate has violated a material term of the Agreement. Agency may, at its sole discretion, allow Associate a reasonable period of time to cure the material breach before termination.

d. **Judicial or Administrative Proceedings.** The Agency may terminate this Agreement if the Associate is found guilty of a criminal violation of HIPAA. The Agency may terminate this Agreement if a finding or stipulation that the Associate has violated any standard or requirement of HIPAA/HITECH, or other security or privacy laws is made in any administrative or civil proceeding in which the Associate is a party or has been joined. Associate shall be subject to prosecution by the Department of Justice for violations of HIPAA/HITECH and shall be responsible for any and all costs associated with prosecution.

e. **Survival.** The respective rights and obligations of Associate under this Addendum shall survive the termination of the underlying Agreement.

5. **General Provisions/Ownership of PHI.**

a. **Retention of Ownership.** Ownership of the PHI resides with the Agency and is to be returned on demand or destroyed at the Agency's option, at any time, and subject to the restrictions found within section 4.b. above.

b. **Secondary PHI.** Any data or PHI generated from the PHI disclosed hereunder which would permit identification of an individual must be held confidential and is also the property of Agency.

c. **Electronic Transmission.** Except as permitted by law or this Addendum, the PHI or any data generated from the PHI which would permit identification of an individual must not be transmitted to another party by electronic or other means for additional uses or disclosures not authorized by this Addendum or to another contractor, or allied agency, or affiliate without prior written approval of Agency.

d. **No Sales.** Reports or data containing the PHI may not be sold without Agency's or the affected individual's written consent.

e. **No Third-Party Beneficiaries.** Nothing express or implied in this Addendum is intended to confer, nor shall anything herein confer, upon any person other than Agency, Associate and their respective successors or assigns, any rights, remedies, obligations or liabilities whatsoever.

f. **Interpretation.** The provisions of this Addendum shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provisions in this Addendum. The interpretation of this Addendum shall be made under the laws of the state of West Virginia.

g. **Amendment.** The parties agree that to the extent necessary to comply with applicable law they will agree to further amend this Addendum.

h. **Additional Terms and Conditions.** Additional discretionary terms may be included in the release order or change order process.

AGREED:

Name of Agency:_____

Signature:_____

Title:_____

Date:_____

Name of Associate: Jeff M. Knight

Signature:

Title: CEO/COO

Date: 2/4/2020

Form - WVBAA-012004
Amended 06.26.2013

APPROVED AS TO FORM THIS 26th
DAY Of January 20 20

Patrick Morrisey
Attorney General

BY _____

Appendix A

(To be completed by the Agency's Procurement Officer prior to the execution of the Addendum, and shall be made a part of the Addendum. PHI not identified prior to execution of the Addendum may only be added by amending Appendix A and the Addendum, via Change Order.)

Name of Associate: _____

Name of Agency: _____

Describe the PHI (do not include any actual PHI). If not applicable, please indicate the same.

Any and All Medicaid Claims and Demographic data.