Kepro

March 14, 2023

Request for **Proposals**

to provide Utilization Management and Prior Authorization Services

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Technical Proposal
Solicitation Number: CRFP BMS230000002

RFP Subject:	Utilization Management and Prior Authorization
Solicitation No.:	CRFP BMS230000002
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March 10, 2023

Megan Harris, President and COO

Date

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SECTION 4: Project Specifications

4.1 Background and Current Operating Environment

4.1. Background and Current Operating Environment: Operating under the umbrella of the West Virginia Department of Health and Human Resources (DHHR), the Bureau for Medical Services (BMS), which includes the West Virginia Children's Health Insurance Program (WVCHIP), the Bureau for Children and Families (BSS), and the Bureau for Behavioral Health (BBH), are seeking a Vendor to provide a quality comprehensive utilization management system. The utilization management system encompasses an array of services and programs provided by the three (3) above-referenced Agencies. The Vendor will provide prior authorization and review for medically and services covered by BSS, dental, and behavioral health services contained in this RFP.

Keystone Peer Review Organization, LLC (Kepro) offers the West Virginia Department of Health and Human Resources (WV DHHR) an unparalleled program for Utilization Management (UM) and Prior Authorization (PA) Services with the guarantee of uninterrupted continuation of our current services. As a trusted partner to the Agency and the WV community stakeholders, we have worked collaboratively with WV DHHR for more than two decades to develop a quality-driven comprehensive utilization management system uniquely focused on meeting the needs of members across the agencies within WV DHHR. We are excited to continue this important work.

Aside from our long-standing partnership with WV DHHR, we are a premier national partner to 33 other State Medicaid agencies today, providing UM, PA, and Waiver program solutions. **We have supported Medicaid agencies nationally for over three decades with our deep clinical expertise and successful program operations, including WV DHHR since 2000.** Our combination of our national UM and PA Services footprint, deep clinical knowledge of both physical and behavioral health services, and decades of proven WV DHHR UM and PA Services program results is unmatched and unique to our proposal.

Did You Know?

Kepro performs over 7 million UM/PA reviews annually with the same scope of services outlined in the RFP.

In this proposal we present our comprehensive UM and PA Services solution for WV DHHR—**a proven solution that will continue to address the State's program goals by leveraging our current processes, systems, tools, and experienced staff to fulfill all requirements of this RFP.**

4.2 Project Goals and Mandatory Requirements

4.2. Project Goals and Mandatory Requirements UM and P A Services. Vendor should describe its approach and methodology to providing the service or solving the problem described by meet the goals/objectives identified below. Vendor's response should include any information about how the proposed approach is superior or inferior to other possible approaches.

We acknowledge and will comply with the project goals and mandatory requirements for UM and PA services. In the following subsections, we describe our approach, methodology, and processes to meeting the goals, objectives, and requirements identified in the RFP. Through our responses, we will demonstrate that we are the right partner to provide UM and PA Services for West Virginia's medical, dental, and behavioral health programs administered by WV DHHR:

- ✓ Collaborative partners: 22+ years of partnership and collaboration with WV DHHR, providing our clinically driven and quality focused UM and PA services program.
- ✓ WV-based team and infrastructure: 146 WV-based staff in place today with deep understanding of program processes and relationships across the agencies.
- ✓ National experience: 6,000,000+ utilization reviews and 300,000+ assessments completed annually.

4.2.1 Goals and objectives

4.2.1 The project goals and objectives are listed below.

As the UM and PA Services program incumbent and a partner to WV DHHR for 22+ years, **we know West Virginia and we understand the unique needs of DHHR and its agencies, the provider and stakeholder communities, and most importantly, the members served**. Throughout our partnership with WV DHHR, we have shared and carried out the Department's objective to help members receive clinically appropriate services at the right time and with the right provider. We are excited for the opportunity to continue our partnership with WV DHHR, providing its agencies with a fully integrated UM and PA Services solution.

As evidenced by the work we do today under our current UM and PA Services contract, we assure the Agency that services will continue to be provided sufficiently in extent, duration, and scope, and accompanied by the appropriate documentation in provider and member files. We also commit to continuing to render authorizations only within the member's coverage and benefit limitations in effect on the date of service. The quality checks we have in place today will continue to support the accuracy and appropriateness of the authorizations we render – and will remain in place for the duration of the new contract.

Providing WV DHHR with a clinically driven and quality focused approach for UM and PA Services for over two decades has benefited the Agency, provider community and the members we serve in many ways, including:

- ✓ **Person-centered approach and evidence-based guidelines drive service delivery –** we ensure each member receives the right services with the right provider and at the right time
- ✓ **Collaborative provider relationships –** we provide education and training that emphasizes clinically appropriate services
- ✓ **Modern Care Management platform streamlines service authorizations and Waiver requests –** we allow providers to focus on service delivery rather than burdensome administrative processes
- ✓ **Proven stakeholder engagement model –** we support a well-informed and educated Provider and stakeholder community with a transparent, inclusive, and proactive approach
- ✓ **Conflict-free service authorization reviews –** we are neither a payor, provider, nor a Medicaid Management Information System (MMIS) claims processor, eliminating the risk of financial or relational conflicts of interest

4.2.1.1 APPROACH AND METHODOLOGY TO ADMINISTERING PROGRAM UTILIZATION

4.2.1.1 Vendor should describe their approach and methodology to administering program utilization through prior authorization and intensive care management of medical and dental authorizations to assure that those agency services are provided sufficiently in extent, duration, and scope, and that the provision of those services are appropriately documented in provider and recipient files and that the services rendered authorized within agency program coverage and benefit limitations in effect as of the date of service.

Only Kepro has unmatched experience and knowledge of the West Virginia health ecosystem and the flexible and innovative platforms and methodologies to tackle the State's complex initiatives. Our approach and methodology for administering the UM and PA Services program is comprised of several strategic layers that work in concert to provide exceptional service and facilitate accuracy and responsiveness to improve program outcomes. We propose a comprehensive solution that prioritizes meeting and exceeding scope of work requirements, expectations, and service levels. Our solution is proven in West Virginia and benefits from the breadth of services we deliver throughout the United States. We continually optimize the services we deliver, including highly responsive and effective call center support and quality improvement programs that help improve health decisions and outcomes for the populations we serve. Our proposed solution for WV DHHR is grounded in the six key components shown in **Figure 1 Kepro's Comprehensive UM and PA Services Solution.**

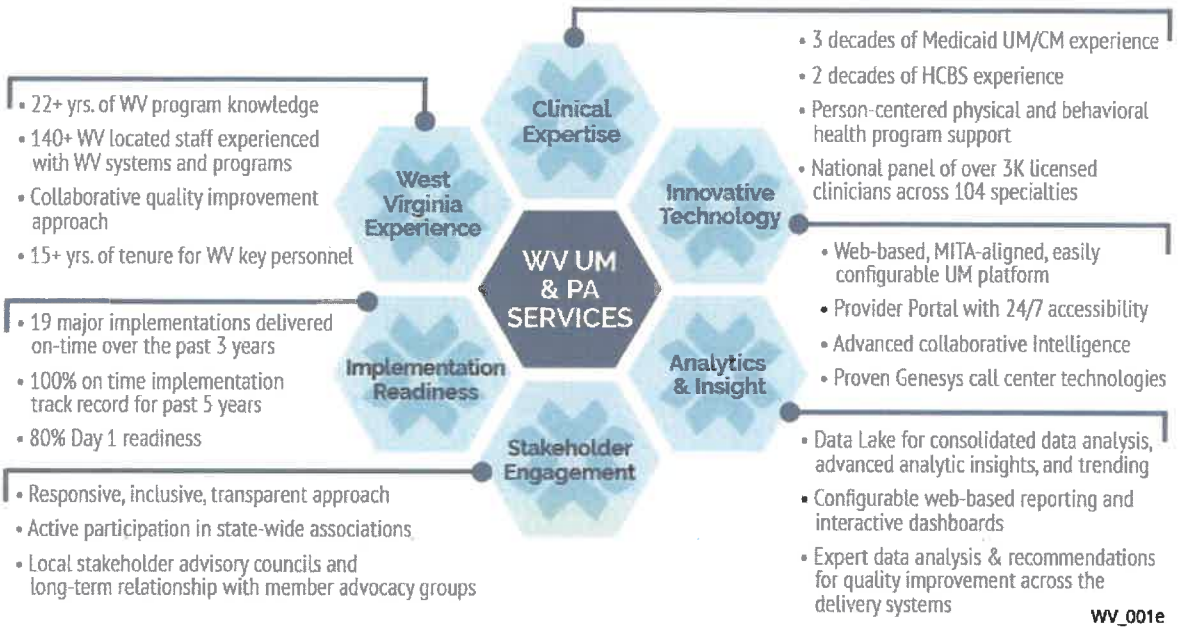


Figure 1. Kepro's Comprehensive UM and PA Services Solution

Our UM and PA Services program includes six strategic components that work together as a comprehensive solution.

West Virginia Experience

Our partnership with WV DHHR began in 2000 and continues today through our current UM and PA Services contract. In our more than 22-year collaboration with WV DHHR, we have built more than a working relationship with the Department and its program stakeholders – **we have built a partnership based on trust, accountability, and our compassion for the members we serve.** Throughout our long-standing partnership with WV DHHR, we have closely collaborated with the State to customize the UM and PA Services program to support WV DHHR internal changes and goals to better serve members **Figure 2 Kepro and WV Have Successfully and Seamlessly Expanded Services.**

We will continue to provide our highly trained and exceptionally qualified staff dedicated to serving WV DHHR program members and providers. All our current and proposed staff and resources are critical to the successful execution of the UM and PA Services program. Our key management personnel are vital resources that provide the overarching support and leadership structure under which clinical reviewers, physician reviewers, and support staff conduct UM and PA services. Our Staffing Plan includes position descriptions for our WV-based team and our continued recruitment plan for acquiring resources to continue to meet the WV DHHR contractual obligations.

Our WV project team is staffed with experienced personnel that are deeply familiar with WV DHHR. Nancy Sullivan has held the Executive Director role since 2019 and will continue to manage the delivery of optimal performance and results from our clinical team. Nancy provides daily support to the team including overseeing the implementation, direction, and management of WV program

deliverables. She also makes sure that the UM and PA functions are performed at or above standards, meeting or exceeding contract requirements and customer expectations. Nancy will leverage her experience and deep familiarity of the work to be performed with the new contract.

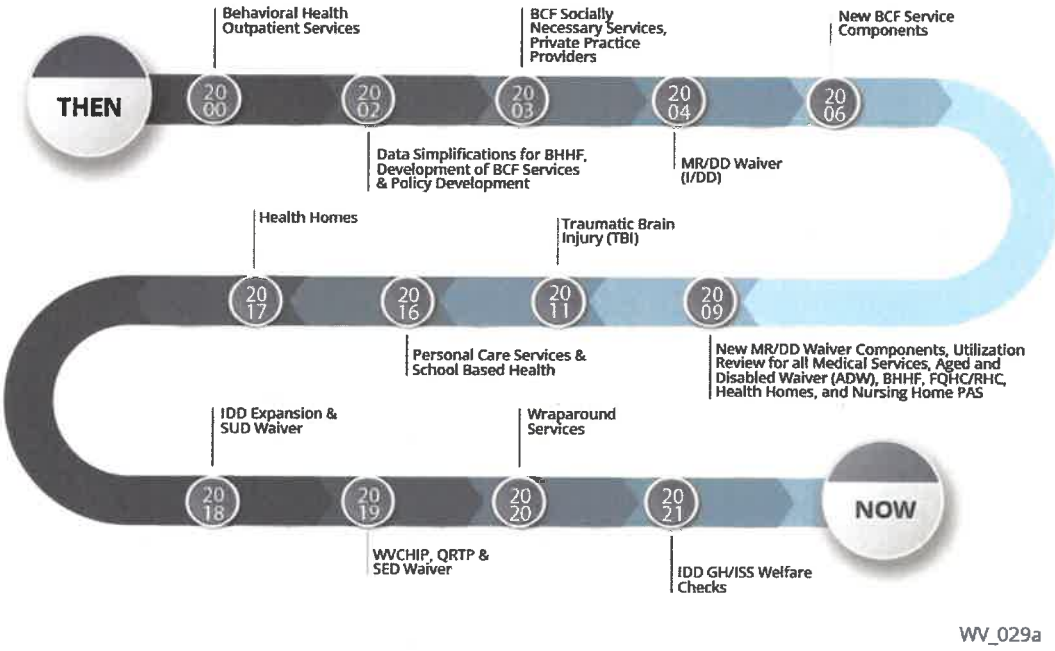


Figure 2. Kepro and WV Have Successfully and Seamlessly Expanded Services
Our UM and PA Services program is flexible and accommodates WV DHHR's new and evolving programs

National and West Virginia Clinical Expertise

Our extensive clinical expertise is evident in the services and outcomes we have provided to WV DHHR for 22+ years. This same level of clinical expertise and experience is critical to the ongoing success of WV UM and PA Services.

Our clinical team brings expertise and experience in successfully managing physical and behavioral health programs with similar scope to that in the RFP. Our current WV DHHR Medical Director, Paul Kuryla, MD, will continue to serve in this role for the new program. Dr. Kuryla leads the operation on all medical aspects relating to the peer review process, utilization review activities, case management, and other activities requiring clinical leadership and consultation.

To further our depth of clinical expertise, we maintain an extensive panel of over 3,000 licensed clinicians (physician and non-physician) across 104 specialties, all our contracted clinicians are board certified based on specialty requirements and are in clinical practice or hold active positions in academia. Our experienced clinical panel gives WV DHHR access to an unprecedented level of clinical expertise and knowledge.

We have been designated as a QIO by the Centers for Medicare and Medicaid Services (CMS) since our inception in 1985. We also maintain QIO-like status. Our long term QIO and QIO-like

designations attest to our consistent delivery of impartial quality assurance practices in our clinical review programs across the nation. **We have decades of utilization review and program monitoring experience through UM and PA Services contracts with 17 state Medicaid agencies** and as a trusted QIO partner to CMS on our Beneficiary Family Centered Care (BFCC) contract through which **we perform quality reviews of UM determinations in 29 states**. Through this experience, we have honed our approach to meet federal requirements and flexibly adapt to state specific standards and expectations.

Our multiple URAC accreditations are further evidence of our commitment to providing quality-infused programs and services that meet or exceed national benchmarking standards:

- Health Utilization Management was first awarded in 2005; reaccreditation in 2024
- Disease Management was first awarded in 2012; reaccreditation in 2023
- Independent Review Organization–Internal/External was awarded in 1999; reaccreditation in 2024
- Case Management was first awarded in 2007; reaccreditation in 2024

Our QIO and QIO-like designations and URAC accreditations provide assurance of our capability to effectively evaluate medical necessity and appropriate use of health care services, procedures, and facilities to help drive quality healthcare delivery systems. The Agency and members benefit through our:

- Knowledge of national standard policies and procedures specific to Medicaid other human services programs
- Extensive panel of experts in medical, behavioral health, and Intellectual and Developmental Disabilities (IDD) specialties
- National quality assurance program experience that meets federal standards for Medicaid and Medicare
- Sharing of clinical best practices and key learnings as opportunities for improvement in our WV DHHR UM and PA Services contract

With this foundation as a quality-driven organization, we will continue to apply our experience and expertise to support the Agency in ensuring members get the care they need.

Innovative Technology

Our proprietary technology platform, Atrezzo Care Management (Atrezzo) provides a single, integrated solution for UM and PA Services. **Atrezzo integrates with states' MMIS and other vendor systems within all our programs – in fact, we currently integrate and share data with current WV MMIS vendor, Gainwell, in multiple states**.

Atrezzo was designed to create a more efficient and compliant process for UM and PA Services for our state Medicaid clients. Atrezzo creates automation and efficiency and supports accuracy in the UM and PA review process by employing turn-key URAC-aligned processes and review workflows, all managed by a flexible and configurable rules engine. This functionality organizes and pre-processes data for clinical review and decision making. The system's automation reduces the need for manual review and improves accuracy of clinical reviews. Together, these features allow providers to quickly receive determinations and start a plan of care for the beneficiary sooner, which can lead to better health outcomes for members. This Health Insurance Portability and Accountability Act (HIPAA) compliant system supports collecting data to track over- and under-utilization of program-funded services; promoting more rapid adoption of health information technology among providers; and integrating data to increase identification of fraud, waste, and abuse.

Did You Know?

The Atrezzo Advantage:
- ✓ No Developers necessary
- ✓ Add or modify workflows, business rules, and service codes
- ✓ Flexible, simple configuration
- ✓ Proven integrations
- ✓ No additional cost

In accordance with the RFP, and evident in our 17 current Medicaid UM programs, Atrezzo is interoperable with the State's current MMIS, the State's Enterprise Data Warehouse (EDW), and other State business partners (e.g., Non-Emergency Medical Transportation vendor). Atrezzo is aligned with Medicaid Information Technology Architecture (MITA) 3.0 standards and follows the Medicaid Enterprise Certification Toolkit (MECT) 2.3 certification toolkit.

Did You Know?

Kepro has an expansive library of 1,500 pre-configured rules for auto-approvals, submission validations, and decisioning.

Two specific characteristics that differentiate Atrezzo from our competitors are:

- Our easily configurable system enables rapid implementation of new deployments and updates to the UM and PA Services program without the need for extensive IT support or software development enhancements. System flexibility guarantees that any changes specific to WV DHHR can also be added at implementation and any time throughout the life of the contract, at no additional charge to the State.
- Our agile, configuration approach means that we can support a wide range of updates including workflow modifications and additional business rules at no cost to WV DHHR.

Atrezzo offers the modularity and flexibility needed to evolve with the changing healthcare technology landscape. **Figure 3 Atrezzo System Overview** below shows the core functionality of Atrezzo's best-in-class platform and key interfaces and outputs that support unique program needs.

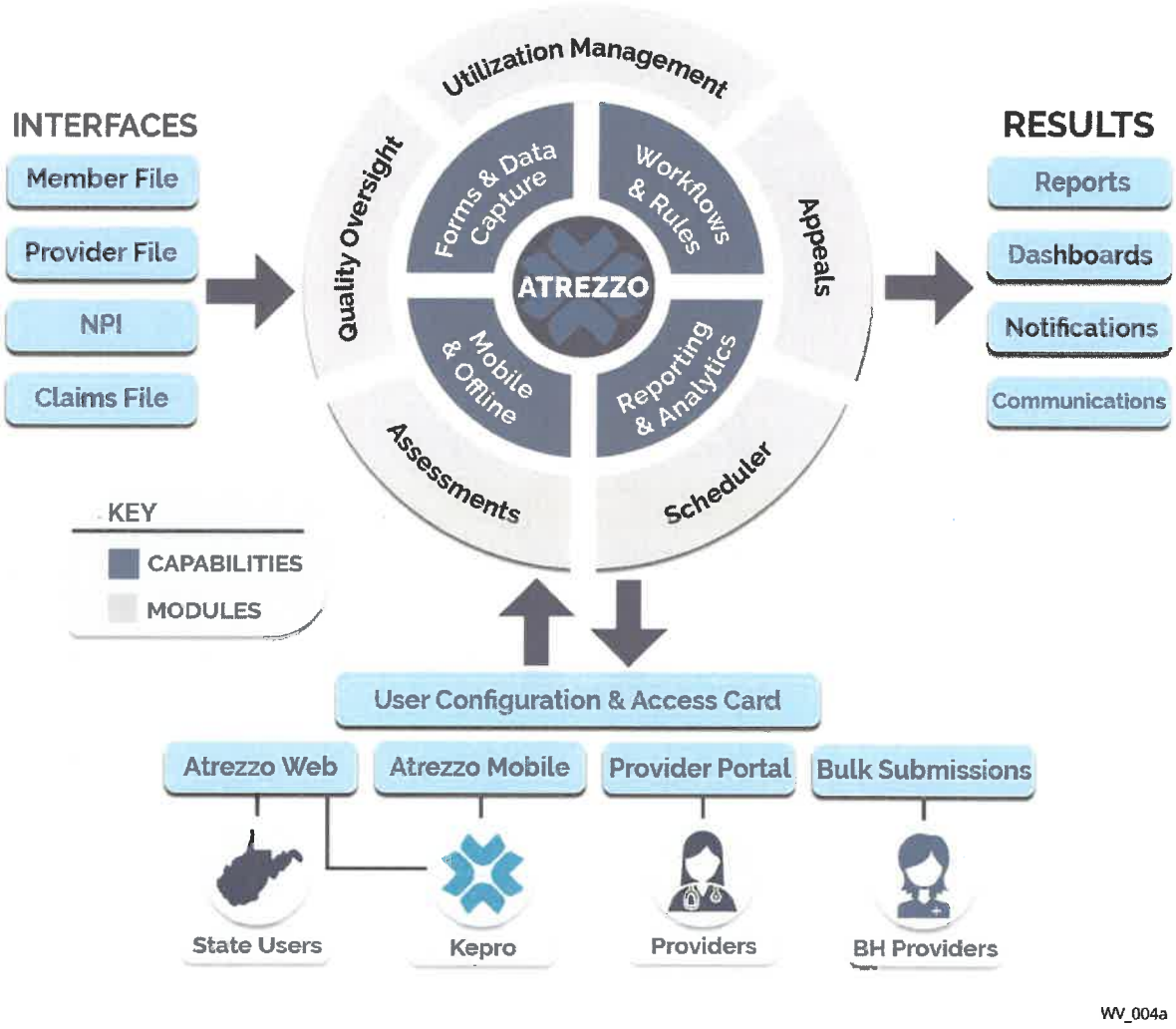


Figure 3. Atrezzo System Overview

Atrezzo provides a single, integrated solution for WV UM and PA Services across the care continuum

Our Atrezzo system provides meaningful data through standard and ad hoc reports that will deliver the necessary information to improve health outcomes and decisions based on analytics. Our full reporting capabilities are described in Appendix 5.

Stakeholder Engagement

As WV DHHR has seen over the past 22+ years, **we embrace partnerships and building relationships with provider and community stakeholders as the most effective means for cultivating a collaborative, well-informed environment to decrease inappropriate utilization, minimize provider abrasion, and reduce costs.** One of the most important components to our UM and PA Services programs is engaging the stakeholders that we jointly identify as integral to the program's success. Our stakeholder engagement strategy is governed by these core principles:

- ✓ **Responsive.** We proactively engage with key stakeholders early and often to identify issues, and act upon the feedback received
- ✓ **Inclusive.** We foster dialogue and collaboration with stakeholders representing various specialties, settings and services, and tailor our operations to address their concerns and meet their unique needs such as cultural and linguistic sensitivities
- ✓ **Transparent.** Transparency in our UM process garners stronger relationships and cooperation – we make information readily available to stakeholders to promote meaningful collaboration
- ✓ **Proactive.** Using data insights on UM practices to provide suggestions on rules or policies
- ✓ **State-Informed.** We partner with the Agency on overall strategy, materials, and communications

Providers say:

Our providers value Kepro personnel, systems, and resources and celebrate our partnership.

"I definitely appreciate the work Kepro does and understand the need for having your existence. The members we serve are in need and we are able to get them into the appropriate service to meet these needs for them. Thank you for your work."

"Everyone I worked with was kind, friendly, and very helpful since I am very new to this."

-from a recent provider survey

Our stakeholder engagement activities for the WV DHHR UM and PA Services program will be led by our dedicated and local provider relations and outreach staff. We prioritize continuous two-way communication from the start to ensure that stakeholders are empowered with the information and resources they need to fully participate in member-centered planning and obtain authorization of services that meet program requirements. We will continue to bolster our collaborative engagement strategy by working with WV DHHR stakeholders to review requirements, define and resolve issues, and refine and update requirements as the contract evolves.

We recognize the need to facilitate stakeholder input in a way that produces actionable feedback for both WV DHHR and Kepro. Our established and proven stakeholder engagement strategy, which includes our Stakeholder Advisory Council, incorporates a feedback loop with ongoing input from key stakeholders. This feedback can be useful in identifying ways to improve the quality and outcomes of the program. Our goal is to engage and educate stakeholders on our policies and procedures, as well as to use feedback to avoid provider and stakeholder abrasion. **Using this approach, we have maintained a 95% satisfaction rate with WV providers for the UM and PA services we provide today.**

We will continue to work closely in collaboration with WV DHHR and key stakeholders such as human service providers, facilities, families, and advocates to nurture strong working relationships and ongoing provider education and support. We conduct provider education to improve processes and outcomes and support ease of communication for all stakeholders throughout the state.

Providers who are well educated in key processes and procedures are essential to an ongoing, successful partnership which is why we tailor our approach to provider education and training. We support both new and existing providers with relevant training and technical support. We provide an orientation for new providers that includes discussion of policies and procedures and encourages provides to take advantage of additional training. Whenever system or major policy changes are made, we offer live virtual training via webinars, and we provide video training that can be accessed by providers at their convenience via the website. We also schedule customized training onsite at the provider's facilities. Using feedback from our clients and stakeholder partners, we identify risks, gaps in knowledge, and process pain points and incorporate those findings into our ongoing support and training. As an example, we quickly adapted a program to assist providers during the recent COVID-19 Health Emergency that included:

> Kepro has proven to be a valued partner in advancing shared goals of balancing quality services with efficient use of resources. Through respectful staff enacting developed utilization review processes, Kepro helps organizations enhance their own internal quality and utilization review protocols. We have found our partners at Kepro to be supportive, insightful, and committed to working with our provider community in improving how important services are delivered."
>
> ***Todd Godwin***
> ***CEO, Community Partners, ME***

- Providing information and assistance for providers and members about the State's COVID Response Plan – and we are continuing to work with the same groups to prepare them for the return to face to face interaction.
- Holding weekly and bi-weekly IDDW provider calls throughout the COVID-19 Health Emergency period to share current information, answer provider questions, and obtain feedback on their experience and needs.
- Assisting BMS in sharing communications with providers across programs regarding the COVID-19 Health Emergency.

Section 4.2.1.16 provides additional information on our approach to provider training and technical assistance.

Focus on client needs and goals would not be complete without in-depth consideration of the populations we serve. We use a person-centered and whole-health approach to understand and manage complex populations for the 34 State Medicaid agency clients we serve. This approach supports empowering members to take charge of their own health rather than being passive recipients of services as patient views, input, and experiences can enhance overall health outcomes. We increase member satisfaction by implementing consistent practices that emphasize freedom of choice, community inclusion, participation in the service planning process and proper documentation of these practices. Our clinical approach considers each person's needs, preferences, culture, geographical network, and values to help increase member adherence to treatment and improve health outcomes.

Our staff receive training tailored to their needs, and we leverage our well-trained clinical review staff and flexible technology to validate that members receives the right care to meet their individual needs, in a timely manner with the appropriate provider. Our well-established and person-centered approach is successfully used in each of our programs and across the service continuum.

Implementation Excellence

We have a 100% on-time implementation record with 25 major implementations delivered on-time over the past five years. Simply put - we provide the lowest-risk implementation compared to our competitors built on 22 years of WV DHHR program-specific experience. We offer:

- 84% of proposed staff already hired, credentialed, in state, and supporting WV today
- An established, operational central office location less than one mile from the Agency
- Trained staff throughout West Virginia - in place today to ensure continuity of services
- Established provider network
- Providers already registered and familiar with our portal
- Staff familiar with the concerns and challenges of our waiver members
- In-depth knowledge of the requirements, expectations, and limitations of the other vendors that provide support and service for Waiver programs

Our familiarity with the program supports a seamless and efficient transition for the program overall, as well as onboarding the new aspects of the program scope. Considering the expanded specialty services scope of work and the associated stakeholders, our experienced implementation team will provide a smooth transition and impeccable service delivery for members, providers, WV DHHR, and stakeholders. We define clear processes, controls and responsibilities that lead to successful implementation and ongoing operations. We proactively identify potential contract risks and develop mitigation strategies to minimize or eliminate any negative impact.

Our implementation plan is described in **Appendix 4**. Beyond implementation of the new contract, we will continue to be the Agency's go-to partner as services are expanded. In the past two years alone, we have expanded and/or implemented the following programs:

- IDD Waiver Managed Enrollment List release of 150 slots funded through the American Rescue Plan
- ISS/GH Health and Welfare Check operations development and implementation
- IDD Waiver Budget Methodology purchases and rate recalculations
- New code development for Medical Necessity Criteria
- Prior authorization of specialty/high-cost pharmaceuticals administered in hospital settings
- Medical case management activities related to COVID-19 for members
- Children with Serious Emotional Disorder (CSED) Waiver Services
- West Virginia Children's Health Insurance Program (WVCHIP) Utilization Management Operations and Case Transitions to Managed Care Organizations (MCOs)

- Aged and Disabled Waiver (ADW) Slot Releases – 1,682 Applicants Released
- Genetics Lab and criteria expansion
- System migration to Atrezzo Care Management System (Atrezzo) for Medical Services

Our approach and methodology for administering WV DHHR's UM and PA Services program will continue to meet or exceed the Agency's requirements and overall satisfaction of program stakeholders.

4.2.1.2 PLAN FOR ANY DATA PROCESSING OR SYSTEMS MODIFICATIONS

4.2.1.2 Vendor should describe their plan for any data processing or systems modifications required to accomplish systems access during the life of the contract without the requiring of modifications to the existing (agency) systems.

Throughout our 22+ year history supporting WV DHHR, we have not required the Agency to make modification or changes to its systems to accommodate our systems. We currently have in place the interfaces necessary for access to and file exchange with the Agency's systems and we do not anticipate the need for additional changes to continue uninterrupted operations. Should it become necessary in the future, we will continue to follow our established processes to make changes to our systems to maintain interfaces with existing agency systems without requiring modification of the Agency's systems.

We have a long and successful history of timely modifications to our own systems to meet the needs of our clients, largely due to thoughtful and detailed policies and procedures related to design, development, testing and implementation of applications. While implementing state-wide Medicaid contracts in West Virginia, Maine, Florida, Virginia, South Carolina, New Hampshire, Minnesota, and Wyoming, we successfully adapted our interfaces and file exchanges to the systems with which interactions are required. All applications developed in-house are built and tested across multiple platforms. We have established a multi-tiered environment for application development, testing, and release. We combine careful consideration and our clear policies to accomplish required changes in an efficient and effective manner. The following paragraphs describe our policies and methodologies to accomplish system changes.

Project Management Experience

We have an established team of project managers who provide greater visibility and transparency for projects and facilitate the alignment of corporate resources. The project management team tracks open projects to provide methodologies and guidance for project leaders to help them better manage their projects. Overall, the project management team is charged with:

- Developing, implementing, and overseeing the Project Management Methodology / Framework
- Enabling the success of project managers through use of repeatable governance and project management processes and tools with established standards and measurement criteria
- Establishing and promoting best practices and the use of standard project management tools

- Monitoring the Project Portfolio for appropriate prioritization and alignment with strategic objectives
- Promoting use of project management tools and providing guidance in their use
- Helping to optimize staff and other assets across projects
- Identifying risks and potentials issues
- Providing status and recommendations to the Information Technology (IT) Steering Committee and Executive Leadership Team

Our project management team works in conjunction with two oversight functions: Change Control Board (CCB) and the Executive Leadership Team (ELT). The CCB was established to provide a forum charged with ensuring that all proposed system changes, both hardware and software-related, are reviewed to determine if they are viable and will not adversely affect operations. We will submit changes to our CCB for modifications required to support systems access during the life of the contract. The change management procedure classifies changes as follows:

- Standard – Any change that is performed as a matter of routine. Examples include anti-virus updates, server patches, and the installation of approved, standard software packages such as Microsoft Office.
- Normal – Any change that is not defined as Standard or Emergency.
- Emergency – Any urgent change

The CCB derives its authority from the ELT. The CCB reviews each proposed Change Order, considering its real or perceived impact on existing services and operations. The CCB has final recommendation over all issues brought before it for review. The ELT is composed of corporate-level and other senior management with authority mediate and resolve conflicts in IT Services' priorities. The senior management group:

- Sets strategic direction and priorities for IT Services initiatives.
- Reviews and approves requests/ recommendations for new or modified IT Services initiatives.
- Gathers input from senior management and other stakeholders into the application development planning and execution process.
- Provides on-going oversight of IT Services initiatives at pre-defined milestones.

In summary, we work with our partners to identify system access parameters, but we do not ask them to make changes to accommodate our systems. **Continued use of our systems and implementation of system changes to meet new requirements will not require the Agency to make modifications to its existing systems.**

4.2.1.3 APPROACH AND METHODOLOGY TO MAINTAIN SECURE ELECTRONIC COMMUNICATION

4.2.1.3 Vendor should describe their approach and methodology to maintain secure electronic communication of medical and dental claims with the Agency, in addition to applicable external service providers which have financial, case management, and/or custody responsibilities.

Currently, we have protocols in place for secure file exchanges across programs and to access the MMIS to conduct coordination of care benefit reviews including the following:

- WV Enrolled Provider Files
- Eligibility Files
- Authorization transmittal to Gainwell, the MMIS vendor, for Provider payment
- Transfer coverage codes (attributes) for Home Health, ADW, IDDW, CSED, and Traumatic Brain Injury Waiver (TBIW)
- Transfer files to contracted Bureau
- Exchange Provider EDI files

As we do today, we will provide data to the Agency's contracted Bureaus via their specified secure file transfer protocol (SFTP) site. We post service request outcomes to our secure web application, accessible by registered service providers. We also provide electronic communications through secure e-mail, fax, and phone lines.

We are acutely aware that security and the safeguarding of personal data is an ever-expanding necessity in the healthcare field. It is also an area that is rapidly changing, with new techniques and technologies. The security techniques we employ meet or exceed standard HIPAA requirements. In fact, they meet the most stringent security tests available.

Our experience with managing application and system security spans over 35 years and includes support for a multitude of federal, state, local, and private healthcare contracts. We use site-to-site Virtual Private Network (VPN) connections to exchange data with our clients, as well as a backup for our Multiprotocol Label Switching (MPLS) Wide Area Network (WAN) connection between our offices. Additionally, we use Secure Sockets Layer/Transport Layer Security (SSL/TLS) to protect data transmissions between our data systems and our clients to protect protected health information (PHI) transmissions and to provide secure email connections between sites. We have been using SFTP to transmit data to the Fiscal Agent associated with our West Virginia, Virginia, South Carolina, Minnesota, Wyoming, and New Hampshire Medicaid contracts for more than 20 years.

We will continue to exchange files with the Agency and applicable external service providers. SFTP is the best fit to protect the security of electronic file exchanges. To facilitate the access, we coordinate the connection to our SFTP sites and provide unique credentials for each of the Bureaus within the Agency and involved providers. We also manage any changes to our system to facilitate data exchange such as changes to our firewall to allow access to Agency sites if necessary.

We have a solid history of ensuring HIPAA compliance and securing our internet connections, as well as complying with any additional requirements of the clients we serve, including WV DHHR. We have multiple contracts that incorporate these requirements, and we adhere to HIPAA laws and regulations by implementing industry standard technologies and processes for safeguarding

protected information. We focus on operational, management, and technical controls to ensure our compliance. The examples below show how we can meet the Agency's requirements:

- Annual HIPAA-Health Information Technology for Economic and Clinical Health (HITECH) Compliance training for all employees
- Annual Security and Awareness training for all employees
- Privacy and Compliance officers perform contract auditing
- Annual physical site assessments
- Cisco Adaptive Security appliances for firewall and securing information system boundaries
- Enterprise application portals configured with 128bit SSL encryption using Active Directory integrated authentication
- SFTP used for data transfer between client sites
- Transport layer security setup for email encryption between sites

In summary we will continue to maintain secure electronic communication with the Agency and service providers that have financial, case management, and/ or custodial responsibilities.

4.2.1.4 COMMUNICATION PLAN FOR FEEDBACK

4.2.1.4 Vendor should describe their communication plan that will provide feedback for medical and dental claims and applicable behavioral health services which will assist in the statewide administration of Agency programs through generation of consumer and service utilization profiles on all the program areas subject to review and utilization management.

We will build on our WV DHHR contract history to continue our record of achievement for quality, accountability, and intersystem communication with the Agency programs for the continuation of effective services. Our communication plan, constructive consultation, a sound utilization management system, and timely reporting of results will continue to assist the Agency with their development and management of the high quality, accountable, system for behavioral health and socially necessary services that is a landmark in public programs.

We meet with representatives of the DHHR Bureaus represented in the scope of work monthly. In addition to the regularly scheduled Contract Management meeting, we meet with the contract manager or representatives of any Bureau on a frequency determined by each Bureau. We will continue to ensure that the Agency is aware of all contract activities and approves all communications in advance. We also send monthly utilization reports to participating providers in addition to detailed feedback provided through retroactive reviews. This detailed information is analyzed at the end of each review cycle to provide both provider and system utilization profiling.

During implementation, and throughout the new contract term, we will continue timely communications to the Agency, the provider community, recipients, and other stakeholders. We will expand the current communication plan to include feedback on additional areas of utilization management in the RFP. We will produce utilization profiles from required reports to provide feedback on program areas in the scope of work. We summarize our communication plan in **Table 1**

Communications Plan Summary and will submit the full plan to DHHR at the start of the implementation period for review, input, and approval.

Implementation Communications	Post-Implementation Communication
Bureau for Medical Services (BMS)	
• Ongoing updates with BMS contract manager regarding readiness and to obtain sign-off on specifications for new scope of work to initiate 90-day implementation phase • Meetings with designated BMS staff to develop specifications for sign-off by Contract Manager • Complete identified tasks in the Readiness Plan and keep Contract Manager apprised of progress • Conduct outreach and educational communication to healthcare community to prepare for changes in medical review, level of care/medical eligibility, and Preadmission Screening and Resident Review (PASRR) reviews. • Attend Contract Management meetings as scheduled per existing protocols	• Ongoing Contract Management meetings monthly, and upon request • Participation in meetings with BMS staff as requested • Participation in committees, work groups, task forces as requested (e.g., Medicaid Redesign) • Provide feedback and continued education to healthcare community on best practices and opportunities for improvement in service delivery and process of medical necessity and eligibility review. • Consultation on topics as requested
Bureau for Children and Families / Bureau for Social Services (BSS)	
• Ongoing updates with BMS contract manager and designated BSS contact(s) regarding readiness and to obtain sign-off on specifications for new scope of work to initiate implementation phase • Meetings with designated BSS/People's Access To Help (PATH) staff to develop specifications for sign-off • Complete identified tasks defined in the Readiness Plan and keep BMS Contract Manager and BSS contact apprised of progress • Attend Contract Management meetings as scheduled per existing protocols	• Ongoing Contract Management meetings monthly, and upon request • Participation in meetings with BSS as requested • Participation in committees, work groups, task forces as requested • Consultation on specified topics as requested
WV DHHR Contractors	
• Regular meetings with MMIS contractor to review existing interfaces and modify or develop interfaces necessary to initiate the required scope of work • Meetings with other DHHR Contractors identified as relevant to the scope of work to develop IT interfaces or other relevant specifications	• Meetings as needed to address issues and facilitate execution of required scope of work

Implementation Communications	Post-Implementation Communication
Medicaid Providers	
• Provide orientation and portal/systems training to new providers including regional training, provider group specific training, and webinars • Update, as needed, and provide web materials for reference: UM Guidelines, Provider Manual, frequently asked questions (FAQ) responses	• Training as needed on topics identified through the review process including regional training, provider group specific training, and webinars • Ongoing development and update of Web materials • Quarterly Newsletter • Provider Quality Improvement (QI) Council • Participate in Gainwell Provider Workshops held twice a year.
Members	
• Consumer and community affairs orientation • Update, as needed, and provide Web materials – consumer manual, general information, contact information	• Focus groups • Community Presentations • Consumer QI Council • Web materials • Quarterly Newsletter
Other Stakeholders	
• Update, as needed, and provide Web materials to introduce the Kepro team, provide orientation to medical necessity, medical eligibility, PASRR, provider quality review and other functions.	• Web materials • Community Presentations • Quarterly Newsletter

Table 1. Communications Plan Summary
We provide an updated, customized WV communications plan

A vital component of our communication program includes surveying applicants and members regarding their satisfaction with the assessment process and the staff member(s) who conducted the assessment for Waiver or Personal Care program eligibility and/or level of care. Our team includes credentialed and experienced staff who conduct face-to-face assessments throughout the State for ADW, IDDW, TBIW, and Personal Care Programs for program eligibility and/or level of care. Conducted according to program policy, or the result of a court order, these assessments are the only direct contact we have with consumers. We use the information gained from these surveys to inform our staff training and development, as well as identify potential improvements to the assessment process.

Each applicant/member is assessed, and their caregiver, family, and other relevant parties can complete a survey to measure their satisfaction with various aspects of the face-to-face assessment. Using a 5-point Likert scale, the individual can express how much they agree or disagree with each survey statement. Agreeing and strongly agreeing are positive ratings indicating satisfaction and high satisfaction, respectively. Results of the latest surveys are shown in **Figure 4 West Virginia Member Assessment Satisfaction**.

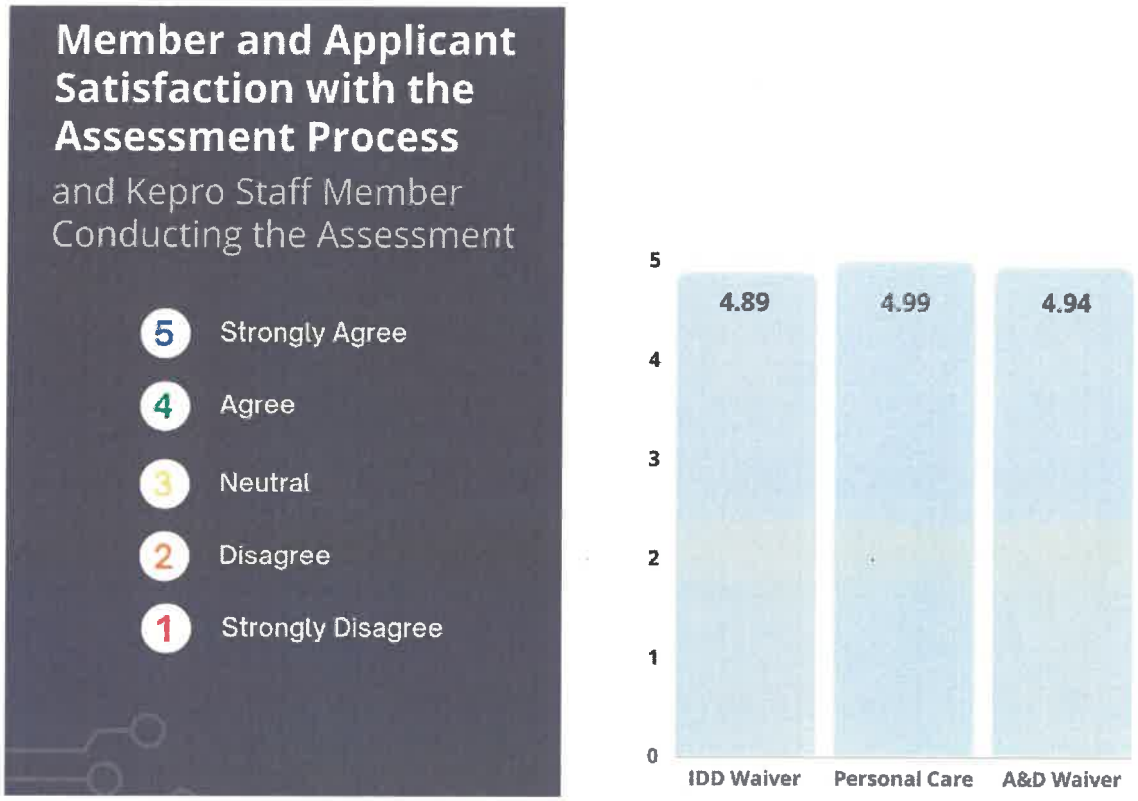


Figure 4. West Virginia Member Assessment Satisfaction
Our Assessment Process Ranks High in Member Satisfaction

4.2.1.5 DENIAL NOTICES

4.2.1.5 Vendor should describe their plan to communicate denial notices to the provider, member, and/or member's representative, and how they will specify what elements of admission or continued stay criteria were not met and/or documentation needed to verify medical necessity and include provider/practitioner reconsideration and the members right to appeal for state fair hearing.

We will continue to use our current process for communicating denial notifications to providers, members and/or members' representatives. Using our Atrezzo Care Management System, we communicate denial notices to providers within one calendar day of the physician decision to deny service(s). Denials are communicated to the referring and servicing provider through electronic means. The denial notice is attached to the prior authorization request record in Atrezzo in a format the provider can access through the Portal and print or download to the member record. Providers are informed of the reconsideration process and actions become immediately available in the system for the provider to request peer-to-peer review (Level I) and/or reconsideration (Level II). Our staff coordinate Peer-to-Peer activities with the providers.

Members, or their representatives, receive denial notification via US mail. All letters include the service denied, the reason for denial (criteria that were not met), and policy relevant to the denial. The physician and member letters state that the physician may request reconsideration of the denial. The member letter informs the member of their right to appeal for a state fair hearing. All

denials reference specific policy and/or criteria that were not met, to assist the member and provider in appealing the adverse decision. **Figure 5 Notice of Initial Denial for Member** and **Figure 6 Notice of Initial Denial for Provider** shows sample denial notices.

Kepro®

NOTICE OF INITIAL DENIAL

JOHN DOE
123 LANE
CITY, WV 25333

Referring Providers: Referring Provider Name
Referring PROVIDER NO: 999999999

MEDICAID ID: 99999999999	**DATE:** Today's Date
Service Start Date: Today's date	**Servicing Provider:** Servicing Provider Name
SERVICE:	**Service Description:**

Kepro is authorized by the Bureau for Medical Services of the West Virginia Department of Health and Human Resources to review services provided to Medicaid members. By contract, Kepro reviews Medicaid services to determine if they are medically necessary and are delivered in the most appropriate setting.

The service listed above has been denied based on the following: **Determination reason here**

Policy citations used: Policy Chapter

WHAT YOU CAN DO:

State Fair Hearing for a WV Medicaid Member: If you have not received the service in question and disagree with the denial decision, you may appeal to the Bureau for Medical Services within 90 days of the date of this letter. A form to request a Fair Hearing is enclosed. At the hearing, you have a right to ask questions. You may bring any witnesses to testify on your behalf and present evidence of your condition. If you wish to consult with legal counsel regarding this denial, the following organizations provide free legal services to eligible persons:

- Legal Aid of WV, 922 Quarrier St., Charleston, WV 25301, 1-866-255-4370 with offices in Beckley, Princeton, Huntington, Wheeling, Parkersburg, Clarksburg, Martinsburg and Logan
- Disability Rights of WV, 1207 Quarrier St., Charleston, WV 25301, 1-800-950-5250
- WV Emergency Medical Services Technical Support Network (WV EMS-TSN) 1609 Garner St., Suite 102, Fairmont, WV 26554 304-366-0896
- Mountain State Justice, 1031 Quarrier St., Suite 200, Charleston, WV 25301, 1-800-319-7132.

WHAT YOUR PHYSICIAN OR PROVIDER CAN DO:

Level II Appeal/Reconsideration Process:
If your physician/provider does not agree with the denial decision, the physician/provider may request a reconsideration of this determination. To exercise this right, a written request and supporting documentation must be submitted by the physician or provider to Kepro within 60 days of receipt of the initial denial notice. The reconsideration request and additional medical information should be mailed to:

Kepro
Attn: Reconsideration Unit
1007 Bullitt Street
Suite 200
Charleston, WV 25301

Kepro will complete the reconsideration within 14 working days of the request. The requesting physician/provider and the member will be notified of the outcome. Your physician/provider will decide whether a Level II appeal/reconsideration is appropriate based on the reasons for the initial denial.

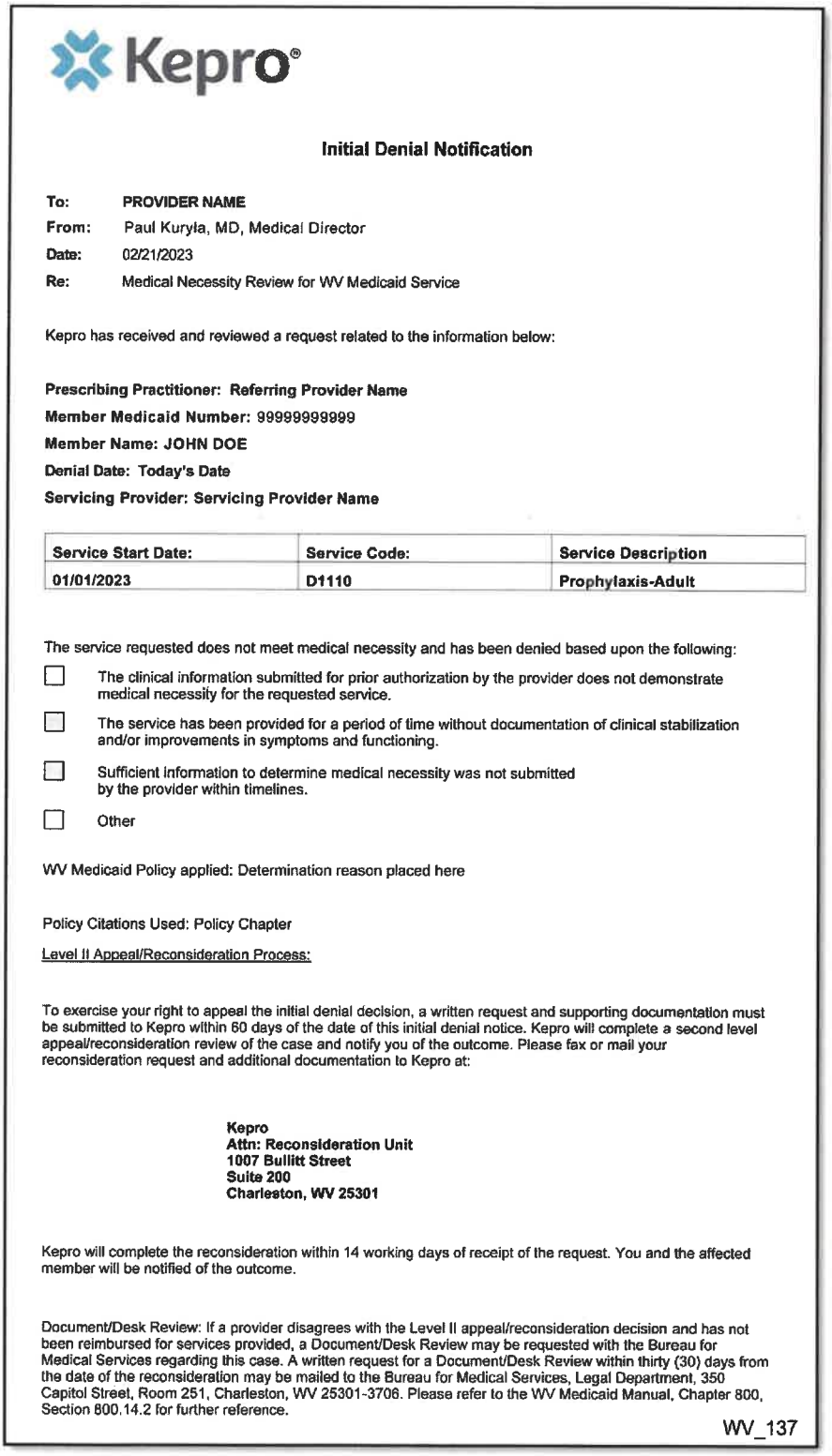
Enc: Release of Information Form
Member Request for Appeal Form

cc: **Referring Provider Name**

WV_136

Figure 5. Notice of Initial Denial for Member

We provide clear explanations and actions in our approved member communications.



Kepro

Initial Denial Notification

To: **PROVIDER NAME**
From: Paul Kuryla, MD, Medical Director
Date: 02/21/2023
Re: Medical Necessity Review for WV Medicaid Service

Kepro has received and reviewed a request related to the information below:

Prescribing Practitioner: Referring Provider Name
Member Medicaid Number: 99999999999
Member Name: JOHN DOE
Denial Date: Today's Date
Servicing Provider: Servicing Provider Name

Service Start Date:	Service Code:	Service Description
01/01/2023	D1110	Prophylaxis-Adult

The service requested does not meet medical necessity and has been denied based upon the following:

- ☐ The clinical information submitted for prior authorization by the provider does not demonstrate medical necessity for the requested service.
- ☐ The service has been provided for a period of time without documentation of clinical stabilization and/or improvements in symptoms and functioning.
- ☐ Sufficient information to determine medical necessity was not submitted by the provider within timelines.
- ☐ Other

WV Medicaid Policy applied: Determination reason placed here

Policy Citations Used: Policy Chapter

Level II Appeal/Reconsideration Process:

To exercise your right to appeal the initial denial decision, a written request and supporting documentation must be submitted to Kepro within 60 days of the date of this initial denial notice. Kepro will complete a second level appeal/reconsideration review of the case and notify you of the outcome. Please fax or mail your reconsideration request and additional documentation to Kepro at:

Kepro
Attn: Reconsideration Unit
1007 Bullitt Street
Suite 200
Charleston, WV 25301

Kepro will complete the reconsideration within 14 working days of receipt of the request. You and the affected member will be notified of the outcome.

Document/Desk Review: If a provider disagrees with the Level II appeal/reconsideration decision and has not been reimbursed for services provided, a Document/Desk Review may be requested with the Bureau for Medical Services regarding this case. A written request for a Document/Desk Review within thirty (30) days from the date of the reconsideration may be mailed to the Bureau for Medical Services, Legal Department, 350 Capitol Street, Room 251, Charleston, WV 25301-3706. Please refer to the WV Medicaid Manual, Chapter 800, Section 800.14.2 for further reference.

WV_137

Figure 6. Notice of Initial Denial for Providers

We provide clear explanations and actions in our approved provider communications.

Our Atrezzo platform delivers the capability to automatically create notifications and alerts, make those notifications and alerts visible to all relevant personnel, and track those notifications and alerts as the review moves through the Atrezzo workflow. Alerts can be added either through automated rules or manually, and the status – either "Pending," "In-Review" or "Completed" - are visible to all users. These status indicators help us manage and keep WV DHHR informed as to the current volumes and turnaround times for review completion demonstrating we are meeting or exceeding timeliness requirements.

Personal Care: If the applicant/member does not meet medical eligibility or does not meet the criteria for the requested service level, we will provide the applicant/member and/or their representative with a denial letter. This letter will include the reason for denial, a copy of the pre-admission screening (PAS), the applicable Personal Care policy manual section(s), notice of free legal services, a Request for Hearing Form to be completed if the applicant wishes to contest the decision and specific timeframes for filing an appeal. Providers will be notified of denial through our provider portal.

Aged and Disabled Waiver: If the applicant/member does not meet medical eligibility, the applicant or member and their representative and the referring physician (for applicants) will be notified by a Potential Denial letter. This letter will advise the applicant of the reason for the potential denial and include a copy of the PAS and ADW policy. The applicant will have two weeks to submit supplemental medical information. Information submitted after the two-week period will not be considered.

After review of the supplemental information, if the applicant is not medically eligible, the applicant and/or their representative and the referring physician will be notified by a Final Denial letter. The Final Denial letter will provide the reason for the adverse decision, include the applicable ADW policy manual section(s), a copy of the PAS, supplemental information documentation (if it has been supplied), notice of free legal services, and a Request for Hearing Form to be completed if the applicant wishes to contest the decision. Providers are notified of a denial through our provider portal.

IDD Waiver: If the applicant/member does not meet medical eligibility, we mail a Notice of Decision letter to the applicant/member and/or their representative. We include the following with the denial letter: Independent Psychological Evaluation (IPE) or functional assessment results if applicable, reason for the denial, applicable policy, forms to request a second medical evaluation and listing of evaluators, free legal resources, and a Request for Medicaid Fair Hearing form. We notify Providers associated with established members through our provider portal.

We will mail a Notice of Decision letter to the member and/or representative upon denial of requested service(s). This letter will include reason for denial, applicable policy, free legal resources, and a Request for Medicaid Fair Hearing form. Providers will be notified of a denial through our provider portal.

Traumatic Brain Injury Waiver: If an applicant/member does not meet medical eligibility, we will send a Potential Denial letter to the applicant, the applicant's referring physician or neuropsychologist, and applicant's representative, if applicable. This letter will advise the applicant of the reason for the potential denial, listing the areas in which deficiencies were found and notice that the medical eligibility standard has not been met. A copy of the PAS, Rancho Los Amigos Scale, and relevant TBI Waiver policy will also be included with the Potential Denial letter. The applicant will have two weeks to submit supplemental medical information.

If our review of supplemental information determines that there is still no medical eligibility, the applicant and/or their representative (if applicable), and the referring physician or neuropsychologist will be notified by a Final Denial letter. The Final Denial letter will provide the reason for the denial, applicable TBI Waiver policy manual section(s), a copy of the PAS and Rancho Los Amigos Scale, any supplemental information or documentation provided, notice of resources for free legal services, and a Request for Fair Hearing form to be completed if the applicant wishes to contest the decision. We will notify providers of the denial through our provider portal, once it is available. Until then, we will send providers an electronic notice of denial.

Nursing Home: If an applicant/member does not meet medical eligibility for Nursing Facility based on their Pre-Admission Screening, we will send a Notice of Denial letter to the applicant/member and their representative. This letter will include the reason for the denial, applicable Nursing Facility policy, a copy of the Pre-Admission Screening, notice of resources to provide free legal services and Request for Fair Hearing form to be completed if they wish to contest the decision. We will notify Providers through our PAS system or electronic communication.

4.2.1.6 APPROACH AND METHODOLOGY TO SUPPORT COMPLIANCE

4.2.1.6 Vendor should describe their approach and methodology to perform functions necessary to support compliance with state and federal requirements for medically necessary and non-medical child welfare services. Vendor should authorize the most economically advantageous item or service deemed to meet the member's behavioral, medical, or dental requirements.

We support compliance with state and federal requirements at multiple levels. The foundation of our approach is an efficient system configured for individual program requirements for medically necessary and non-medical child welfare services. We designed the Atrezzo system to support the specific policies and approved criteria for the review areas like those specified in the RFP, state policy, and regulations. Specific fields are mandated and validated in the application to ensure that the request includes the information needed to authorize the appropriate and most cost-effective service, quantity, that, and duration. Our system alerts providers through error messages if they attempt to submit a request does not contain all mandatory fields. We designed error messages to the submitting provider to indicate unit limits and member benefit limitations. Programming in the application is designed to alert the Nurse Reviewer to areas not meeting policy requirements and/or criteria checks. These exceptions are displayed as pend reasons that guide the reviewer to areas of policy that require special attention when the review criteria are applied to the

authorization request. This approach provides consistency in the review with respect to service limits, areas of possible service duplication, possible service combination edits, and diagnostic or other restrictions applicable to specific services.

We provide a second level of assurance through job descriptions and qualifications carefully aligned with clinical and technical requirements of the work performed. Hiring individuals who meet these requirements at the highest level adds a third level of assurance through detailed knowledge of requirements and, just as importantly, knowledge and experience with delivery of quality services. In this way, we provide a comprehensive approach to determining the most economically advantageous item or service necessary to meet the member's behavioral, medical, or dental requirements.

4.2.1.7 PROVIDING SERVICE AND RETROSPECTIVE REVIEWS FOR AUTHORIZATION REQUESTS

4.2.1.7 Vendor should describe their plan for providing service and retrospective reviews for authorization requests as outlined in policy.

We will continue to provide service and retrospective reviews for authorization requests in accordance with the policies of each program. We summarize our processes in the following paragraphs. Following contract award, we will work with the Agency and its Bureau staff to update our processes as needed to fully align with the scope of work in this RFP.

BMS Services. Provider Educators implement a retrospective review of provider documentation practices and utilization management processes. With implementation of this scope of work, Provider Educators also review service invoices provided by BMS. We will review each BMS provider at least once every eighteen-month cycle. Additional reviews may be warranted based on:

- The volume of authorizations over a 5- to 6-month period
- The scores from the past review period
- The number of services provided by the provider
- The intensity of service authorizations (Tier 1 through Tier 3)
- Special requests from BMS or Care Managers

Based on these factors the Educator will conduct a desk audit or an on-site review for each selected provider. A random sample is selected based upon the volume and complexity of the service array of the enrolled provider. The designated Educator will schedule consultations with providers four to six weeks in advance. If the provider cannot be immediately reached by telephone, the Educator will leave a message for the provider to return a call. If the call is not returned the same day, the Educator will attempt to contact the provider daily for three business days. If no return call is received within three business days, the Educator will email the provider with three possible dates for review. If no reply to the email is received within three business days, the Provider Educator Team Lead is apprised of the situation.

During the phone call to schedule the consultation, the Educator outlines the retrospective process and its purposes. The Educator confirms the provider's mail and email addresses during this phone call and confirms the contact to which the sample should be sent. The Educator then informs the provider of the secure email process. The list of case records for potential review will be provided by fax or e-mail (per provider preference) three days prior to the review to allow time to pull the requested records. The sample is generated by the Data Analyst. Consultation activities include technical assistance and the review of specific case records. The Educators maintain confidentiality as per HIPAA guidelines. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information while the Trainer Consultants are on-site. The Educator will use the following tools to complete the reviews:

- UM Guidelines manual
- Copies of review instruments
- Kepro Interpretive Guidelines (proprietary)
- Copy of each consumer's system record with demographic information and summary clinical information

Once on-site, the Educator begins the review by interviewing the primary contact person for the provider. Using the sample printout sent to the provider, a record is selected by the Educator for review. The start date, service category, and service are noted for the most recent authorizations. If there are multiple services for the same period, all documentation referring to that service is reviewed. The member's profile with fields reflecting the consumer's functional deficits and the focus of the service is compared to any information in the record and the service plan for consistency. If there are multiple re-authorizations for the same service, the Educator reviews case notes, service plans and any documentation that indicates progress on service objectives and appropriateness of services delivered to the member.

The Educator conducts an exit conference with the provider, or their representative, at the end of the on-site review where the most significant findings of the consultation are discussed along with consideration of strengths and areas of needed improvement. The Educator addresses any provider questions brought up during the introductory conference or throughout the review. Information obtained through this conference is included in the Exit Technical Assistance form that must be completed by the Educator and returned to the office. A Consultation Report, which includes a discussion of the results along with recommendations for improvement, is provided within 30 business days of the completed review. The Educator follows up on the Technical Assistance consultation within 10 days of the report submission and addresses areas for improvement.

This process will be modified for providers using the Medicaid manuals, such as Behavioral Health Clinic and Rehabilitation Services, to require disallowance reviews. Clinic and Rehabilitation Providers were notified by BMS that deficiencies in the following areas will result in disallowance:

- Credentialing
- Crime Identification Bureau (CIB) (fingerprint check at initial and every three years - can do name-based check for 90 days while waiting on print returns)
- Office of Inspector General (OIG) monthly checks
- Degree (diploma and transcripts)
- License verification
- Internal credentialing for services including a policy for services provided while seeking internal credentialing
- Clinical Supervision
- Chart demonstrating the clinical "chain-of-command"
- Supervisor must have an equal degree, clinical experience, credential, or higher than the supervisee
- 72-hour Authorization forms for Coordinated Care
- Signed Service Plans (physician, physician extender, licensed psychologist, supervised psychologist)
- Legible Records
- Documentation requirements of date, start/stop times, place of service, signature, and credentials
- Duplicate billing
- UP-coding
- Services not permitted by Tele-health
- ACT team composition and credentials

The process for the completion of disallowance reviews will follow the description in **Table 2. Monitoring of Rehabilitation Services Process**.

Monitoring of Rehabilitation Services
"The primary means of monitoring the quality of Rehabilitation services is through provider reviews conducted by OHFLAC and the Contracted Agent as determined by BMS by a defined cycle. The Contracted agent performs on-site and desk documentation provider reviews and face-to-face member/legal representative and staff interviews to validate documentation and address CMS quality assurance standards. Targeted on-site Rehabilitation provider reviews and/or desk reviews may be conducted by OHFLAC and/or the Contracted Agent in follow up to Incident Management Reports, complaint data, Plan of Corrections, etc. Upon completion of each provider review, the Contracted Agent conducts a face-to-face exit summation with staff as chosen by the provider to attend. Following the exit summation, the Contracted Agent will make available to the provider a draft exit report and a Plan of Correction to be completed by the Rehabilitation provider. If potential disallowances are identified, the Rehabilitation provider will have 30 calendar days from receipt of the draft exit report to send comments back to the Contracted Agent. After the 30-day comment period has ended, BMS will review the draft exit report and any comments submitted by the Rehabilitation provider and issue a final report to the Rehabilitation Provider's Executive Director. The final report reflects the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of

Monitoring of Rehabilitation Services
Rehabilitation Services. A cover letter to the Rehabilitation provider's Executive Director will outline the following options to effectuate repayment: (1) Payment to BMS within 60 days after BMS notifies the provider of the overpayment: or (2) Placement of a lien by BMS against further payments for Medicaid reimbursements so that recovery is effectuated within 60 days after notification of the overpayment: or (3) A recovery schedule of up to a 12-month period through monthly payments or the placement of a lien against future payments. If the Rehabilitation provider disagrees with the final report, the Rehabilitation provider may request a document/desk review within 30 days of receipt of the final report pursuant to the procedures in Common Chapter 800 (A), General Administration of the West Virginia Medicaid Provider Manual. The Rehabilitation provider must still complete the written repayment arrangement within 30 days of receipt of the Final Report, but scheduled repayments will not begin until after the document/desk review decision. The request for a document/desk review must be in writing, signed and set forth in detail the items in contention. Continued review cycles may expand the areas for potential disallowances per direction from BMS. For further information on the provider reviews, the VW Clinic and Rehabilitation manuals can be accessed at http:/Ailww.dhhr.wv.oov/bms/Paqes/ProviderManuals.aspx. lf you have any questions regarding this process, please contact me at 304-356-4936 or Cynthia.A.Parsons@wv.gov."

Table 2. Monitoring of Rehabilitation Services Process
Excerpt from Table 19 Chapter 503.9 Rehabilitation Provider Reviews

We will review these providers on an 18-month cycle with disallowances implemented at least one of the possible three times a provider may be reviewed in a cycle. BMS will make the final determination on how frequently disallowances will be implemented within a review cycle.

BMS Psychiatric Residential Treatment Facility (PRTF) Retrospective Review. We will complete on-site reviews of all providers receiving an authorization for PRTF services at least once within an 18-month cycle. A 10% sample will be utilized for each review or a minimum of three charts—whichever is greater. The retrospective reports consisting of a policy review, clinical review, and areas *that* need to be improved to meet WV's standards will be provided to BSS and BMS within 30 business days of the exit conference.

Please see specific Waiver discussions for the approach to retrospective review for those programs.

4.2.1.8 APPROACH AND METHODOLOGY FOR PROVIDING TIMELY AND ACCURATE REPORTS

4.2.1.8 Vendor should describe their approach and methodology for providing timely reports and accurate reporting and analysis of practices for all areas of review. This plan may be accomplished through, but not limited to, such activities as accurate and timely data reporting, trend analysis, and retrospective reviews for authorization and meeting of invoicing requirements respective agencies.

> **Did You Know?**
>
> Kepro completed 100% of all required Agency reports within designated timelines and to specification.

We excel at meeting the analytic and reporting requirements of the Bureaus in our current contract and will continue this successful record of accomplishment into the next contract period. Our approach will consolidate all data analysis and reporting functions within Kepro to provide DHHR with a single report point of contact. We describe our process to respond to specific reports and invoicing requirements in Reporting. We presented our approach to retrospective reviews for authorization above. **In the last reporting fiscal year Kepro completed 248 ad hoc reports for the Agency.**

Data Access Across Bureaus

To ensure that we will be able to provide crosscutting trends and analyses, we will implement a comprehensive database structure that provides access to data for all Bureaus. Our analysts will access this database to conduct analyses for monthly, quarterly, annual, and ad hoc reports.

Data Reporting, Trend Analysis, and Profiles

We will provide timely reports and accurate reporting/analysis through reviews and provide the same timeliness when adding the additional invoicing and credential checks to the procedure. We will also conduct analysis of activities for inclusion in the annual and other reports.

Collaborative Intelligence

> **Did You Know?**
>
> Kepro's work with advanced analytics and OpenAI was highlighted by Microsoft in the Keynote address at the 2022 Microsoft Build conference.

In addition to providing a comprehensive clinical system, we are implementing Collaborative Intelligence capabilities in Atrezzo that combine our staff's clinical and administrative talent with machine learning and automation. These tools use state of the art natural language processing technology to help improve care management and population health programs by extracting information from unstructured text data sources, such as patient notes, medical records, surveys, and social determinants of health (SDOH) data. This information can be used to identify trends and patterns in patient populations, develop predictive models of disease risk, and personalize care plans for individual patients. Our technology can efficiently extract the most relevant and critical information from diverse datasets to produce automated summaries for clinical review and action to improve the efficiency, reliability, and quality of care.

Collaborative Intelligence is a significant differentiator for Kepro and can provide important benefits to WV DHHR including:

- ✓ Better care coordination and communication between providers, patients, and caregivers.
- ✓ More efficient use of resources due to improved data analytics and decision support tools.
- ✓ Enhanced patient engagement and empowerment through self-management tools and portals.
- ✓ Improved population health outcomes through targeted interventions and better disease management programs, helping to reduce health disparities and promote health equity
- ✓ Greater cost-effectiveness and sustainability of care management initiatives through increased efficiency and effectiveness

Since 2019, we have been partnering with Microsoft's Cognitive Services teams in the early development and testing of state-of-the-art machine learning products including Text Analytics for Health (TA4H) and Azure OpenAI and applying these technologies in an ethical and secure manner.

Atrezzo enables client staff to directly access monitoring data on demand, in real time. The system also gives our clients the capability to produce a wide range of ad hoc management reports in a secure, online environment. Our client-configured and out-of-the-box Tableau dashboards display relevant information on program performance, productivity, caseloads, and utilization, to uncover vital information that drives improved results and consistent outcomes.

Our integration and data sharing capabilities are sustained through the Kepro Health Intelligence (HI) Data Lake. The data lake is a server platform populated through transactional replication with data from all active databases supporting the contract, including transactional review data, telephony data, customer satisfaction data, claims data and compliance data. By leveraging transactional replication, the data lake can provide real-time reporting and analysis for on-demand needs. The data lake can be linked to other systems and populated with data in numerous ways. **Figure 7 HI Data Lake** illustrates how Atrezzo generates data-driven reports using the data lake.

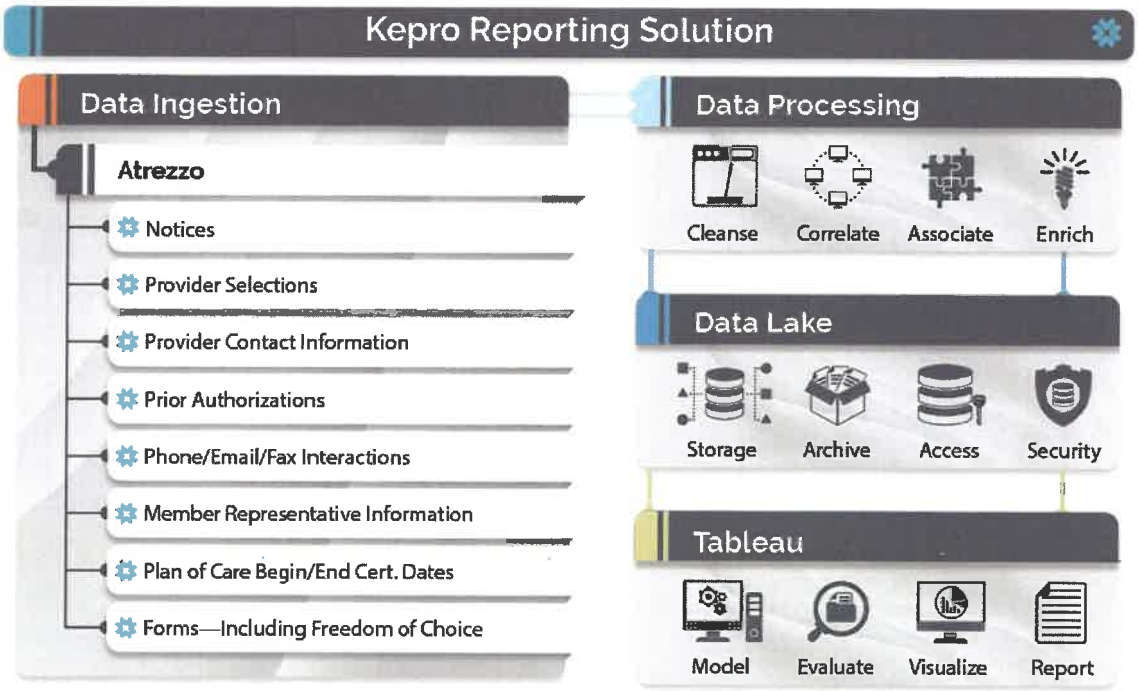
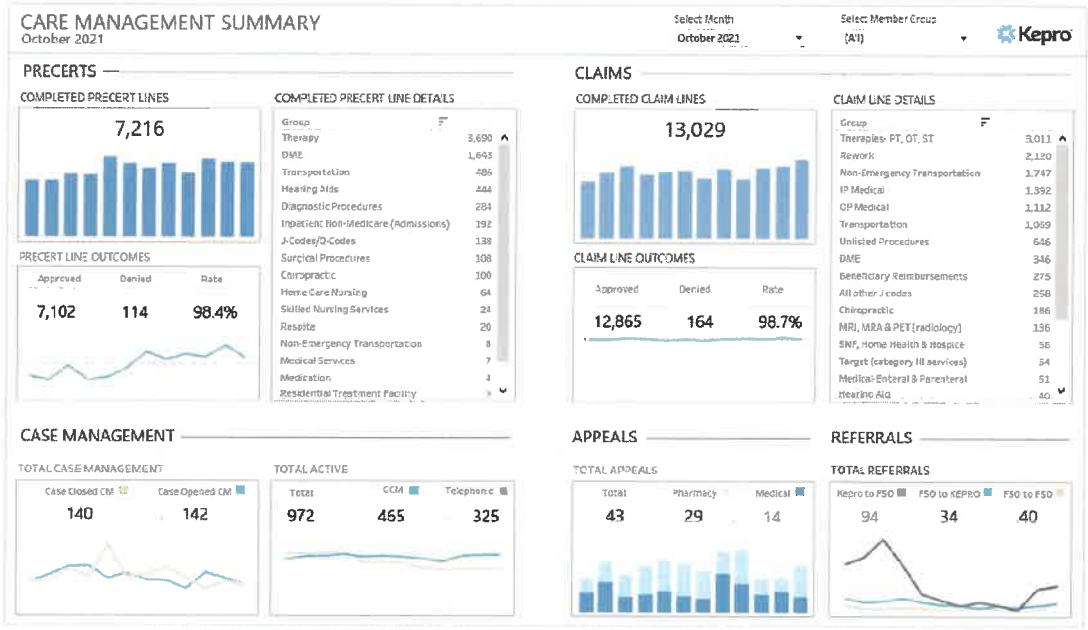


Figure 7. HI Data Lake

Our systems ingest a variety of data from multiple sources, then process and store that data in the data lake making it accessible to our clients for subsequent manipulation, analysis, and reporting.

Seamless integration with WV DHHR data sources into our HI Data Lake will provide advanced data analysis, including risk stratification, to enhance the identification of high-risk member needs. As part of our data-driven approach to easing administrative burdens and improving health outcomes, our HI Team is a true differentiator. Our HI Team assists in improving health outcomes with state-of-the art HI tools, leveraging data collection, evaluation, reporting and interactive dashboards to support clients with a comprehensive view of their population. Our healthcare analytics experts use the latest in reporting and analytics software to produce custom and ad hoc reports, automatically generate interactive program dashboards, and perform quantitative analysis. Our HI tools assist in providing the evidence needed to track program progress as well as identify and mitigate potential risks to keep the program informed and on point. We leverage this data, alongside our clinical expertise, in our pursuit and commitment of continuous quality improvement for each program.

The HI Data Lake allows us to provide a true 360° view of available data and the members we serve. We can see trends and develop operational strategies to address those trends. An example dashboard report using sample data can be seen in **Figure 8 Care Management Dashboard.**



WV_006

Figure 8. Care Management Dashboard

Dashboards can be configured specifically for the WV DHHR program.

4.2.1.9 OBTAINING DOCUMENTATION FOR INITIALLY PENDING AUTHORIZATION

4.2.1.9 Vendor should describe their plan for development and implementation of initially pending authorization, which are identified as needing further documentation, during the review process, prior to denying the authorization. This includes, but is not limited to the following:
4.2.1.9.1 Contacting the practitioner via secure electronic media, web-based, telephonic, facsimile, or written request through the mail of the needed documentation for approval.
4.2.1.9.2 Establishing a time frame that the documentation must be received by the Vendor, or the pending authorization will be denied.
4.2.1.9.3 Vendor should include in their plan, steps to assure that pending notices specify documentation needed in the non-medical child welfare services necessity review of services covered by BSS as listed in 4.2.1.25 and efforts that the Vendor will take in collecting specified documentation.

We have developed a clear method for suspending review of prior authorization requests that require additional documentation to complete the review. In the medical program and BSS non-medical child welfare services:

- Documentation is reviewed and missing documentation is identified at time of submission. If the provider uses the provider portal to direct data enter (DDE) a request, they are alerted through a variety of means that documentation is needed to complete the review. For those applications that are solely DDE (such as ADW, behavioral health) the provider is notified through pend reasons or error messages if submissions do not meet requirements. For the medical program which allows faxed requests, if the documentation is not received upon fax of the request a "fax back" form is completed that delineates the missing information and faxed

to the provider. For DDE requests, electronic and telephonic notification is used as in the other programs.

- Timelines have been established for the various programs to establish parameters for the timely receipt of documentation. If documentation is not received within specified timeframes, the request is either administratively closed or denied depending on the information initially received. Timelines are three business days for the medical and behavioral health programs to receive documentation. Providers have been notified of these timeframes and the verbal and electronic notifications remind them of these timelines. When the reviewer places a request in the "documentation requested" status, the review timeline is suspended and resumes when the documentation is received. If the documentation is not received within specified timelines, the request is administratively closed. The provider may resubmit the request with the corrected, updated, or additional information using a "copy for new submission" feature.

Long-Term Care Management

IDD Waiver: Upon receipt of a request for service authorization through our web-based system, the service is automatically placed in a "pend" status. A Registration Coordinator (RC) will review and make an initial determination within two days of receipt. Should we require additional information, the RC will place the requested service(s) in "documentation requested" status and will include a note outlining the follow-up or documentation needed. This change of status automatically sends a notification of the update and requested information to the provider. The provider has 10 days to respond with necessary documentation or the request will be administratively closed.

TBI Waiver: Upon receipt of a request for authorization, the request will automatically be placed in a "pend" status. A TBI Waiver staff will review and make determination within two days of receipt. Should we require additional information, the TBI staff will request documentation or follow-up by the provider electronically (email or web-based system, when available). The provider has five days to respond with necessary documentation or the request will be administratively closed.

> "I wanted to let you know that [Project Manager, Long Term Care Services] Melody [Cottrell] did a great job helping on my 91-year-old grandmother's case. She was amazing and deserves a lot of accolades. She does great work in the LTC arena!"
>
> ***Feedback from Customer Satisfaction System***

Personal Care: We receive authorization requests for Personal Care services via our electronic system. If, upon review, we find the request incomplete or that it does not substantiate medical eligibility, we will request documentation from the submitting provider through the system. The provider has five days to respond with additional information. If no response, the request will be administratively closed. The provider may submit a new request at any time.

Nursing Facility: We review requests for Nursing Facility approval in the PAS system. If the PAS does not include criteria to establish medical eligibility, we will request additional information

through the system. Submitting providers have five days to respond, else the PAS will be administratively deactivated. The submitter may submit a new request at any time.

Aged and Disabled Waiver: The service level change request is the only ADW process applicable to this section. In the event an ADW member requires/requests an increase in their service level, the ADW provider will submit a request through our system. If upon review, we find we cannot approve the request, we will request additional information or follow-up through the system. Providers have five days to submit the information needed or the request will be closed.

4.2.1.10 IDENTIFYING CRITERIA FOR DENIAL NOTICES

4.2.1.10 Vendor should describe their plan for identifying criteria for denial notices which were deemed not met during the review process and advise the practitioner of the reconsideration process and the member of their right to appeal. Vendor should include in their plan steps to assure that denial notices specify criteria which were deemed "not met" in the non-medical child welfare services necessity review or review of services covered by BSS as listed in 4.2.1.25.

We will follow the established Standard Operating Procedure for denials. Denial notices sent to providers and members contain the specific policies and/or criteria not met. In the medical program, we generate letters based on specific clinical criteria that are not met as well as policy citations when policies are not met. Atrezzo is configured to capture the criteria deemed not met during the review process. Atrezzo business rules, configured as part of letter development during implementation, assures denial notices specify criteria deemed "not met" within the designated section of the denial notice. Denial letters for regular residential, foster care and STAT homes are currently generated outside of Atrezzo and, prior to release, are reviewed by a WV clinician to verify the appropriate criteria is referenced.

Denial notices are specific to the program or service and behavioral, medical, dental, non-medical child welfare services, and Waiver denial letters all provide specific criteria that was not met to the provider and member as to why the service was denied. Denial notices also specifically inform the practitioner of the reconsideration process and the member of their appeal rights. WV Medicaid Fair Hearing request forms are included with each program's denial letters. For the BSS Special Medical Cards and PRTF services, we use the same procedures for denials as used for notification except the member/DHHR worker will be directed to the Bureau of Social Services Grievance process as they are the payer. For residential services, therapeutic foster care and stabilization and treatment homes, the denials will be tailored to BSS' criteria and appropriate appeal resources.

4.2.1.11 RECEIVING REQUESTS VIA MULTIPLE COMMUNICATION AVENUES

4.2.1.11 Vendor should describe their plan to receive requests via secure electronic media, web-based, telephonic, facsimile, or written request through the mail for all services that require medical necessity. Vendor should receive web-based requests for all services covered by BSS as listed in 4.2.1.25.

We receive authorization requests for services covered by BSS (as listed in RFP Section 4.2.1.25) from providers via web-based or electronic data interchange (EDI) submission. We will retain existing formats for services it already manages and will develop web-based formats through the

application as well as accepting fax, telephonic or written requests for service authorization that are completed within specified guidelines. Where appropriate to improving the efficiency of the prior authorization request process we will encourage providers to utilize the application and will provide training and technical assistance for using the application. Below we have provided additional details on the process for receiving requests for all services that require medical necessity for each Bureau.

Bureau for Medical Services

We accept requests for prior authorizations and concurrent reviews for medical necessity through our web-based interface as well as through telephone, fax, and mail requests for authorization. Since submitting requests directly through a web interface enables providers to increase the accuracy and efficiency of their requests with real-time field-specific edits, pull-down choice entry, as well as selection boxes, we will encourage medical providers to use this format and provide the training and technical assistance to help them adopt this method. In addition, submission of electronic requests enables us to avoid time-consuming entry of telephoned, faxed, or mailed information – this process reduces data entry errors as well. Providers can access the system 24 hours a day, 365 days a year (except for periodic system maintenance). Finally, the system features a copy and repeat feature for concurrent review requests that helps providers avoid time-consuming re-entry of information that is repeated from the original prior authorization, for added efficiency and data quality.

In our current scope of work, behavioral health providers submit requests electronically via the web-based system. All provider types are eligible to access this site for submissions. Providers who usually have a large volume of requests (e.g., Licensed Behavioral Health Centers) elect to submit through EDI. This submission method allows providers to gather all requests and submit one or more files to Kepro rather than direct data entering each request into the website.

Based upon the large group of providers currently submitting electronically, we suggest consideration be given to maintaining the requirement for electronic submissions for Behavioral Health providers; this approach is consistent with current practice and prevents potential disruption to providers. Additionally, we will encourage providers use web access to systems to improve efficiency and data quality.

Bureau for Social Services

We receive requests for BSS-covered services via the web from all providers. Based upon the large group of providers currently submitting electronically, we suggest consideration be given to maintaining the requirement for electronic submissions for agency and individual providers while allowing foster and biological parents to submit via fax or telephone.

Bureau for Behavioral Health (BBH)

BBH Comprehensive providers currently submit via EDI or web submissions. We suggest consideration be given to maintaining the requirement for electronic submissions for BBH Comprehensive providers; this process is consistent with current requirements and prevents the need for change to new methods across the provider network.

4.2.1.12 MEDICAL/BEHAVIORAL HEALTH ASSESSMENT TOOL

4.2.1.12 Vendor should describe their plan to develop utilization and on-going analysis of a basic medical/behavioral health assessment (which may be standardized and specified by the Agency) to be used for initial and on-going assessment of consumer progress in treatment, identification of appropriateness of level of service, and for preparation of federal reports National Outcomes Measurement System (NOMS) , Treatment Episode Data Set (TEDS), Uniform Reporting System (URS) tables, and Block grant reports requirements. Data collection will require the collection and validation of demographic, diagnostic and service level data for BBH funded treatment, residential and community support services provided to both licensed and other BBH-funded providers throughout the state. The plan should address and allow for modifications to data sets and reports as needs and requirements change.

The current system serves as a basic behavioral health assessment that has been standardized by DHHR and is utilized by clinic, rehabilitation, TCM, psychologists, psychiatrists, and BBH contract providers and certain BSS funded providers. The applications contain basic demographic information that facilitates tracking individuals in both programs and reporting across the programs. We have incorporated medical information into the assessment, uses for initial and on-going assessment in treatment and identification of the appropriateness in level of care as relevant. The data requirement for behavioral health providers is tiered to provide comparable demographic and diagnostic information on all recipients of behavioral health services to BBH and to provide a more robust data set (which includes information about symptoms, functional impairment, current treatment plan goals and other pertinent data relevant to authorizing behavioral health services) when more intensive services are requested. BBH contracted providers must submit a larger basic data set for federal reporting, discharge data for specified services, Substance Abuse Block Grant reporting, and the federal reporting data when the member has a substance abuse diagnosis. BBH contract providers also submit basic demographic and diagnostic data (and federal reporting data, if applicable) for BBH eligible individuals and individuals with other payer sources (for example, third party payers).

We made will make the necessary revisions and additions to the federal reporting data set to collect information on persons with addictive disorders. The current military data set can be validated by Kepro or can continue to be sent to BBH without validation as is the current practice. We will also worked with BBH and their contract providers to develop the required data sets for children/adolescents and information to be collected from state hospitals as well as hospitals and private inpatient facilities that receive diversionary patients from the state hospital when there is no bed availability. Data from BBH contract providers, state hospitals, inpatient psychiatric hospitals handling diversions, and other providers of BBH services designated by BBH, will be

collected upon entry in the system, at critical treatment junctures and at intervals designated by BBH (for example, discharge). Data will be utilized to complete specified BBH reports.

4.2.1.13 COLLECTING DATA FOR PERSONS SERVED

4.2.1.13 Vendor should describe their plan to collect and process basic information about all persons served to include demographic information, diagnosis, medical eligibility for service, level of service need and other basic service information; information to be collected upon initial entry into the system, at regular intervals, and at critical treatment junctures.

Information is collected upon initial program entry, at critical treatment junctures or when prior authorization is requested, depending on the purpose for collecting the data. Data is utilized for evaluating ongoing program eligibility, authorizing services, determining individual budgets, and reporting. Data is collected in the system and members who are involved in various programs can be managed by evaluating utilization across programs. Data is collected through our secure web portals and stored in such a manner to track requests as well as report on identified areas. As the incumbent, we have designed our platforms to work cohesively in member program identification, tracking, and service utilization across programs.

4.2.1.14 COLLECTING DATA FOR BSS-SERVICES

4.2.1.14 Vendor should describe their approach and methodology to collect and process the same basic information submitted by licensed behavioral health providers and of services covered by BSS as listed in 4.2.1.25 as required by the Agency in contract/enrollment for individuals who are uninsured, other third party insured, or receiving services not funded by Medicaid; information to be collected upon initial entry into the system, at regular intervals, and at critical treatment junctures.

Basic demographic data is collected for all behavioral health and BSS covered service recipients so that reporting can be done across programs. Throughout our 22-year history with the State, we have expanded and enhanced data collection. We are accustomed to obtaining and sharing data through our utilization management program, Waivers, BBH, and BSS file exchanges. Initiating with Licensed Behavioral Health Centers, data collection includes member demographics, service utilization, and member eligibility. An example is shown in **Figure 9 BBH Data Collection Process**.

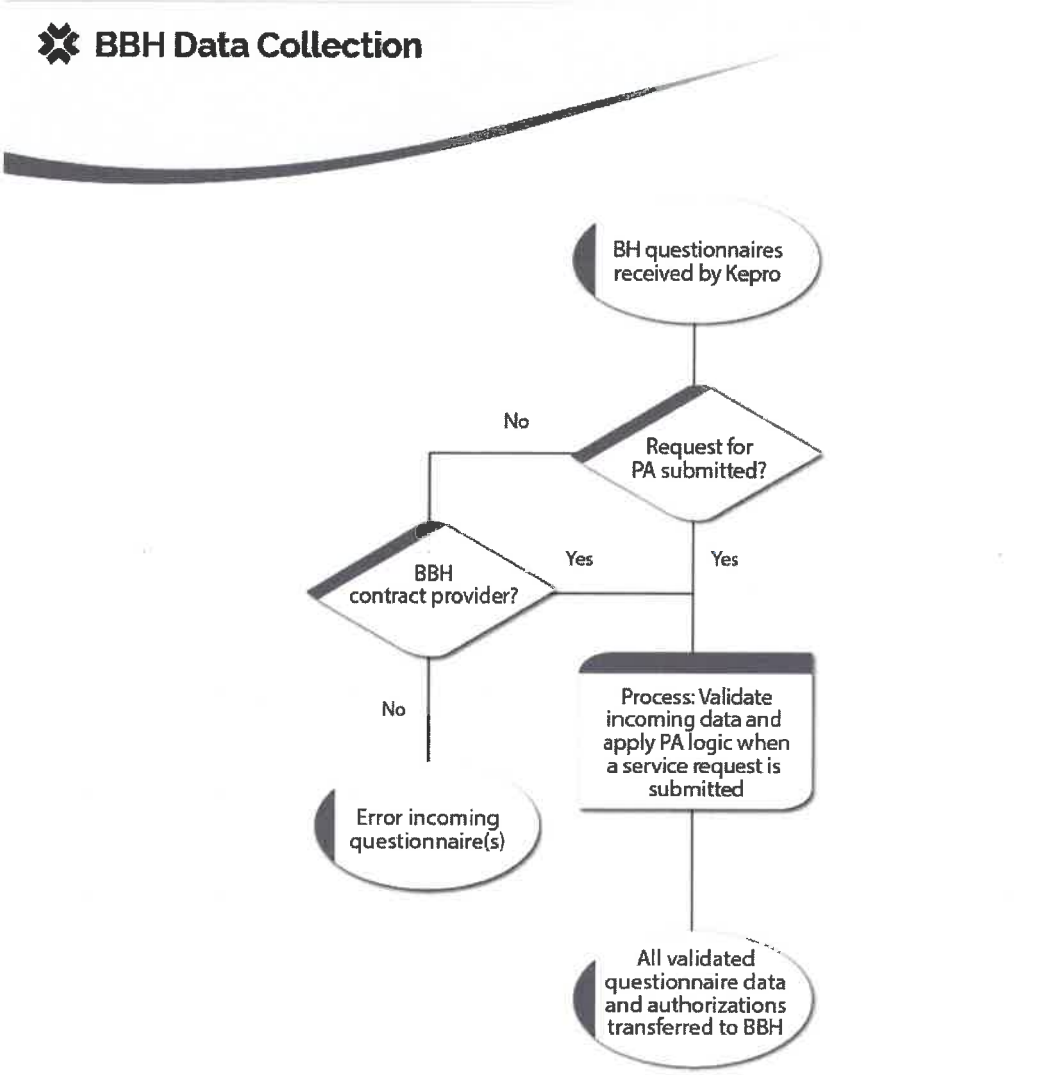


Figure 9. BBH Data Collection Process

We have a customized solution to collect member information as well as other provider data submitted

Data reports specific to BBH include the Consumer Service Data Report and federal data reporting to capture all member service information, regardless of their funding. Our data collection efforts expanded with WV Medicaid's provider base, encompassing private practitioners, Federally Qualified Health Center (FQHCs), and other licensed practitioners. Collection of data occurs at the time of admission, during critical treatment junctures, and scheduled treatment periods recognized within policy. We strive to collect and provide member level data across programs, supporting a comprehensive picture. We will utilize the same methodology regarding data collection, integrated reporting, and service evaluation across program areas and within optional services identified.

Section 4.1.2.8 provides additional information on our approach to providing timely and accurate reporting and analysis.

4.2.1.15 COLLABORATION WITH FISCAL AGENT

4.2.1.15 Vendor should describe their plan to collaborate with the Agency's fiscal agent in order to collect data necessary to produce and communicate to the agency quarterly program specific reports regarding service utilization, prior authorization, and demographics and processing of such reports as necessary. These include, but are not limited to, claims analysis related to the services that receive prior authorization.

We have an established relationship with the MMIS vendor, the Agency's fiscal agent, to access their system to verify member's eligibility status and to check the status of authorizations issued. We additionally receive clinic, rehabilitation, TCM, psychology, and psychiatry claims information for analysis. We will continue to follow the procedure established by BMS for receipt of claims data. We will expand the claims analysis to include the expanded scope of authorizations. We will continue to interface our systems with the MMIS vendor to complete required reports and claims analysis and will work with the vendor to establish a method for receipt of claims data on a more frequent basis to accommodate the requirement for quarterly reports on claims.

As a part of the previous scope of work, we identified cost outliers and areas of fiscal concern pertinent to the system, specific services, consumers, and/or participating providers. Comprehensive reports have been provided to BMS with summary data provided to Contract Management (comprised of representatives from the DHHR Bureaus with which Kepro contracts). These reports are used to analyze service usage, revise policy, predict budgets, training and reporting to various stakeholders. When requested, we provide ad hoc reports to assist BMS with various issues and requests. We have never missed a standard reporting deadline and has been consistently responsive to ad hoc variable deadlines. We will continue to produce the required reports in a timely manner and the statistical budget analysis with Explanation of Benefits (EOBs) for the IDD Waiver Program.

We will maintain the approved process for receiving and distributing data. We will meet with the fiscal agent to expand the claims analysis scope of work further to include all medical claims. Through this efficient and accountable system for funding appropriate services can be maintained.

We will work collaboratively with BSS's Office of Finance and Administration to determine what data from the existing system, and their financial data are required to produce quarterly reports and will design required reports based on this consultation.

4.2.1.16 TECHNICAL ASSISTANCE AND TRAINING FOR PROVIDERS

4.2.1.16 Vendor should describe their plan to provide technical assistance and training for Agency providers regarding trends, performance, documentation, assessment, and medical eligibility for services as requested, not to exceed one per month in each agency region.

Providing training and technical assistance to the provider community has remained a strength of throughout our tenure with the State. Based post-training surveys conducted over the past three

years, providers are very satisfied with our training as demonstrated in the **Table 3 Post-Training Evaluation Results for Past Three Years.**

	Knowledge	Clarity	Relevance	Preparedness	Satisfaction	# of Surveys
2022	4.59	4.64	4.69	4.65	4.64	316
2021	4.48	4.55	4.63	4.47	4.53	535
2020	4.49	4.58	4.62	4.42	4.56	281

Table 3. Post-Training Evaluation Results for Past Three Years
Survey results demonstrate that providers are very satisfied with our training

Our post-training surveys use a 5-point Likert scale with a rating of 5 (strongly agree) being the most positive rating or highly satisfied, then 4 (agree) indicates satisfied. A rating of three is neutral/no opinion with ratings of 2 and 1 being negative ratings indicating low satisfaction. Our survey results consistently score in the satisfied to highly satisfied range.

We look forward to continuing this record of support and collaboration. We will continue to offer general regional training sessions for Agency providers, not to exceed one per month in each agency region, addressing trends, performance, documentation, assessment, and medical eligibility for services, and other agreed upon topics. We will offer continuing education units for qualifying training sessions.

During our 22+ years of service, we have had the opportunity to explore various ways to find the most effective and efficient way to share trends and details with our providers. Working with providers, we found that information provided in large group settings was often not passed down to those staff providing the services. Our Trainer Consultants have found that offering smaller, targeted training sessions at each individual provider's site is the most successful. This approach allowed providers and Kepro to pinpoint which skill/trend and detail needed the most support and directly reach the appropriate staff Moving to small group onsite sessions allowed providers to take ownership in the training and technical assistance process. Coordinating the training with provider's schedules to provide multiple sessions at their site also minimized impact on the provider's operations.

In addition to regional and onsite training and technical assistance, we will also continue to provide webinars to reach more people. Using webinars allows us to offer more sessions on various days and times. With no need to arrange staff transportation, webinars give providers additional flexibility to schedule staff at different times, minimizing impact on providing services.

Did You Know?

171 formal trainings were conducted during FY2021 offering providers' staff over 412 hours of education.

For providers who receive retrospective quality reviews, we develop tailored training plans based on their review results. Trainer Consultants are available for on-site visits to assist providers in implementing the new information and/or answer questions specific to their work. Onsite provider training allows providers to choose a traditional PowerPoint informational training or use actual cases from their office as examples.

Our process to develop and deliver technical assistance and training includes the following activities, which we will finalize with the approval of the Agency:

- **Needs assessment**. We will work with the Agency and the provider community to identify training and technical assistance needs at the provider and regional levels. We will also use information from our eligibility verification and data validation processes to identify areas where providers may require technical assistance and/or training. An important aspect of needs assessment is the analysis of data trends and patterns of provider performance that vary from Agency requirements. Needs observed among providers will be documented and reviewed with the Agency, with our recommendations for training and technical assistance services that address the identified needs.
- **Development of training programs to address identified needs.** With approval from the Agency on provider training needs, we will develop training materials and programs for the provider community, such as documentation requirements, aspects of medical eligibility for services that can be improved among providers, and the assessment process and results of reports on provider performance. These materials will be submitted to the Agency in advance for review and approval and revised after comment from the Agency as needed.
- **Scheduling of technical assistance and training.** Technical assistance and training opportunities can be delivered at the individual provider level and/or to the provider community at large. In this discussion, we address scheduled regional training and technical sessions for providers. We will continue to provide one-on-one training and technical assistance to Agency providers as needed. Regional training sessions will be scheduled so that providers can be notified of the training and agenda, location, and timeframes at least 30 days in advance of the training session. This information will be distributed directly to providers as well as posted on the Kepro website. As with training and technical assistance materials, we will submit the proposed training schedule, locations, and agendas to the Agency in advance, as part of our collaborative planning and management process.
- **Delivery of technical assistance and training for providers.** Our team members will conduct the regional technical assistance/training sessions as proposed. During the training sessions, providers will also be encouraged to identify other topics for future training

Provider evaluation comments attest to Kepro's ability to deliver relevant training:

- "Thank you for explaining how to tie medical necessity into my treatment strategy. Well done!"
- "Fantastic job of keeping the training interesting and the participants engaged!"
- "Content was relevant and will be very useful to me as a therapist"

sessions, as well as request and schedule opportunities for technical assistance at the individual provider or provider group level.

- **Evaluation of technical assistance/training.** As with all training we have conducted, we carefully evaluate the success of each session through feedback from participants. This information allows us to assess each component and determine its success in meeting the technical assistance/training need identified. Participants will be asked to complete a questionnaire on the session that helps us evaluate the extent to which the:
  - Training format and content provided relevant information.
  - Training format and content provided useful information.
  - Session content could be improved and in what way.
  - Session scheduling could be improved and in what way.
  - Overall, format and content were satisfactory or very satisfactory.
- **Improvement of technical assistance and training programming.** Feedback from the provider community and the Agency will be used to improve the content and process of developing and delivering these programs.

We will use this process to identify, develop, deliver, and continuously improve technical assistance and training programs that are highly tailored to identified needs among the provider community and successful in meeting those needs, to continue to ensure the highest quality services for consumers receiving services from providers.

4.2.1.17 WEB-BASED REPORTING PORTAL

4.2.1.17 Vendor should describe their plan to provide a web-based reporting portal for prior authorization of Medicaid and non-Medicaid covered services to community behavioral health service providers. This system would permit for expansion and collection of unique data sets for program specific information.

We have existing, easily accessible, web-based portals for purposes of reporting an array of information. Providers currently access the system applications for programs such as behavioral health, BSS-covered services, IDD Waiver, Aged and Disabled Waiver and Personal Care services. Medical, TBIW, and CSED programs have transitioned to the Atrezzo platform, and the remaining programs are anticipated to transition during the implementation period of the new contract. The applications have components tailored to the specific program types and perform functions related to prior authorization, budgetary model modifications, and non-medical necessary services. In addition, WV Medicaid medical and nursing home services are reported through the web-based system application. **Figure 10 Kepro Web-based Reporting Portal** shows some of the fields that can be used for searching and reporting.

As indicated previously, reporting capabilities are well established and may be expanded. We have history of responsive, accurate, and useful data reporting to assist the Agency and providers. If further reporting options are desired, we will be glad to meet with Agency representatives to address issues. See Appendix 5 For more information on our reporting capabilities.

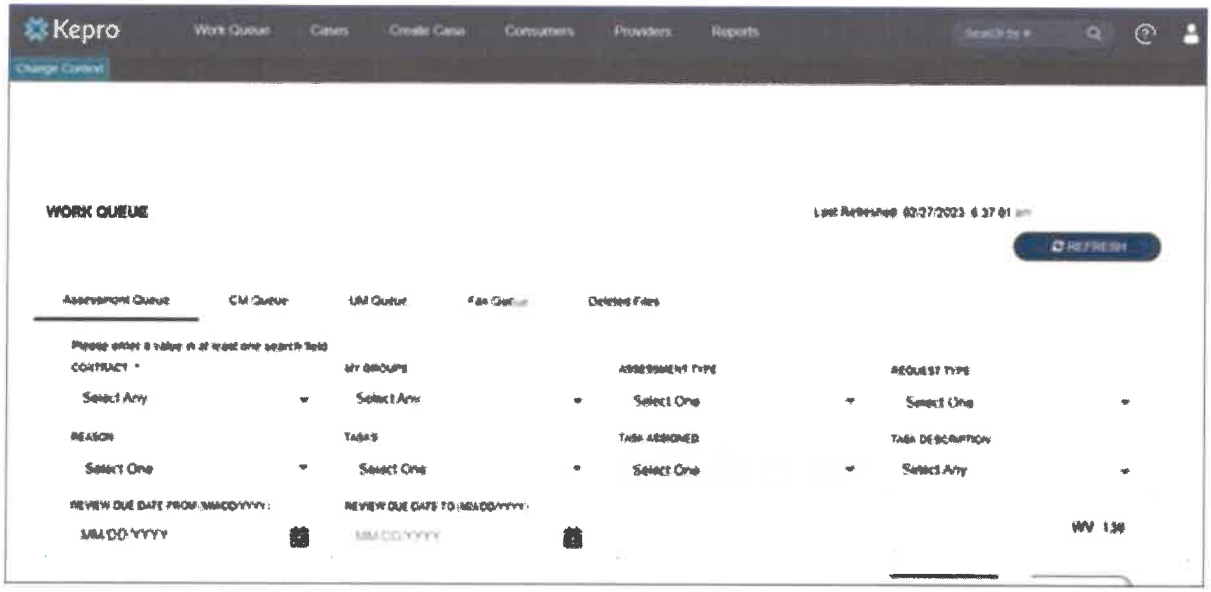


Figure 10. Kepro Web-based Reporting Portal
Our Atrezzo portal provides a full array of information

4.2.1.18 REFERRAL OF SUSPECTED FRAUD

4.2.1.18 Vendor should describe their plan to refer any instances of suspected fraud to the following parties:
4.2.1.18.1 Medicaid fraud should be submitted to the BMS Office of Program Integrity (OPI).
4.2.1.18.2 Instances of suspected fraud in the delivery of services covered by BSS as listed in 4.2.1.25 should be reported to the BSS Office of Finance and Administration.
4.2.1.18.3 Instances of fraud related to BBB-funded programs should be submitted to the BBH Office of Compliance and Monitoring.

We are dedicated to the integrity of West Virginia's health and social services programs and is vigilant in identifying and reporting suspected fraud to the appropriate agencies. We understand that instances of suspected Medicaid fraud will be reported to the BMS Office of Program Integrity (OPI); instances of suspected fraud related to services covered by BSS (as listed in 4.2.1.25) will be reported to the BSS Office of Finance and Administration. We will go beyond the mandatory requirements of this item to help ensure the most effective approach to preventing waste, fraud, and abuse. We monitor utilization patterns and trends and report suspicious or concerning activity to the WV Office of Program Integrity.

We will continue to promote effective and appropriate utilization of Medicaid services. This support will be accomplished by ongoing communication, technical assistance/training for providers along with reinforcement of the West Virginia Medicaid manual. While best efforts continue, a select few providers have experienced difficulty in maintaining adherence to regulations. In these instances, we will continue to report suspected fraud to the Bureau's Office of Program Integrity (OPI). After review by OPI or the Bureau, if the need for technical assistance or further training is identified, we will develop and implement trainings.

4.2.1.19 PRE-HEARINGS AND HEARINGS

4.2.1.19 Vendor should describe their plan to attend, coordinate, and participate and/or represent the Agency in member prehearings and hearings as requested by or on behalf of a member who disputes their denial of services. The plan should include the Vendor's attestation to:

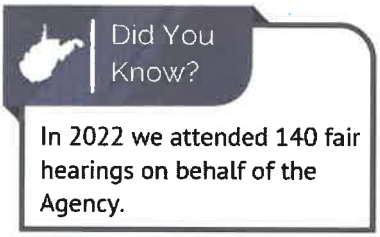
4.2.1.19.1 Provide appropriate staff to attend and testify at the hearing, either in person or telephonically, whichever is requested by the Agency.

4.2.1.19.2 Schedule and coordinate the hearings with the State Hearing's officer, member, legal representative, and any other agency/individual required.

4.2.1.19.3 Prepare and distribute the hearing packets and schedule as required by the Agency to all parties involved in the scheduled hearing.

We have worked with WV DHHR over our long-term partnership to create, maintain, and adjust a Complaint Policies and Procedures Manual. The manual and any modifications require written consent and approval by the Agency, ensuring that any associated processes remain in compliance with WV DHHR requirements, including the fair hearing process.

We have a base list of key policies and procedures used to support prehearings and hearings. We will modify and/or add new documentation based on WV DHHR feedback and information discovered during the initiation, discovery, and development phases of Implementation. We are constantly evaluating process gaps and opportunities for additional policies and procedures through our Continuous Improvement processes. For example, we attended Medicaid fair hearings via teleconference based on the State's guidelines during the COVID-19 Health Emergency.



We work with BMS to participate in prehearing conferences related to our Waiver programs; often reaching amicable decisions before a fair hearing option is exercised. Staff participating in prehearings/fair hearings have a depth of knowledge related to the case in question, program services and associated policies.

We understand that there are inherent differences across WV DHHR programs, our plan to represent the Agency in member prehearings and hearings is based on contract requirements and the specific needs of each program:

IDD Waiver: We have been and will continue to provide appropriate staff to attend and testify at prehearing conferences and/or service denial hearings when requested by the Agency (eligibility denial hearings are attended by the state's Medical Eligibility Contract Agent). We will continue to schedule and coordinate applicable hearings with the State Hearing officer, member and/or their representative, and any other agency/individual required. We will continue to provide hearing packets to applicable parties within designated timelines. If a member has acquired legal services, we will only communicate with the Bureau and the Bureau's attorneys.

TBI Waiver: We have been and will continue to provide appropriate staff to attend and testify at prehearing conferences and/or hearings when requested by the Agency. We will continue to schedule and coordinate applicable hearings with the State Hearing officer, member, and/or their

representative and any other agency/individual required. We will continue to provide hearing packets to applicable parties within designated timelines. If a member has acquired legal services, we will only communicate with the Bureau and the Bureau's attorneys.

Aged and Disabled Waiver and Personal Care Services: We have been and will continue to provide appropriate staff to attend and testify at prehearing conferences and/or hearings when requested by the Agency. A co-vendor, Bureau of Senior Services (BoSS), is responsible for coordinating applicable hearings with the State Hearing officer, member, legal representative, and any other agency/individual required. If the Agency releases optional Aged and Disabled Waiver services, we will assume these responsibilities. We will continue to make available assessment, eligibility, and service level information to the Bureau of Senior Services through our system so they can prepare hearing packets. Implementation of this system for these programs has drastically reduced the time it takes BoSS to acquire necessary information for preparing hearing packets.

Behavioral Health Services: We understand that fair hearings may occur when requested by members following service denials. We receive notification from the Agency when a hearing is requested and the date of the hearing. We gather all information related to the service request and denial, and that information is sent to the Agency for distribution to all parties.

We will continue to perform activities related to scheduling, coordination of the hearing, document gathering, and packet distribution according to the Bureau's planned specifications. We will retain the staff necessary to participate, in person or by phone as required by the Agency, in member fair hearings.

4.2.1.20 REVIEWS WITHOUT NATIONAL STANDARD CRITERIA

4.2.1.20 Vendor should describe their plan for reviewing all activities for which there is national standard criteria available. The Vendor should identify those criteria (Interqual is preferred but not required) and provide an analysis of the pros and cons of utilizing the criteria in the West Virginia contract. The Agency may, at its option, require use of any or all criteria sets so identified.

We have evaluated national criteria sets. It is important to note that in the application of all criteria, the reviewers' clinical judgment is used to interpret the diagnosis, identify relevant criteria, and use those criteria to assess the extent to which the services that are proposed are appropriate to address the diagnosis. Referral to an additional level of review occurs if approval cannot be issued at the first level of review. This is true whether InterQual® or other BMS-approved criteria are utilized. Therefore, our experience with the Medicaid Provider Manual and the selected criteria is a critical factor in achieving inter-rater reliability and understanding the needs of the West Virginia Medicaid population.

InterQual criteria are recommended in review areas where it is available. Medical providers are familiar with InterQual guidelines for determining eligibility for various services, and several of them have adopted InterQual for internal use because it makes internal Quality Assurance/Quality Improvement determinations congruent with external prior authorizations. Additionally, current

medical reviewers have extensive experience with InterQual. By continuing to use these criteria for medical review, we significantly reduce the time and cost associated with re-training across the system.

In review areas where there are no applicable InterQual criteria that can be used for review (i.e., dental, orthodontia, chiropractic, speech therapy, etc.) or inadequate criteria exist (i.e., cases requiring follow up imaging post-scan to monitor disease progression, wide surgical excisions, post-positive biopsy); we will work in collaboration with the Agency to establish criteria that meet the medical necessity guidelines outlined in West Virginia Medicaid policy to ensure policy intent is inherent in the selected criteria. In such cases we will work with provider experts to develop or modify evidence-based review criteria for use by initial clinical reviewers. Use of the modified criteria will prevent delays in review determinations and reduce case review costs by eliminating the physician review step of the process for some reviews. The modifications that we propose will be based on the experience and observations of our clinical staff, physician reviewers, and our Medical Director. These modifications will enhance the quality, timeliness, effectiveness, and cost efficiency for the Medicaid program. We will submit our proposed criteria to the Agency in advance for review and approval. We will review the criteria on an annual basis to identify any need for refinement in responses to program updates.

Requirements in several areas of review (for example, dental/orthodontia and genetic testing) have specific timelines and requirements for development, ongoing review, and submission of medical necessity criteria. These requirements are specifically discussed in these sections of the RFP.

For all review areas, the Medicaid Policy Chapter relevant to the review area is used in the review process to establish limits on services, establish benefit parameters, provide specific review criteria in some instances, and provide guidance in areas where Medicaid may necessitate development of local medical policies or specific local edits to InterQual criteria to ensure Medicaid policies are implemented appropriately in the utilization management/prior authorization process.

4.2.1.21 COUNCIL ON ACCREDITATION (COA) AND OTHER APPLICABLE STANDARDS

Vendor should describe their plan for reviewing Council on Accreditation (COA) standards or other applicable service, program or certification standards as identified and recommended by BSS.

We will work closely with BSS to identify applicable service, program or certification standards that can be applied to the UM and PA processes. For example, the Council on Accreditation (COA) standards address best practices for organizations providing community-based social and behavioral healthcare services such as:

- Child, youth, and family services
- Behavioral health services
- Aging services
- Homelessness services
- Intellectual and developmental disabilities services

- Residential services
- Additional social services

We will review COA and other applicable program or certification standards to develop or modify evidence-based review criteria used by our reviewers. Using criteria based on recognized standards will enhance the quality, timeliness, effectiveness, and cost efficiency for the Agency's programs. We will submit our proposed criteria to the Agency for review and approval prior to use. We will review COA and other applicable standards identified and recommended by BSS annually to identify any need for refinement in response to new or revised standards and/or program updates.

4.2.1.22 EVIDENCED-BASED CRITERIA

4.2.1.22 Vendor should describe their plan to review and stay current with evidenced- based criteria, and if appropriate and necessary, recommend updates and/or alternative criteria. If there are no specified criteria for a requested service, the Vendor should research and render a recommendation subject to the Agency's approval.

We maintain a robust corporate process to monitor and evaluate the selection of criteria for specific projects. We use InterQual for medical review in West Virginia, Virginia, and nationally for Tricare, as well as for other state and commercial clients. We use MCG Care Guidelines for behavioral health review. Working with these national organizations, we have access to their extensive and evidence-based process to assess peer-reviewed literature, emerging technology, and other developments in national standards of medical care and behavioral healthcare and we update criteria as needed. Additionally, as a URAC-accredited company for Health Utilization Management, Case Management, and Disease Management, we have processes to evaluate and reflect updates in criteria in policies and procedures. These materials are distributed throughout the organization through a process of communication and training to ensure implementation.

Along with our in-state clinical and programmatic resources we have the expertise available to research peer-reviewed and other topical information, consult with experts in the field locally and nationally, and identify and recommend criteria to the Agency for review and approval. We used this approach in the development of BSS's non-medical service criteria and when identifying the need to add American Society of Addition Medicine (ASAM) standards to our review criteria. The relevant department Project Manager is responsible for this process when we identify areas lacking national standard criteria, depending on the nature of the service. Just as important is our ability to communicate and train providers when the Agency approves new criteria or updates existing criteria. Through our online, regional, and one-on-one training process, we disseminate requirements throughout the provider community, providing orientation and training for other stakeholders as well. Through this process, we promote high degrees of compliance in the provider community as well as understanding and acceptance among other stakeholders.

4.2.1.23 TRACKING ALL INFORMATION

4.2.1.23 Vendor should describe their plan for tracking all information for statistical and reporting purposes. All information for statistical and reporting should include any member identifier in the Agency's system(s).

We capture and store Agency member information, including any member identifier in the Agency's system(s), for statistical and reporting purposes. We use the Medicaid member number and other identifiers unique to the individual member to track the member within and between programs in the utilization management system. Examples of other unique member identifiers include the Medicaid/BBH Consumer ID and/or Gainwell Claimant ID. These identifiers allow us to provide unduplicated member counts for accurate state and federal reporting.

4.2.1.24 EMERGENCY ADMISSIONS AND RETROSPECTIVE REVIEWS

4.2.1.24 Vendor should describe their plan for having a system to ensure emergency admissions, or an admission in which member eligibility for the service is denied retroactively and will be subject to retrospective review.

Emergency admissions for medical services will be reviewed in accordance with approved timelines and established clinical criteria. Emergency medical admissions that occur for enrolled members on weekends, holidays, or at a time the review process is unavailable will require submission within 10 business days following the service. As always, authorization does not guarantee approval or payment for the service(s). We identify behavioral health emergency admissions to acute inpatient facilities as urgent/emergent and they receive priority in review. The system addresses emergency requests:

- **New Medicaid members.** For a member who has recently enrolled in WV Medicaid but is not yet present in the eligibility file, the provider can request a courtesy review if the member needs an emergency service. This allows the provider to create a record that can be clinically reviewed and authorized, if appropriate. This process ensures that member access to services is not impeded. Once the member's Medicaid information is available in the eligibility file the courtesy review is linked to the Medicaid ID and the authorization is exported to Moline.
- **STAT orders or emergency services.** Telephonic review is available in areas where medically urgent service is needed, and timely performance of the service is essential to ensure the well-being of the member. In these instances, the provider may contact Kepro, and a record is entered in the system and reviewed. The authorization determination is communicated to the provider. Additionally, the provider may submit the record via DDE and indicate the request is urgent/emergent. In instances where this status is marked the case is expedited to ensure timely service can be obtained.

4.2.1.25 REVIEW OF IN-NETWORK AND OUT-OF-NETWORK SERVICES

4.2.1.25 Vendor should describe their plan for reviewing both in-network and out-of-network services for medical necessity at the closest in-network location. This also applies to the services covered by the BSS, which include the special medical card, psychiatric residential facilities outside the borders of WV, out-of-state residential provider reviews, qualified residential treatment programs (QRTP) independent program assessments, special psychological evaluations, and the therapeutic foster care program.

Our in-place policies and procedures facilitate the review both in-network and out-of-network services for medical necessity at the closest in-network location. Medicaid policy requires that any service provided by an out-of-network provider be prior authorized except for emergency room services, labor and delivery, and services to foster children at facilities near their placement when prior authorization is not normally required for the service. We have worked extensively to define and refine this process to ensure that Agency policy is implemented appropriately, and that out-of-network services are utilized appropriately. We have also worked with the enrollment vendor and claims payer, Gainwell, to ensure that out-of-network providers approved to serve WV members are reimbursed appropriately. Additionally, any services falling in this category reimbursed by BSS will follow the process for Medicaid's corresponding service area. **Figure 11 WV Medical UM Non-Standard Out of Network Provider** outlines our process for out-of-network provider review.

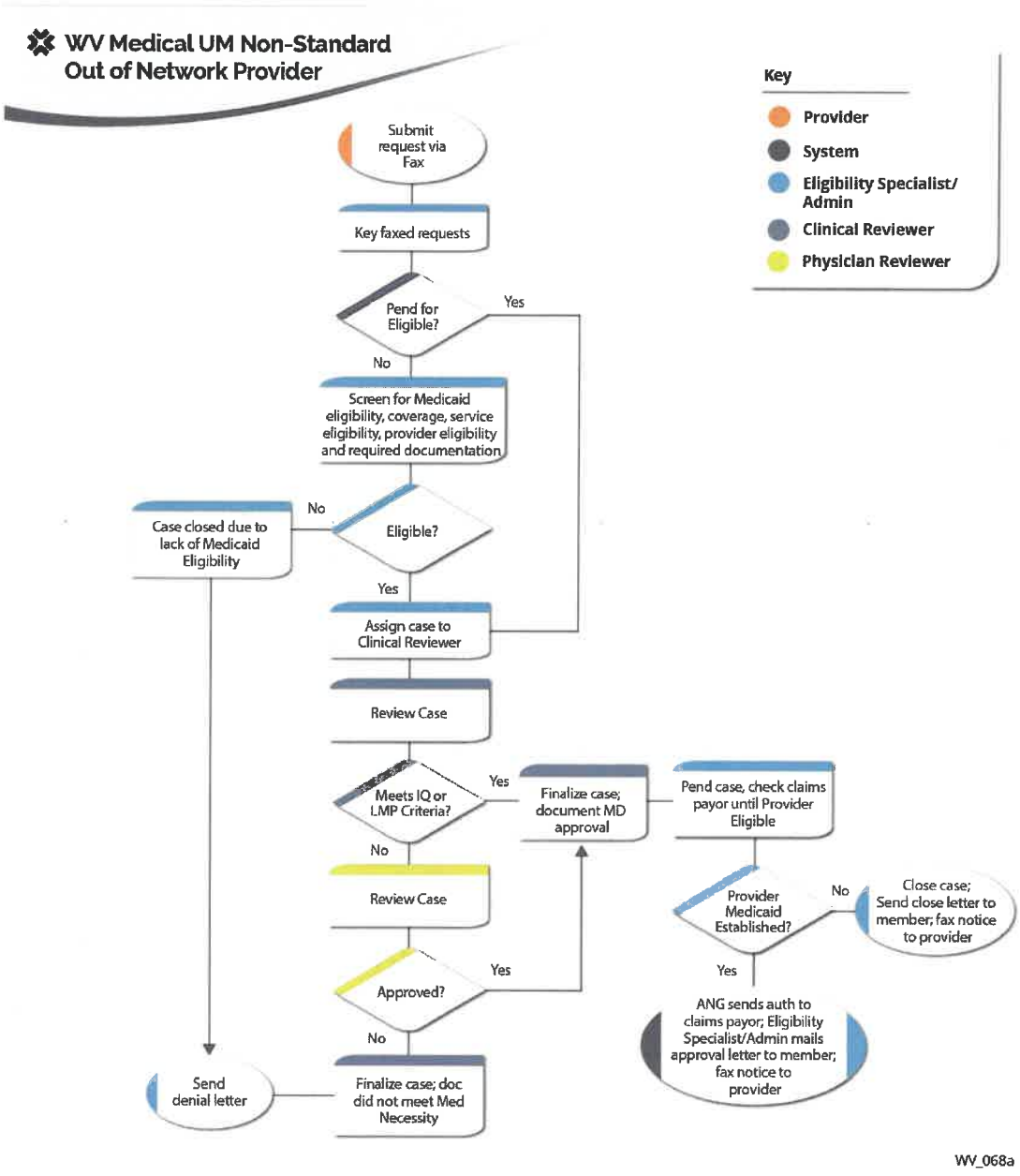


Figure 11. WV Medical UM Non-Standard Out of Network Provider

Our process ensures compliance with BMS policy, and that out-of-network services are utilized appropriately.

4.2.1.26 RETROSPECTIVE QUALITY REVIEW PROCESS

4.2.1.26 Vendor should describe their plan for a Retrospective Quality Review process for applicable services covered by BSS as listed in 4.2.1.25. This review process should include analysis of the services provided by the specific provider, an assurance that the staff providing the service and/or the Agency have the appropriate and current credentials necessary and that the case documentation and invoice reflect that the service was provided according to the established UM Guidelines. All providers should be reviewed on an 18-month cycle with the exceptions allotted for special request at the discretion or direction of the applicable Agency.

After the prior authorization Provider Educators implement a retrospective review of provider documentation practices and utilization management processes. The Educators will review service invoices provided by BSS or provided directly from the provider, and the provider's credentialing information, while on-site for the retrospective review. Each provider will receive at least one review every 18-month cycle. Additional reviews may be warranted based on:

- The number of authorizations over a 5- to 6-month period
- The scores from the past review period
- Special requests from BSS or Care Managers

Providers with 10 or more unduplicated consumers authorized for services covered by BSS (as listed in 4.2.1.25) will receive an onsite review. Providers with less than 10 unduplicated consumers will receive a desk audit. A random sample is pulled based upon the volume and complexity of the service array of the enrolled providers. Consultations with providers will be scheduled at least four to six weeks in advance by the designated Educator. If the provider cannot be immediately reached by phone the Educator will leave a message for the provider to return a call to the Educator. If the call is not returned the same day, the Educator will attempt to contact the provider daily for three business days. If no return call is received within three business days, the Educator will email the provider with three possible dates for review. If no reply to the email is received within three business days, the Project Manager, Health Homes (HH), CSED, qualified residential treatment programs (QRTP), and TBI Waiver Services will be apprised of the situation.

During the phone call to schedule the consultation, the Educator outlines the consultation process and its purposes. The Educator confirms the provider's mail and email addresses during this phone call and asks to whom the sample request should be sent. The Educator then informs the provider of the secure email process. The list of case records for potential review will be provided by fax or e-mail (per provider preference) three days prior to the review to allow time to pull the requested records. The sample is generated by the Data Analyst. Consultation activities include technical assistance and the review of specific case records. The Educators maintains confidentiality according to HIPAA guidelines. If questions arise, providers will be given the opportunity to provide an explanation or to locate missing or misfiled information. The following tools are required:

- UM Guidelines manual
- Copies of review instruments
- Kepro Interpretive Guidelines

- Copy of each consumer's record with demographic information, current living situation, and service plan summary, presenting problems, level of support questions, guardianship status and free text field information.

Did You Know?

Since 2016, Kepro has conducted over 3,500 onsite Facility Reviews for our South Carolina client to determine eligibility for Continued Stay.

Once onsite, the Educator begins the review by interviewing the primary contact person for the agency or the service provider. This person is queried regarding how referrals are received, what information is received at first contact, how is information gathered for the system, and whether there are concerns about the admission process. Using the sample printout, the Educator selects a record for review. The consumer's system record with fields reflecting the consumer's functional deficits and the focus of the service plan is compared to any information in the record and the service plan for consistency. If there are multiple re-authorizations for the same service, the Educator reviews case notes, service plans, any documentation that indicates the worker was contacted at the re-authorization period, that progress towards service objectives was addressed, and all agreed that the services should continue. Provider personnel charts will also be reviewed to ensure that the proper credentials and requisite background and safety checks such as the OIG list have been completed. A portion of the review report will directly address the results of each personnel chart. If questions or concerns about specific records arise during the consultation, they can be discussed by phone with the Project Manager, HH, CSED, QRTP, and TBI Waiver Services.

We meet with providers at the conclusion of the on-site review. We discuss the most important review findings and assess strengths and areas of improvement for the provider. The Educator addresses any provider questions brought up during the entrance meeting or during the review process. After the meeting, the provider completes an Exit Technical Assistance form and returns it to Kepro. A Consultation Report, which presents results and recommendations for improvement, is distributed electronically to the provider immediately following the exist conference. A consultation follow-up technical assistance call addresses areas for improvement identified through the review process and is made within 10 days of the provider's receipt of report. The outcomes of these reviews will also be provided to BSS and reviewed to determine if any further action is required.

4.2.1.27 SCHEDULE OF RETROSPECTIVE QUALITY REVIEWS FOR BSS-COVERED SERVICES

4.2.1.27 Vendor should describe their plan to provide BSS a schedule of retrospective quality reviews to be conducted on providers of services covered by BSS as listed in 4.2.1.25. BSS shall provide a sampling of invoices to the Vendor for claims made for BSS-covered services. As a part of the retrospective review, the Vendor shall review the supporting documentation in the provider records to ensure the services invoiced and paid for have been provided and all reports have been sent to the BSS.

We will provide the monthly consultation review schedule to the BSS by the last week of the month. BSS will pull a random sample of provider invoices which will be sent to Kepro within two

business days of receipt of the schedule. This approach will allow our Data Analyst to pull a supplemental sample of services and charts to meet our sampling volume requirements.

At the scheduled time, we will conduct the consultation review using consultation tools that were previously approved by BSS. Each chart will be assigned a score based upon the established scoring criteria. We will also compare the service documentation to the BSS invoices, verifying the services invoiced were provided, appropriately documented, and consistent with established UM guidelines and BSS service definitions. Invoiced services that do not meet these requirements will be reported to BSS within five business days of the end of consultation reviews.

During the consultation review, we will also verify the degree and licensure or certification of the provider staff members whose names were documented in the consumer record by visually inspecting the personnel record or other provider confirmation of staff credentials. Any staff member whose degree and license cannot be immediately verified to conform with the degree and/or licensure requirements for the service will be (within one business day) reported to BSS. The provider will be informed of this report and will be directed to cease utilizing the staff member for the applicable service code until this matter is resolved by BSS. We will conduct an Exit Interview with the provider immediately after the conclusion of the consultation review and will present salient findings and issues to the provider at that time. All reports will be reviewed with BSS staff and plans made for technical assistance.

4.2.1.28 SCHEDULE OF ALL RETROSPECTIVE QUALITY REVIEWS FOR AGENCY

4.2.1.28 Vendor should describe their plan to provide the Agency a schedule of all retrospective quality reviews to be conducted for Agency service providers. As a part of the review process the Vendor should propose a quality management plan for Agency services as well as a schedule of the review cycle. This will include all the performance measures for the Title XIX Intellectual/Developmental Disabilities Waiver (IDDW) and the Traumatic Brain Injury Waiver (TBI) in order to meet the CMS standards for the program.

We will prepare and disseminate a schedule of retrospective quality reviews to the Agency quarterly. Each schedule will include the provider to be reviewed, the expected start date of the review (or week provider will be reviewed) as well as the Provider Educator who will lead the team of reviewers. We propose to continue the existing methodology for provider quality reviews, which we believe has served the Agency and providers well.

> I wanted to take a minute to thank all of you [TBI Waiver Team] for the great work you do on these denials and Auths. I really appreciate each of you and all you do to help our staff get things done they need to do."
>
> **Feedback from DHHR Program Manager**

We will review every TBI and IDD Waiver provider who actively serves (or served) a member during the review period annually. We have Agency-approved performance measures that will be used for the next approved TBI and IDD Waiver cycle. We will collect and report this information on the Discovery and Remediation Report monthly.

We integrate total quality management into every aspect of the work we do. We will continually seek to improve the quality of our own services as well as the services provided and offered to program members. We request feedback through surveys for functional and eligibility assessments, provider reviews, and training. We approach our provider quality reviews through a lens of the desire for total system improvement. We focus on identifying individual and systemic issues that require improvement. We make decisions and recommendations based on facts. We effectively communicate the issues, plans for improvement and expectations for the programs. We develop and implement training for providers, members, and stakeholders as the needs for such evidence. As part of our proposed quality management plan, we will:

- Review every provider every year with an emphasis on the approved CMS quality indicators, policy, and procedures approved by the Agency
  - We will provide technical assistance during and after every provider quality review.
  - Providers will be expected to complete and submit a Plan of Correction following their reviews. We will work with the provider until the plan is acceptable/approved.
  - For those providers with a deficiency identified on their Plan of Correction, we will complete a desk or on-site follow-up review. This second review will focus on the provider's implementation of their approved Plan of Correction.
  - We will report findings of any follow-up review(s) per an Agency-approved plan.
- Evaluate data from statewide provider reviews to determine potential areas of improvement
- Present data to the Quality Improvement Advisory Council (comprised of members, providers, and other program stakeholders) for feedback on areas of improvement and potential interventions
- Make recommendations to the Agency on additional training, technical assistance, or policy clarification
- Implement training, technical assistance, or policy clarification(s)
- Evaluate impact of the intervention upon the next cycle of provider quality reviews
- Continually execute an Assess, Advise, Plan, Implement, and Evaluate cycle

We will provide an advance schedule of all retrospective reviews to the Agency program managers. For each completed review, we will provide a copy of the site review report and any follow up plan developed based on the outcome of the review.

4.2.1.29 USE OF SUBCONTRACTORS

4.2.1.29 The Vendor should list all subcontractors that the Vendor intends to use for any administrative functions of the Utilization and Prior Authorization Program. Additionally, for each subcontractor, the Vendor should:

4.2.1.29.1 List the subcontractor's name, address, contact person, and phone number.

4.2.1.29.2 Detail the exact nature of the subcontractor's responsibility for the Utilization and Prior Authorization Program, and the projected dates the subcontractor will begin and end work.

4.2.1.29.3 Detail the time period, scope of work, and quality of performance for any past work performed by the subcontractor in conjunction with the Vendor.

4.2.1.29.4 State the consequences of failure to perform.

4.2.1.29.5 Provide three (3) references for the subcontractor.

4.2.1.29.6 Provide a draft of the proposed subcontract.

We do not intend to use subcontractors for any administrative functions of the Utilization and Prior Authorization Program. By continuing our 22-year partnership with WV DHHR and its agencies, we assure continuity of services and performance in the context of a local company with a national presence in all requirements.

4.2.1.30 TRACKING TAKE ME HOME PARTICIPANT'S STATUS AND ACCESS

4.2.1.30 Vendor should describe their plan to track Take Me Home participant's status and access to Aged and Disabled Waiver (ADW), TBIW, Personal Care Programs, and services received by these members.

We have been involved with and collaborated with the Take Me Home-WV (TMH) program since it was approved in 2011. This Money Follows the Person demonstration program has successfully supported eligible members' transition from long-term care facilities to their own homes and communities. We have prepared and disseminated correspondence to program stakeholders (such as Traumatic Brain Injury Waiver providers) on behalf of the TMH program. We have participated in TMH Advisory Council and quarterly meetings and conference calls. We are prepared to continue these efforts and to incorporate TMH services into existing systems and procedures.

Upon notice from TMH staff that an Aged and Disabled Waiver, Traumatic Brain Injury Waiver, or Personal Care applicant is eligible for Take Me Home (TMH) services, we will flag the application as related to a TMH members. As related to ADW, TMH members are already "flagged" in the ADW system along with a start date and end date for TMH approval. To best coordinate TMH services with existing programs, this feature can be added to the Personal Care and Traumatic Brain Injury systems. Along with flagging the case, we will incorporate a TMH user role into the system. This will allow for instant notification to designated/approved TMH staff of medical eligibility determinations including denials and potential denials, chosen service model, provider selections, Fair Hearing requests and determinations and will allow TMH staff to update the status of TMH participation.

We will prepare monthly status reports on the status of TMH members accessing Waiver and State Plan Personal Care services – as based on the member's eligibility status. We will work with TMH staff to determine the elements and documentation requirements necessary for best practice related to provision of TMH Services. Upon development of an approved review tool, we will conduct on-site and/or desk reviews of these services and prepare a summary report of review findings. We propose that a documentation/desk review is conducted initially with providers of TMH Services for a representative sample of members. If review findings are not satisfactory as determined by the Agency's threshold, then an on-site follow-up review and education/technical assistance will be conducted.

4.2.1.31 POLICY COVERAGE RECOMMENDATIONS

4.2.1.31 Vendor should describe their plan to develop policy coverage recommendations based on nationally accepted evidence-based guidelines and propose how Vendor will research and provide recommendations for approval by the Agency when no nationally accepted guidelines exist. Vendor should describe how all past, current, and future recommendations will be updated as standards change.

We have worked with the Agency in a consultative role to make recommendations on policy coverage and to recommend criteria for reviewing services for medical necessity. Annually, BMS reviews new and edited Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS) codes to make decisions regarding coverage, changes in coverage (for example, previously investigational/experimental procedure is now recognized as an accepted practice and could be covered), prior authorization recommendations, and impact of changes on policy. This process is completed through the Procedure Code Work Group. Once decisions are made regarding coverage, we make recommendations regarding criteria for services requiring prior authorization. The Procedure Code Work Group process also evaluates changes in service limits, prior authorization requirements, and practitioners, providers, or specialties approved to perform the service. Additionally, we serve as a consulting member of the Bureau for Medical Services Policy Committee. This group evaluates and updates Agency policies, including the benefit contained in each manual chapter and the covered services in each chapter.

Through these processes we assure that the appropriate services are being prior authorized in the correct amounts and within policy guidelines. This process also serves to verifies that services being authorized are in line with the requirements for claims payment through alignment with the requirements of the Claims payer such as Correct Coding Initiative (CCI) edits. This integrated approach ultimately benefits the member by ensuring that services requiring prior authorization are reviewed using sound, nationally accepted guidelines, and the provider by increasing the likelihood that claims for authorized services will be paid.

We are proud of the active role it has played in the past 20 years in researching evidence-based guidelines and established clinical guidelines to assist the Agency in making policy decisions. Clinical standards do change, and we have assisted and will continue to assist the Agency, making recommendations as new information becomes available.

4.2.1.32 EARLY, PERIODIC, SCREENING, DIAGNOSIS, AND TREATMENT DATA COLLECTION

4.2.1.32 Vendor should describe their approach and methodology to collect documentation, process, price, and approve non-covered services and/or services over established service limits, when they are requested as a result of an Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) screen.

We have worked extensively with all parties involved in the Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) process to develop an approach to ensure children identified with needs not normally covered within the standard Medicaid guidelines can be evaluated and served. We developed an approved definition for evaluating EPSDT eligibility and imbedded a workflow process in the system that allows a provider to make requests for non-covered services, unpriced

items, and for services over limits or for combinations of services not normally allowable under policy guidelines. We have worked to refine the process for all medical and behavioral health services, to interface with Pharmacy services and with the Bureau for Medical Services, the EPSDT program and the Children with Special Health Care Needs Program to develop a protocol for serving children requiring medical foods.

We are committed to continuation of our work with EPSDT requests for the State, providing reviews for over 150 reviews in 2022 alone. We utilize WV's HealthCheck forms for all EPSDT requests, verifying yearly examinations by approved physicians and supporting documentation is complete. Services requested are identified as either within current benefit guidelines or outside WV's Medicaid plan. All EPSDT requests will receive clinical review, focusing on member age, provider enrollment status, application of national or local guidelines, and service specific documentation requirements. The EPSDT program continues to develop, and we will continue to provide the consultation necessary for expansion of the program within its' defined parameters and assure that members with needs identified through the EPSDT process receive services.

4.2.1.33 CERTIFIED BRAIN INJURY SPECIALIST

4.2.1.33 The Vendor should describe their plan for providing a Certified Brain Injury Specialist to conduct initial assessments and annual assessments for all appropriate members to determine program initial medical eligibility and/or re- eligibility for the TBI Waiver program, and upon eligibility determination develop service plan.

We will continue to provide a process of medical eligibility determination that Is timely, equitable, person-centered, and include relevant stakeholders in the determination process. Through this process, we will document the member's initial and continuing medical eligibility for participation in the TBI Waiver and provide notification to relevant parties to promote a thorough understanding of the process as well as the member's Fair Hearing rights and process. See **Appendix 1, Section A1.1.m. Traumatic Brain Injury (TBI) Waiver Services** for the TBI Waiver medical eligibility workflow.

A Certified Brain Injury Specialist (CBIS) will conduct the initial and re-evaluation assessments. Initial assessments will be scheduled and completed within 45 days of receipt of financial eligibility approval. Reevaluation assessments will be completed at least 30 days prior to the member's established Anchor Date. These assessments include the Pre-Admission Screening (PAS) and the Rancho Los Amigos Scale pursuant to all Agency prescribed instructions, guidelines, and program requirements. The CBIS will review all pertinent physician orders, assessments, and other documentation available during the assessment.

To initiate this process, we will receive daily referral requests for Waiver program assessment, including requests for either an initial or reevaluation. We will process applications on a first-in, first-out basis. We will conduct an initial screening of the application to ensure that it is complete, correct and includes all components necessary (such as within age requirements and has applicable diagnosis, etc.). We will notify the applicant in the event additional information is required. Once the application is complete, we will mail the applicant (using the Agency's approved

letter) and prompt them to obtain financial eligibility through their local DHHR. At this time, they may also select a Case Management Agency to assist them with this task.

Upon receipt verification/approval of financial eligibility, we will contact the member, establish a date, and time for the medical evaluation, abiding by policy related to contacts, appointments, notices, and other measures. If the assessment cannot be completed, we will discontinue the medical eligibility process and notify the relevant parties to reinitiate the process should they wish to pursue application.

We will make every effort to complete assessments within the established timeframe. When an assessment cannot be completed timely due to unforeseen circumstances, such as inclement weather or member cancellation, we will track and report on the reasons for inability to complete within designated timeframe. Once the assessment is completed, the CBIS will submit the evaluations. We will then run the data from the assessment through a computerized algorithm based on current program policy and establish a determination of medical eligibility.

- "[RN Assessor] is such a wonderful person. She is sweet and so kind. We absolutely love her. She always treats us so kind and answers all our questions."
- "Everything was great today. [RN Assessor] took very good care of me and my sister."
- "[RN Assessor] did a great job, very informative, very appreciative. She is such a sweet and kind person."

Applicant and Member Satisfaction, PC Assessment Process, and RN Assessor Survey Comments

We will notify the member/representative about the outcome of the assessment. We will provide a copy of the assessment, and the member/ representative may provide additional information in the event the determination results in a denial of eligibility. Members will be notified of Fair Hearing rights in the event of a denial. Additional information will be considered if received, and a new determination may be made.

If a member is ultimately eligible, we will notify all parties. Members who are eligible when no Waiver slot is available will be placed on a managed enrollment list. When there is no managed enrollment list, the provider agency will be prompted to complete and submit a Service Plan.

4.2.1.34 PERSONAL CARE ASSESSMENTS

4.2.1.34 The Vendor should describe their plan for reviewing initial assessments and evaluations of all Personal Care applicants to determine medical eligibility and service.

We propose a continuation of existing processes and procedures related to the review of Personal Care services for prior authorization. We will have a Registered Nurse review all requests for Personal Care, regardless of service level.

Personal Care provider agencies complete an initial or reevaluation request for Personal Care Services. Providers coordinate with physicians or complete the Pre-Admission Screening (PAS) for submission and to request prior authorization through our system. They must enter/submit basic

member demographic information and then have the option to either data-enter and attach the original PAS – or to just attach the original signed PAS into the system and our staff will key the assessment. Currently more than 50% of requests are data entered by the provider.

Providers must attach the signed PAS as well as any other required documentation (such as physician orders, plans of care, assessments, or other forms) for review into the system. When all data is entered, a Registered Nurse (RN) reviews the request and any attached documents. The RN verifies accurate data entry (if DDE by the provider), confirms required documentation is attached and available within our system and evaluates the medical necessity of the request according to clinical judgment and policy. The RN may approve or request additional information to support the request. The provider is given opportunity to submit additional information and a second review will occur. If approved, an authorization will be generated and sent to the Claims payer. If medical necessity cannot be determined, the RN will consult with another qualified RN prior to denying the request. We will provide the denial notice with Medicaid Fair Hearing rights, if applicable.

4.2.1.35 BMS/WVCHIP DETAILED SPECIFICATIONS IN APPENDIX 1

4.2.1.35 The Vendor should provide detailed response to the BMS/WVCHIP Detailed Specifications, included in Appendix 1.

Appendix 1, BMS/WVCHIP Detailed Specifications includes our response to RFP Appendix 1. As the incumbent, we are the low-risk choice for WV DHHR. We will continue to provide the BMS/WVCHIP contract services as we currently do. During the implementation period, we will modify our procedures and processes to address requirements that are new or different from the work we perform for DHHR today.

4.2.1.36 BSS DETAILED SPECIFICATIONS IN APPENDIX 2

4.2.1.36 The Vendor should provide detailed response to the BSS Detailed Specifications, included in Appendix 2.

Appendix 2, BSS Detailed Specifications includes our response to RFP Appendix 2. Through our years of experience in WV, we have developed an in-depth understanding of BSS requirements. We will continue to perform the BSS contract work as we currently do. During the Implementation period, we will modify our current procedures and processes to address requirements that are new or different from the services we provide for DHHR today.

4.2.1.37 BBH DETAILED SPECIFICATIONS IN APPENDIX 3

4.2.1.37 The Vendor should provide detailed response to the BBH Detailed Specifications, included in Appendix 3.

Appendix 3, BBH Detailed Specifications includes our response to RFP Appendix 3. We will apply our experience supporting WV DHHR to continue to provide the BBH contract services with our highly experienced WV staff. During the implementation period, we will modify our current procedures and processes to address requirements that are new or different from the work we perform for DHHR today.

4.2.1.38 IMPLEMENTATION SPECIFICATIONS AS APPENDIX 4

4.2.1.38 The Vendor should provide detailed response to Implementation Specifications, included as Appendix 4.

Appendix 4, Implementation Specifications includes our response to RFP Appendix 4. As a partner to WV DHHR for 22+ years. We bring a wealth of WV-specific UM and PA experience that our competitors simply do not have. Our Appendix 4 response describes many advantages we offer the Agency as it relates to implementation and seamless continuity of service delivery.

4.2.1.39 REPORTING REQUIREMENTS IN APPENDIX 5

4.2.1.39 The Vendor should provide detailed response to reporting requirements, included in Appendix 5.

Appendix 5, Reporting Requirements includes our response to RFP Appendix 5. We currently provide the majority of the requested reports to the Agency, and we will continue to do so through the next contract term. During the implementation period, we will make modifications and/or develop new reports to meet the Agency's reporting requirements.

4.2.1.40 IMPLEMENTATION PLAN

4.2.1.40 The Vendor should provide a plan to complete all implementation activities within three (3) months.

Our implementation work plan is included as **Attachment 4 Implementation Work Plan and Gantt Chart**. It lists the tasks and subtasks as well as the timeline for each activity and documents how we will complete implementation activities within three months. Our experienced implementation project manager, Lori McGurty, will manage the implementation work plan to make sure tasks are completed correctly and on time. This process is described in further described in Appendix 4, Implementation Specifications.

4.2.2 Mandatory Project Requirements

4.2.2. Mandatory Project Requirements - The following mandatory requirements relate to the goals and objectives and must be met by the Vendor as a part of its submitted proposal. Vendor should describe how it will comply with the mandatory requirements and include any areas where its proposed solution exceeds the mandatory requirement. Failure to comply with mandatory requirements will lead to disqualification, but the approach/methodology that the Vendor uses to comply, and areas where the mandatory requirements are exceeded, will be included in technical scores where appropriate. The mandatory project requirements are listed below.

We provide our response to the mandatory project requirements as an experienced Vendor, building on 22+ years of successful contract performance for WV DHHR. Examples of how we go beyond the mandatory requirements include:

- We exceed minimum requirements for compliance with RFP Section 4.2.2.1 by researching, developing, and submitting for approval criteria and utilization management guidelines to comply with federal requirements and DHHR policy intent.
- To maintain our close working relationship with the Agency, we maintain an office location less than one mile from the Agency.
- We exceed reporting requirements by offering analytics-based recommendations on program enhancements. For example, we recommended coverage of new codes and updated Dental Review Criteria that once approved were implemented for statewide use.
- To complete implementation in less than three months, we have begun pre-implementation activities and assigned a Transition Lead with WV program experience
- We propose to have a Registered Nurse review all requests for Personal Care, regardless of service level.
- Our system (Atrezzo) was designed to support system modifications and enhancements while maintaining contracted service levels. In FY 2021, we modified or implemented 12 programs while still meeting or exceeding deliverables related to the scope of work and new program implementation.
- The Atrezzo platform exceeds requirements by enabling on demand ad hoc reports in a secure, online environment. For example, we delivered 248 ad hoc reports in FY 2021 far exceeding the 10 reports suggested for estimating purposes.

In the sections that follow, we confirm our ability to meet each mandatory requirement and provide details of documentation to support our capabilities.

4.2.2.1 COMMITMENT TO COMPLY WITH FEDERAL REQUIREMENTS

4.2.2.1 Vendor shall meet the federal requirements concerning the agency's obligation to assure that services reimbursed by Medicaid are necessary and appropriate and provided in the appropriate setting and most cost-effective manner. (42 CFR Part 456 Subpart B, which can be found at: https://www.ecfr.gov/cgi-bin/textidx?SID=3fe0742c4f642172abfec6b2917630f7&mc=true&node=sp42.4.456.b&rgn=div6). The Vendor is to meet the same requirements concerning the Medicaid agency's obligation to assure that services reimbursed by Medicaid are medically necessary, appropriate, provided in the appropriate setting, and most cost-effective manner for that target population identified. - (such as the BSS and covered under their "special medical card" process, for out of state residential facilities under a provider agreement with the BSS.)

We support compliance with state and federal requirements to safeguard program funds for medically necessary, appropriate, and cost-effective services delivered in the proper setting to members eligible to receive the services. The foundation of our approach is an efficient system configured for individual program requirements. We designed our systems to support the specific policies and approved medical necessity criteria for the review areas specified in the RFP. Specific fields are mandated and validated in the applications to ensure that the information needed to authorize the appropriate services, duration, and amount are contained in the request. Programming in the application is designed to alert the clinical reviewer to areas not meeting policy requirements and/or criteria checks. These exceptions are displayed as pend reasons that guide the reviewer to areas of policy that require special attention when the review criteria are applied to the authorization request. This approach provides consistency to the review with respect to service limits, areas of possible service duplication, possible service combination edits, and diagnostic or other restrictions applicable to specific services.

4.2.2.2 MEDICAID PROGRAM COVERAGE POLICY AND BENEFIT LIMITATIONS

4.2.2.2 Vendor shall be responsible for authorizing services in conformance with current and future Medicaid Program coverage policy and benefit limitations. To meet this requirement, the Vendor must:
4.2.2.2.1 Validate the member eligibility and Managed Care Organization (MCO) enrollment status of each request.
4.2.2.2.2 If the member is assigned to an MCO or has other primary insurance coverage, the provider must be notified that the request must be submitted to the primary payer in conformance with the coverage, rules, and procedures of the MCO or primary payer.

We will continue to adhere to the requirements of this section. We authorize services in conformance with current Medicaid program policy coverage and benefit limitations. We configure our systems to meet the verification and eligibility validation required by the Agency for their specific programs. This includes, but is not limited to, validating the member eligibility through a daily eligibility feed from the MMIS Vendor, and verifying MCO enrollment, other insurance coverage, or Third-Party Liability.

We verify the benefit coverage of each member (or applicant) for whom a request is made. When no coverage exists for the requested start date of service or no benefit for the requested service, the request is administratively closed, and the provider and member are notified accordingly.

For services that are the responsibility of the MCO, if the member has MCO enrollment during the requested dates of service, we close the request and notify the requesting provider of the specific

MCO covering the member and provide contact information. If we find another primary payer, we notify the provider to submit the request to the primary payer. In cases where the primary payer denied payment or indicated non-coverage for a Medicaid member, the provider must attach an EOB or Certificate of Non-Coverage to the request for a review to proceed.

4.2.2.3 INTEGRATION WITH MEDICAID MANAGEMENT INFORMATION SYSTEM

4.2.2.3 Vendor shall issue prior authorizations through direct entry into the prior authorization module of the Medicaid Management information System (MMIS) or through the electronic interface with the Integrated Eligibility System (IES) and Medicaid Management Information System (MMIS) or other means with approval from the Agency. Those authorizations that are not directly entered into the MMIS must meet the HIPAA compliant 278 standard format.

We confirm that we will continue to meet the requirements of this section. We will issue prior authorizations through direct data entry into the MMIS module and through an electronic interface with both PATH and the WV MMIS. Our solution fully complies with UM and PA connectivity requirements for submission of HIPAA-compliant 278 standard format records via electronic interface with the WV MMIS.

4.2.2.4 RECEIVING AND RESPONDING TO WEB-BASED AND ELECTRONIC PRIOR AUTHORIZATIONS

4.2.2.4 Vendor must have the capacity to accept and respond all prior authorizations in a web-based/electronic format.

We confirm our capacity to accept and respond to prior authorizations in a web-based/electronic format. We will accept requests for prior authorizations and concurrent reviews for medical necessity through our web-based interface. Submitting requests directly through a web interface enables providers to increase the accuracy and efficiency of their requests through field-specific edits, pull-down choice entry, as well as selection boxes. The system also includes a copy and repeat feature for concurrent review requests that helps providers avoid time-consuming re-entry of information that is repeated from the original prior authorization. This feature promotes data quality and adds efficiency. Finally, submission of electronic requests enables us to avoid time-consuming entry of telephoned, faxed, or mailed information – this process improves data accuracy as well. This web-based electronic submission application will available 24 hours a day, 365 days a year (except for periodic system maintenance). All provider types are eligible to access this site for submissions. Based on the advantages to both Kepro and the providers, we will encourage providers to use this format. We will provide training and technical assistance to help providers adopt this method. Responses to prior authorization requests are available to the provider through this website.

Providers who usually have a large volume of requests (e.g., Licensed Behavioral Health Centers) can submit through electronic data interchange (EDI). This submission method allows providers to gather all requests and submit one or more files to us rather than direct data entering each request into the website.

We can accommodate other types of submission modes such as telephone, fax, and mail according to the individual service needs within the expanded provider base (i.e., inpatient psychiatric, partial hospitalization, and other services).

4.2.2.5 MAIN OFFICE LOCATION IN WEST VIRGINIA

4.2.2.5 Vendor shall maintain a main office and professional staff in a separate location from the state agency located at 350 Capitol Street, Charleston, WV.
4.2.2.5.1 The Vendor shall have the main office located in Kanawha County, West Virginia due to frequent meetings with Agency staff. The Vendor may have other satellite offices located throughout WV, but staff shall be located and managed in WV.
4.2.2.5.2 The Vendor shall maintain hours of operation during standard business hours (i.e., 8:00 am to 4:00 pm, 8:30 am to 4:30 pm, or 9:00 am to 5:00 pm ET), Monday through Friday excluding State holidays, which can be found at: https://personnel.wv.gov/employees/benefits/pages/holidays.aspx.
4.2.2.5.3 Professional staff shall include at a minimum registered nurse, dentists, physician advisors for adults and children, psychiatrists, psychologists, certified brain injury specialist, Master of Social Work (MSW's), and physicians located, managed, and licensed in the state of West Virginia within their specialty required for review and reconsideration.

We will continue to meet the requirements to provide a man office with professional staff in a separate location for the Agency. As the incumbent for the last 22 years, we fully recognize the need for proximity to the state agencies for on-going and urgent communication, meetings, planning, and consultation. Additionally, we understand the criticality of having staff not only located in proximity but also managed locally to address the immediate requests the Agency may have for reporting, analysis, IT, clinical consultation, support for requested information by legislators/etc. and addressing critical issues. We will locally manage all clinical, reporting/analysis, quality, consumer, provider, training/education, call center activity, consultation, and other core contract functions. We will manage the corporate business support functions (such as HR, Finance, IT development and legal) that will support the local operations. We will continue operations out of our current location (less than on mile from the Agency) at 1007 Bullitt St, Charleston, WV 25301. **Figure 12 Kepro Office in Charleston, West Virginia** demonstrates the proximity of our Main Office to the Agency.

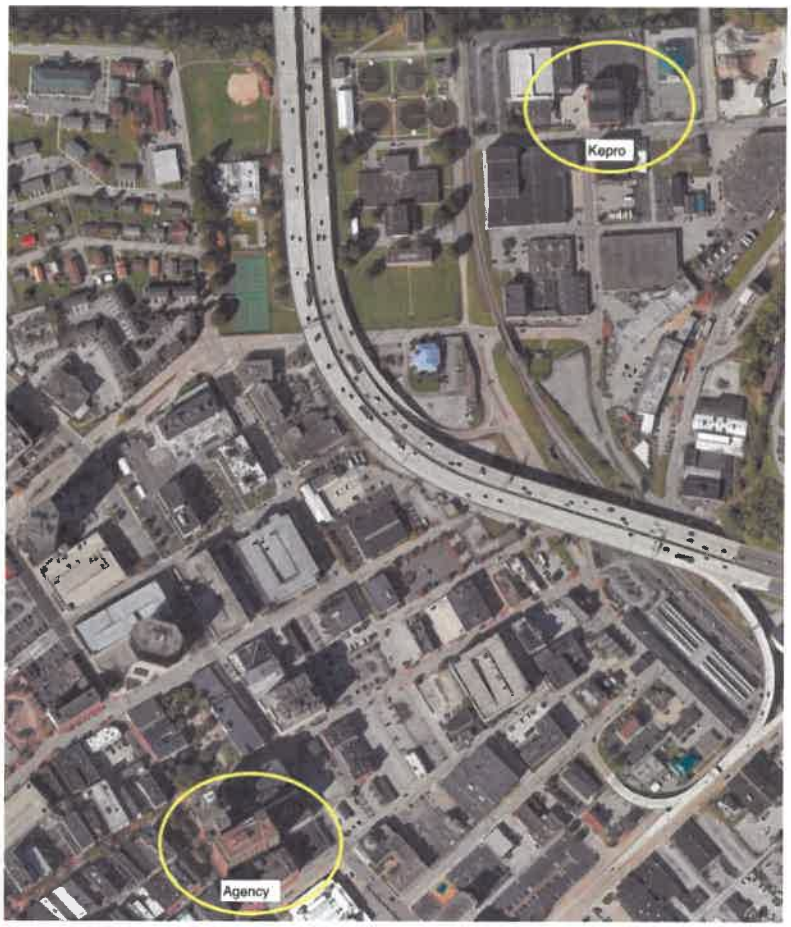


Figure 12. 1Kepro Office in Charleston, West Virginia
Our staff are located less than one mile from the Agency

4.2.2.6 INTEGRATION WITH OTHER AGENCY VENDORS AND SYSTEMS

4.2.2.6 Vendor is responsible for providing start-up and operations tasks and subtasks including, but not limited to, access to agency or other systems including the Medicaid Management Information System (MMIS), Family and Children's Tracking System (FACTS), Recipient Automated Payment Information Data System (RAPIDS), or the Integrated Eligibility System (IES), and the data warehouse, utilization review and authorization of utilization management of all behavioral, medical, and dental services listed and services covered by BSS as listed in 4.2.1.25 in this document. DHHR is in the process of implementing a new system to replace FACTS and RAPIDS. The Vendor will be responsible for interfacing with the system at the time of contract award and the new system when it is implemented.
4.2.2.6.1 The Vendor is required to accept data transfers in the current formats and correct exceptions for processing. This includes, but is not limited to, changes in the client identification that supports utilization reporting. Any work product developed during the course of implementation cannot be considered proprietary.

We will continue to meet the requirements of this section. Our Implementation Plan, found in Appendix 4, describes how we will complete start-up and operations tasks and sub-tasks necessary to complete transition to the new contract. As the incumbent, we currently perform utilization review and authorization of utilization management of behavioral, medical, dental, and other

services described in the RFP. In our current contract with WV DHHR, Atrezzo integrates with States' MMIS and other vendor systems within all our programs. We have established access to agency and other systems including the MMIS, Family and Children's Tracking System (FACTS), Recipient Automated Payment Information Data System (RAPIDS), the Integrated Eligibility System (IES), and the data warehouse. In accordance with the Agency's change in January 2023 from FACTS, we recently established access with the People's Access To Help (PATH) system. We will coordinate with the State to establish access with the system replacing RAPIDS at the appropriate time.

Throughout the term of the new contract, we will work closely with the Agency to ensure access to the appropriate systems and to meet the Agency's requirements for data and data transfers. We will continue to support the existing interfaces and associated electronic data structures, data transmittal processing and application functionality. We will accept data transfers in the current formats and make needed corrections for processing, which includes change in the client identification that supports utilization reporting. Gainwell agrees that work product developed during implementation cannot be considered proprietary.

4.2.2.7 COMMITMENT TO SERVICE LEVEL AGREEMENTS IN APPENDIX 6

4.2.2.7 Vendor must agree to be bound by all Service Level Agreement(s), included in Appendix 6.

We agree to be bound by the Service Level Agreement (SLA) included in Appendix 6. Throughout the current contract, we have consistently exceeded SLAs for timeliness and accuracy (**Table 4 Fiscal Year 2022 Deliverables**).

WV DHHR UM and PA Program	Minimum Standard	FY2022 Average
Behavioral Health Service Request Timeliness	100%	100%
Socially Necessary Service Request Timeliness	100%	100%
I/DD Waiver Modification Timeliness	100%	100%
Nursing Home PAS Review Timeliness	95%	98.9%
Audit Report Timeliness	100%	100%

Table 4. Fiscal Year 2022 Deliverables
We have built a record of timely delivery of UM and PA Services

4.2.2.8 COMMITMENT TO REPORTING REQUIREMENTS IN APPENDIX 5

4.2.2.8 The Vendor must agree to all reporting requirements, included in Appendix 5.

We have met and will continue to meet all reporting requirements as we have done throughout our 22 years serving the Agency. We pledge to continue this successful record through the provision of timely delivery of accurate routine and ad hoc reports.

Our approach has and will continue to be an intimate one in that our data analytic and reporting staff, dedicated to the WV DHHR contract, provide a single point of contact for report requests and development. In addition, we can easily acquire the support and assistance from an extensively

skilled corporate-based health research team should the need arise. Our ability to meet reporting requirements is fully described in Appendix 5.

Exceeding Standards

FY 21/22 Reporting:

- Delivered 100% of required and ad hoc reports with accuracy and within timeliness requirements.
- Collected, processed, and delivered 100% of utilization management reports on time.

4.2.2.9 ACCURATE AND TIMELY DATA REPORTS

4.2.2.9 The Vendor must collect, process, and provide accurate and timely data reports on service utilization for all activities contained within this RFP.

We will not only provide timely reports and accurate reporting/analysis through reviews but will also provide the same timeliness when adding the additional invoicing and credential checks to the procedure. We also conduct analysis of activities for inclusion in the annual and other reports.

4.2.2.10 COMMITMENT TO 3-MONTH IMPLEMENTATION SCHEDULE

4.2.2.10 The Vendor must agree to complete all implementation activities within three (3) months.

Did You Know?

West Virginia native and former Kepro Director of LTC in West Virginia Lori McGurty, PMP, is supporting pre-implementation activities today.

Based on our position as the on-the-ground incumbent – we are working today on pre-implementation activities. We have assigned our Implementation Lead Lori McGurty. We will formally begin implementation activities immediately upon contract award. Combined with our implementation experience with similar sized utilization management and behavioral health programs, we anticipate the total implementation timeframe to be approximately three months following a contract award. This timeframe will allow our team to begin delivering improved service to WV DHHR, members, and providers as quickly as possible. Upon award and kick-off, Kepro will work with the Agency to adjust the schedule based on WV DHHR needs. We are confident in our ability to implement the WV DHHR – as described in Appendix 4 - we are at 80% readiness on day 1 after contract award. We look forward to beginning implementation activities as quickly as possible.

4.2.2.11 LEVEL II DETERMINATIONS REVIEW BY REGISTERED NURSE (RN)

4.2.2.11 The Vendor must agree to a Registered Nurse (RN) review of all Level II determinations.

We agree that a Registered Nurse (RN) will review all Level II determinations. Though this RFP requires an RN only for Level II services, we propose to have an RN review all requests for Personal Care, regardless of service level.

4.2.2.12 ADDITIONAL SERVICES

4.2.2.12 The Vendor shall provide additional services to comply with externally driven changes to programs and requirements, including but not limited to, any State or Federal laws, rules, and regulations. Additional services shall be bid as an all- inclusive hourly rate for all Agencies and shall require Agency approval of a Statement of Work (SOW) and submission of a related Cost Estimate. For bid evaluation purposes, this is estimated at one hundred (100) hours per year, though actual utilization may be more or less.

We agree to provide additional services the Agency may request to comply with externally driven changes to programs and requirements, including but not limited to, any State or federal laws, rules, and regulations. Our bid for additional services represents an all-inclusive hourly rate for all Agency requests. We agree that no work shall begin until we receive Agency approval of a Statement of Work (SOW) and related Cost Estimate.

We propose using our WV Change Request (CR) process as the framework for requesting, reviewing, approving, and monitoring the Agency's request for additional services. This will ensure all parties involved have a complete understanding of the request and the agreed requirements. The key elements of the process will include, but not be limited to, the following:

- Submitter's Request:
  - Type of CR – enhancement, change, etc.
  - Project/Program initiative owner
  - Goal and/or expected outcome of change
  - Brief description of request (background and SOW)
  - Submitted Date
  - Date Required
  - Attachments/references where appropriate
  - Approval Signature
  - Approval Date
  - Vendor Project Manager Initial Analysis
  - Preliminary specifications of the project
  - Hour/duration impact
  - Key deliverables and related timelines
  - Other recommendations for consideration
  - Cost impact
- Submitter and Vendor Decision
  - Final discussion meeting for Submitter and Vendor
  - Adjustments to document per discussion
  - Approval signatures on documents

Did You Know?

In FY 2021 Kepro successfully administered several system modifications and implementations for the WV DHHR program including:

- ✓ Medical Necessity Criteria development for new codes
- ✓ Increased medical case management activities (COVID)
- ✓ CSED Waiver Services
- ✓ WVCHIP
- ✓ Genetics Lab and criteria expansion

Once approved, depending on the type of CR (such as IT, clinical, process, program, other), the appropriate Project Manager will be assigned. The Quality Coordinator will provide oversight and tracking of deliverables until completion of CR.

4.2.2.13 AD HOC REPORTS

4.2.2.13 The Vendor shall provide ad hoc reports as requested by the Agency. Ad Hoc reports are considered reports that are included in the reporting requirements document, as Appendix 5. Ad Hoc reports shall be bid as an all-inclusive cost per report. For bid evaluation purposes, this is estimated at ten (10) reports per year, though actual utilization may be more or less.

We agree to provide ad hoc reports, as requested by the Agency. We acknowledge Ad Hoc reports are included in Appendix 5. We confirm our bid for ad hoc reports is an all-inclusive cost per report.

We excel at meeting the Agency's ad hoc reporting requirements, doing so throughout our 22 years with the Agency. We readily generated and delivered an abundance of frequently requested ad hoc reports for the WV DHHR. The ad hoc reports varied in scope, complexity, and presentation. Regardless of the required effort, we value the Agency's need for information and data, thus addressed each requested ad hoc report with vigor, all the while striving to exceed the requestor's expected delivery time.

Exceeding Standards

In FY 2021 Kepro delivered 100% of the 248 ad hoc reports to BMS and BCF within or before the required timeline.

We pledge to continue this successful record through the provision of timely delivery of accurate ad hoc reports. We will work with the appropriate Agency business owner to confirm understanding of the intended content and desired format of each ad hoc report. We will then develop the report, review it with the Agency to assure we have met expectations and gain the Agency's approval on the report content and format.

4.2.2.14 PROVIDER MANUAL

4.2.2.14 The Vendor shall develop and maintain a Provider Manual which contains all policies and procedures for the UM Program the must be approved by the Agency. The manual is to be provided within thirty (30) days of contract award and be reviewed, updated, approved by the Agency every twelve (12) months afterwards, or whenever changes in operations are made. Once approved, the provider manual shall be made available to providers electronically.

Did You Know?

Educational videos and training guides were added to Provider Manuals in 2021 to support Providers with the migration to Atrezzo.

By leveraging our current Agency approved Provider Manual which contains all policies and procedures for the UM and PA program, upon contract award we will modify the manual to accommodate the new contract's scope of work. During the Implementation phase of the new contract, within 30 days of contract award, we will submit the draft Provider Manual to the Agency for review and approval. We will review and update the Provider Manual annually, submitting any proposed changes to the Agency for review and approval. In addition, we will generate updates to the Provider Manual whenever operational or system changes are made that impact the manual. Once approved by the Agency, the Provider Manual will be available to providers through our web portal.

4.3 Qualifications and Experience

4.3. Qualifications and Experience: Vendor should provide information and documentation regarding its qualifications and experience in providing services or solving problems similar to those requested in this RFP. Information and documentation should include, but is not limited to, copies of any staff certifications or degrees applicable to this project, proposed staffing plans, descriptions of past projects completed (descriptions should include the location of the project, project manager name and contact information, type of project, and what the project goals and objectives where and how they were met.), references for prior projects, and any other information that Vendor deems relevant to the items identified as desirable or mandatory below.

4.3.1 Qualification and Experience Information

4.3.1. Qualification and Experience Information: Vendor should describe in its proposal how it meets the desirable qualification and experience requirements listed below.

As the incumbent vendor for the services being procured by this RFP, we are uniquely qualified to and experienced to provide the exact type of services being requested in this RFP. In fact, we have worked collaboratively with the West Virginia Department of Health and Human Resources (WV DHHR) for more than two decades to develop a program uniquely focused on meeting the needs of DHHR while simultaneously optimizing the care received and, thus, the health outcomes of West Virginians. We are excited to continue that important work. Throughout our partnership with WV DHHR, we have shared and carried out the Agency's vision, ensuring members receive clinically appropriate and person-centered services in a way that both facilitates members' access to services while also driving equity of access to services across the affected population. In the following sections, we demonstrate our unique qualifications and experience to deliver the services sought under this RFP and to continue supporting WV DHHR's long-term, program-wide goals.

4.3.1.1 PROPOSED STAFFING PLAN

4.3.1.1. The Vendor should propose a staffing plan that includes staff that can address the unique needs of members while assuring that services are provided in the most economical manner. In their proposal, the Vendor should describe how the staffing plan will provide the skills necessary to meet the requirements of the project throughout the life of the contract. The Vendor's proposed staffing plan should include:

In this section, we describe how our staffing plan delivers staff with the skills necessary to meet the project requirements throughout the contract term. Since 1985, we have staffed and managed healthcare contracts for varying scopes of work and for communities in both rural and urban settings across the nation. As an organization we have developed the skillset and resources necessary to seek, train, and retain top talent in the industry, as evidenced by the qualified and high performing staff we have consistently employed over the past two decades for our current

contract with WV DHHR. Our staffing plan for the new Utilization Management (UM) and Prior Authorization (PA) Services contract includes our current WV-based 146-person team as well as the addition of 26 staff to accommodate increased volumes and duties noted in this RFP, and Optional Services should the State choose to include these services.

Did You Know?

Our Talent Acquisition Strategy yields:

- ✓ 50% improvement in volume of qualified candidates
- ✓ Decreased position fill time from 40 to less than 20 days
- ✓ 38% increase in web traffic for applicants

By utilizing our existing staffing model and experienced in-place program staff, we are uniquely positioned to provide a seamless transition to the new contract, with zero interruption in meeting program requirements, or in addressing members' needs, and ensuring services are provided in a clinically appropriate and cost-effective manner. We will continue to employ a strong, person-focused, and locally experienced team to provide timely and quality focused UM and PA services.

As we begin our 23rd contract year serving as WV DHHR's vendor for the current contract, our in-depth familiarity with this complex program's staffing needs is invaluable to the continued success of the UM and PA Services program operations. With Kepro, the State will continue to benefit from our WV-customized and proven staffing model designed to match qualified staff with expert oversight to continue to effectively address the unique characteristics of each component of the scope of work defined in the RFP. Today, our staffing plan for WV DHHR's program is a best-in-class model, one that has evolved over the past 22 years. Our plan is specifically designed to provide for the retention of qualified staff to continue fulfilling our responsibilities to WV DHHR and continuing to provide efficient hiring of additional qualified staff as those needs arise. As we have demonstrated over the last two decades, we are experts in hiring and retaining highly qualified staff who understand and can address the unique needs of the members we serve, while ensuring optimal care and cost outcomes for WV DHHR. Our WV DHHR program team's average tenure ranges from 7 to 15 years.

We are uniquely positioned today with an established staffing structure that will seamlessly continue to meet the contractual requirements of the UM and PA program, resulting in continued stellar UM and PA program performance and outcomes. **With the new contract, we will maintain our existing staff structure, including the 5 project-specific teams led by our 5 expert Project Managers (also known as Kepro Directors).** Our Project Managers have the qualifications and proven experience to make sure their respective team's staffing needs are met and maintained with the necessary staff to effectively meet our contractual obligations and the needs of the vulnerable individuals we serve.

Advantages of our staffing model to support the seamless transition to the new contract, and specific to the requirements of the RFP, include:

- **Our full-time Executive Director has extensive knowledge and working experience with WV DHHR**, understands Medicaid policies and the landscape, and is a lifelong resident of WV

- **Our 5 full time Project Managers are in-place today** with extensive experience serving the WV DHHR UM and PA program, and all are lifelong WV residents
- **Our established and long-standing WV office** is already fully equipped with telephone and computer systems for efficient management of the UM and PA program services
- **146 West Virginia staff are in pace today** with all staff residing in West Virginia and 100% dedicated to the WV DHHR contract

We have maintained a Charleston, West Virginia office location since the inception of our initial contract with WV DHHR more than 22 years ago. We commit to continuing to hire local staff to perform the duties under this contract, throughout the term of the contract

4.3.1.1.1 OUR WV TEAM ORGANIZATION CHART

4.3.1.1.1 Organizational chart(s) showing the number and geographic location of all staff that will perform duties under the Contract, including Vendor and subcontractor staff. Key staff members, off-site (i.e., location other than the Vendor's in-house call center facility) Vendor staff, and subcontractor staff should be clearly identified as such on each organizational chart.

Figure 13 Kepro WV Project Team Organizational Chart presents our West Virginia staff members and shows the number and geographic location of all staff assigned to work on the contract. All positions indicted on the organization chart are filled with our staff. We currently do not utilize, and do not plan to utilize, subcontractor staff to perform duties under the contract.

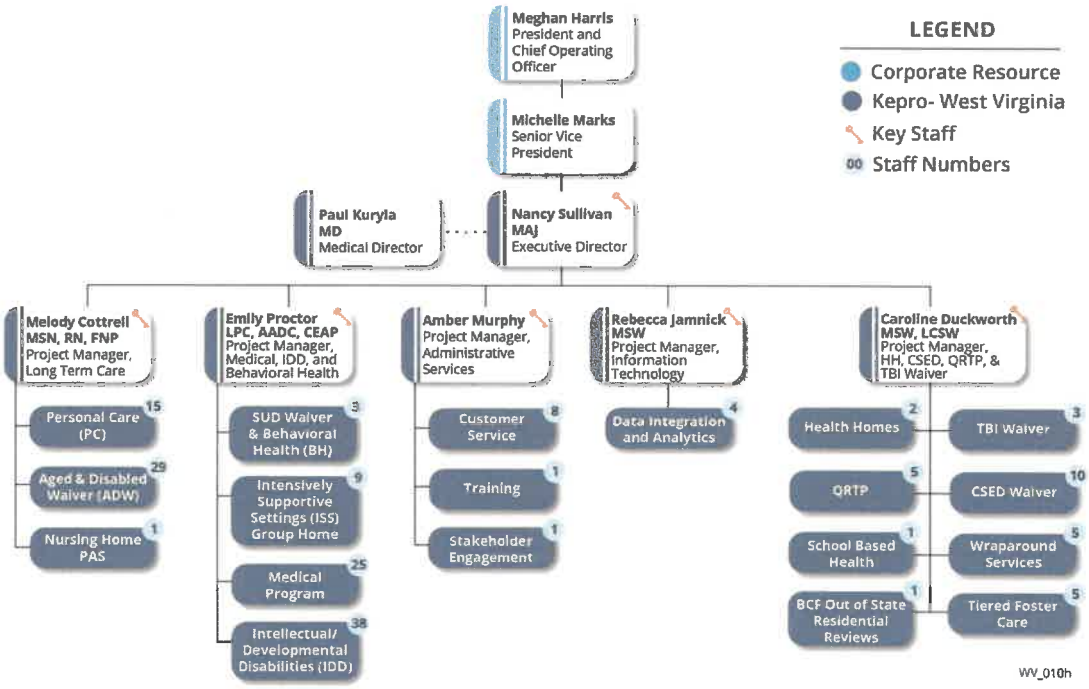


Figure 13. Kepro WV Project Team Organizational Chart

Our team includes individuals on the WV DHHR contract today and executives to ensure customer satisfaction

4.3.1.1.2 KEPRO CORPORATE ORGANIZATION

4.3.1.1.2 Chart showing the Vendor's entire organizational structure, including all parent entities. This chart should show the relationship of the Vendor's proposed project organization to its overall organizational structure.

Our organizational structure was designed to support streamlined and direct access to senior and executive leadership staff. **Figure 14 Kepro Corporate Organizational Management Structure** shows our entire organizational structure and its relationship with our WV UM and PA program team, including how our WV program team lines of responsibility and authority report up to corporate leadership and relate back to the broader organization.

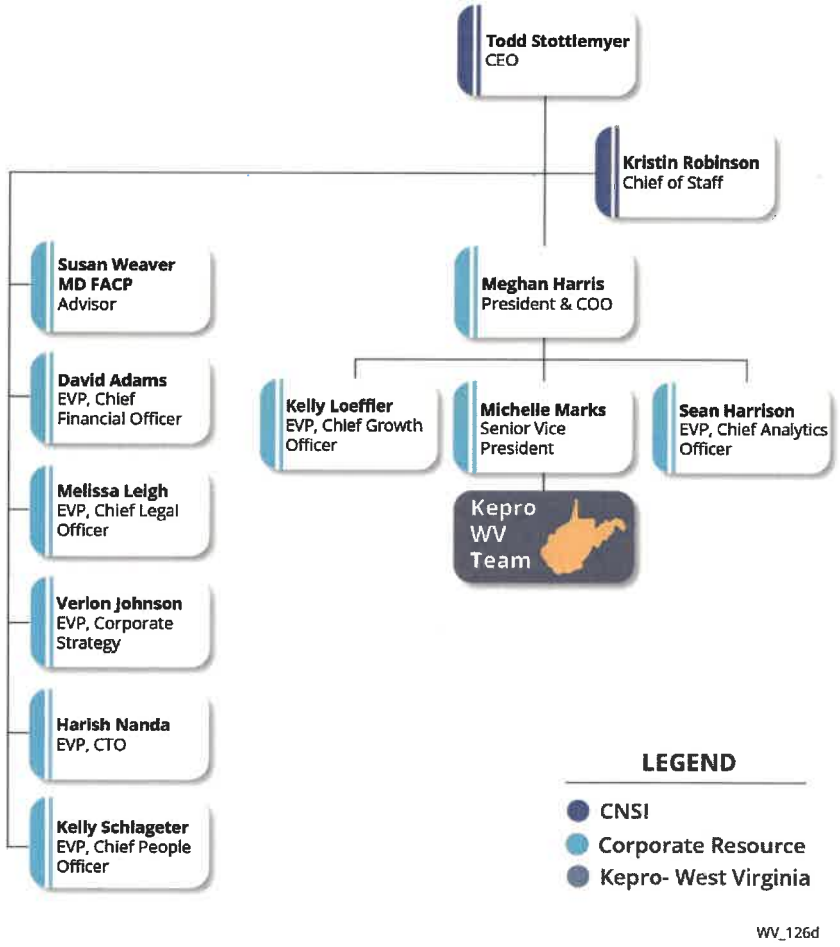


Figure 14. Kepro Corporate Organizational Management Structure
Our corporate leadership and management team brings over 150 years of combined experience to WV DHHR

Kepro's parent organizations are shown in **Figure 15 Kepro Parent Organization**. Our parent organization is Bluebird Kingsman Holdings, Inc. located at 777 East Park Drive, Harrisburg, PA, 17111.

Figure 15. Kepro Parent Organization
Bluebird Kingman Holdings, LLC is our parent organization

4.3.1.1.3 CHANGES TO KEPRO'S ORGANIZATION

4.3.1.1.3 The Vendor should provide a revised organizational chart within five (5) business days at any time during the Contract period that a change is made in the organizational structure.

We agree to provide a revised organizational chart within five business days whenever a change is made in the organizational structure, at any time during the contract period.

4.3.1.1.4 ROLES, RESPONSIBILITIES, AND SKILLS

4.3.1.1.4 Description of the roles, responsibilities and skills associated with each position on the organization chart(s).

In **Table 5 Project Team Roles, Responsibilities and Skills** we present the roles, responsibilities, attributes, and skillsets for each position identified on our organization chart present previously in **Figure 13, Kepro WV Project Team Organizational Chart**. Our staff roles, responsibilities, skills, and corresponding job descriptions also include the skill sets required to provide the services identified in Addendum 2, Vendor Questions and Answers, Questions 12-14, including Intellectual/Developmental Disabilities (IDD), Intensively Support Settings (ISS) Group Home (GH) Health and Welfare check assessments, and substance use disorder (SUD) Waiver Authorization.

Position/Role	Responsibilities, Attributes, and Skillsets
Executive Director	**Responsibilities:** This individual is responsible for the overall administration of the contract(s) with the WV DHHR. Additionally, the WV Executive Director is the primary contact with WV DHHR. This individual is responsible for the management and all deliverables for the various programs and makes sure all contract functions are performed to the highest standards and meet or exceed contract requirements and customer expectations. This individual is responsible for overseeing the design, development, and implementation of all programs; member and community relations; business management functions; program strategy, vision, and leadership; and team development. **Desired Attributes and Skillsets:** • Master's degree in business, human or social services, health management, or related field • 5 years' management experience in healthcare or social services • Working knowledge of best practices in Medicaid, direct care services, behavioral health, and/or other state programs • Strong leadership, problem solving, staff development, and customer relations skills • Demonstrated record of success facilitating progressive change and development of innovative business functions and programs • Must reside in West Virginia
Project Manager, Long Term Care	**Responsibilities:** This individual is responsible for the management and deliverables of work performed in the Long-Term Care department, which includes the home and community-based services, Aged and Disabled Waiver (ADW), Personal Care, and the Nursing Home Pre-Admission Screening (PAS). This individual makes sure that all functions are performed to the highest standards to contract requirements. More specifically, their role includes managing the operations to meet contract deliverables, as well as providing leadership and supervision to staff assigned to the contract. Additionally, this individual will assess policy and procedure to continually promote a high level of customer satisfaction for all stakeholders, as well as monitor, evaluate, and recommend changes to existing contract and potential new business. **Desired Attributes and Skillsets**: • Bachelor's degree in human services or related field (master's degree preferred) • 3 years' experience in West Virginia Long-Term Care programs • 3-5 years' prior leadership and/or supervisory/management experience • Working knowledge of best practice in content areas and government policy and structure • Responsible for recommending new or modified clinical care guidelines and UM and PA tools based on coverage policies, changing membership populations, or evolving state/federal regulatory requirements.

Position/Role	Responsibilities, Attributes, and Skillsets
	• Ability to lead and manage direct reports, analyze data, and develop reports to meet the contract's goals of quality care and cost-effectiveness • Must reside in West Virginia
Project Manager, Medical, IDD and Behavioral Health	**Responsibilities:** This individual is responsible for the management and deliverables of the Medical UM, SUD and Behavioral Health, Intensively Support Settings (ISS) Group Home, and Intellectual/Developmental Disabilities (IDD) services. This individual's role is to make sure that functions are performed to the highest standards of the contract. These functions Include prior authorization of all medical services; ambulance and air transportation; provider education; training and technical assistance; quality improvement activities; data collection; and analysis of metrics and reports. This individual will also be responsible for effectively managing the team and programs to meet all contract deliverables, providing leadership and supervision for all medical staff, and providing consultation to the Agency. This individual will review and evaluate policy and procedures on an ongoing basis to promote a high level of customer satisfaction for all stakeholders, as well as uphold ongoing communication and collaboration with the Medical Director. **Desired Attributes and Skillsets:** • Registered Nurse (RN) or master's degree in a health-related field • Appropriately licensed and/or certified, or hold credentials in a related field • 3-5 years' supervisory and program management experience • Knowledge and experience with medical utilization management processes • Understanding of the customer service approach for medical provider stakeholders • Familiarity with InterQual criteria for all review areas, including Medicaid and Medicare, government structure and policy and related programs • Must reside in West Virginia
Project Manager, Administrative Services	**Responsibilities:** This individual leads the Customer Service team in meeting the needs of provider and individual stakeholders. This individual is responsible for our overall customer service functions, including customer service operations, quality, and training teams. This individual also participates in quality management/quality improvement activities. **Desired Attributes and Skillsets:** • Bachelor's degree in business, health services, or a related field • 5 years' experience in Medicaid programs or similar health related programs and operations • 3-5 years' supervisory/management experience in a customer service or related field

Position/Role	Responsibilities, Attributes, and Skillsets
	• Working knowledge of best practice in customer service and government policy and structure • Must reside in West Virginia
Project Manager, Information Technology	**Responsibilities:** This individual is responsible for IT-related deliverables and work performed according to the highest standards and contractual requirements. The individual is responsible for supporting change orders, reports, and related business. This individual also continually assesses IT policy and procedure to promote a high level of customer satisfaction for all stakeholders. Additionally, this position will provide consultation on system and policy issues. **Desired Attributes and Skillsets:** • Bachelor's degree in information management or related field • 3-5 years' supervisory and program management experience in related technical area, preferably in a Medicaid or other healthcare environment • Working knowledge of best practice in content areas and government policy and structure • Must reside in West Virginia
Project Manager, HH, CSED, QRTP and TBI Waiver	**Responsibilities:** This individual is responsible for the management and deliverables of work performed for Health Homes (HH), Children with Serious Emotional Disorder (CSED), school-based programs, qualified residential treatment programs (QRTP), Bureau for Social Services (BSS) out-of-state residential reviews, tiered foster care, and Traumatic Brain Injury (TBI) Waiver programs. This individual provides general supervision; develops tools for tracking and analysis; conducts staff reviews; analyzes data; and establishes team policies and procedures. The individual identifies, assesses, and maintains operational guidelines and review and assessment tools. **Desired Attributes and Skillsets:** • Master's degree in social work, counseling, or psychology • Clinical license and/or certification (such as LGSW, LCSW, or LPC) • 3-5 years' experience related to child welfare, behavioral health services, utilization management, and systems planning • 3-5 years' supervisory and program management experience • Working knowledge of best practice in content areas and government policy and structure • Must reside in West Virginia
Medical Director	**Responsibilities:** The Medical Director Is responsible for providing principal leadership to the Medical UM team on all medical aspects of the program. Provides oversight of all utilization management and prior authorization activities. The Medical Director is responsible for evaluating, redirecting and/or responding to physician, provider, and member inquiries. They represent and promote Kepro at seminars, professional societies, hospital medical staff meetings and other professional meetings as appropriate. The

Position/Role	Responsibilities, Attributes, and Skillsets
	Medical Director conducts appropriate external relationships with attending physicians/surgeons by response to telephone calls and letters. They participate in speaking engagements before physician and provider organizations. They analyze and remain updated regarding national, state, and local regulations and legislation impacting the healthcare profession and work with staff in addressing and meeting changing requirements, assuring compliance with regulatory and accreditation requirements. The Medical Director also oversees the medical content of company publications, participating in activities specific to contractual arrangements, and participating in Kepro's Quality Management Committee to validate organization compliance. The Medical Director also reviews medical information trends, experiences, and approaches, and assists in the development of strategic plans for clinical improvements, while working with medical, nursing, and administrative staff to identify matters that need shared attention. **Desired Attributes and Skillsets:** • Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) • Current West Virginia Board of Medical Examiners non-restricted license • Board certification in a clinical specialty • 10 or more years of clinical practice with preferable • 5-7 years' experience as a physician executive with significant accomplishments in development programs and coaching medical staff on healthcare business and practice issues • 2 or more years' experience as a Medical Director in a managed care company • Trained in quality assurance and utilization review • Understanding of major trends in healthcare and managed care • Must be a systems thinker with strong organizational skills who can meet deliverables on time and within budget • Preferred qualities include experience in Utilization Management and Case and Disease Management with knowledge of Medicaid and Medicare programs, prior experience or quality assurance committee responsibility in a hospital setting, and knowledge of federal, State, and private health related activities. • Must reside in West Virginia

Table 5. Project Team Roles, Responsibilities and Skills

Each position identified on the project team organization chart has specific requirements to support success in providing the service and support that meets WV DHHR's expectations

4.3.1.1.5 JOB DESCRIPTIONS

4.3.1.1.5 Job descriptions and requirements for in-house Call Center staff demonstrating a high school diploma or equivalent certification, Case Reviewer staff demonstrating certification as a Registered Nurse (RN), Physician Reviewer/Medical Director staff demonstrating a MD/DO; and all management staff demonstrating a Bachelor degree and at least two years qualifying experience for this project.

Our experience providing program services for WV DHHR for more than 22 years has provided us with the background and knowledge necessary for a firm understanding of the skillsets required of our WV project team. Job descriptions for each position within our WV project team can be found in **Attachment 1**. These job descriptions include specific requirements such as:

- Customer Service (Call Center) staff must have a high school diploma or equivalent certification
- Case Reviewer staff must be Registered Nurses (RNs)
- Physician Reviewer/Medical Director staff must be licensed as a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO)
- Management staff must hold a bachelor's degree and at least two years qualifying experience

The following tables provide a summary list of each position assigned to the UM and PA contract for our five major teams:

- Long Term Care Services (Table 6)
- Medical, IDD, and Behavioral Health (Table 7)
- Administrative Services (Table 8)
- Information Technology (Table 9)
- HH, CSED, QRTP, and TBI Waiver Programs (Table 10)

Name/ Function	Position Title	Staff in Place
Long Term Care Services Team		
	Project Manager, Long Term Care	✓
	UM Manager	✓
	UM Quality Nurse	✓
Personal Care (PC) Team		
	Personal Care Services Manager	✓
	Case Reviewer	✓
Aged and Disabled Waiver (ADW) Team		
	ADW Manager	✓
	ADW Case Reviewer	✓
	ADW UM Support Staff	✓
Nursing Home PAS		
	Manager Nursing Facility Services	✓
	Case Reviewer, PAS Programs	✓

Table 6. Long Term Care Services Positions

Our Long Term Care Services Team is currently staffed and assigned to WV UM and PA Services

Name/ Function	Position Title	Staff in Place
Medical, IDD, and Behavioral Health (BH) Team		
	Project Manager, Medical, IDD, and BH	✓
	Medical Director	✓
Behavioral Health and SUD Waiver Team		
	Provider Educator	✓
Intensively Support Settings (ISS) Group Home		
	ISS/Group Home Waiver Manager	✓
	High Intensity Nurse Reviewer	✓
	ISS/Group Home Lead	✓
	Provider Educator	✓
Medical Program		
	Eligibility Specialist – Medical	✓
	Medical Program Specialist	✓
	Medical UM Physician Reviewer	✓
	Medical UM Case Reviewer	✓
	Medical UM Manager	✓
	Medical UM Support Staff	✓
Intellectual/Developmental Disabilities (IDD) Team		
	IDD Waiver Consumer and Family Educator	✓
	IDD Waiver Registration Coordinator	✓
	Lead IDDW Provider Educator	✓
	IDD Waiver Provider Educator	✓
	Lead IDDW Service Support Facilitator	✓
	IDD Service Support Facilitator	✓

Table 7. Medical, IDD, and Behavioral Health Positions
Our Medical, IDD, and Behavioral Health Team is currently staffed and assigned to WV UM and PA Services

Name/ Function	Position Title	Staff in Place
Administrative Services Team		
	Project Manager, Administrative Services	✓
Customer Service Team		
	Customer Service Representative	✓
Training		

Name/ Function	Position Title	Staff in Place
Administrative Services Team		
	Training Specialist	✓

Table 8. Administrative Services Positions
Our Administrative Services Team is currently staffed and assigned to WV UM and PA Services

Name/ Function	Position Title	Staff in Place
Information Technology		
	Project Manager, Information Technology	✓
	Data Analyst	✓
	Reporting Specialist	✓
	Technical Liaison	✓

Table 9. Information Technology Positions
Our Information Technology Team is currently staffed and assigned to WV UM and PA Services

Name/ Function	Position Title	Staff in Place
HH, CSED, QRTP, and TBI Waiver		
	Project Manager, HH, CSED, QRTP, and TBI Waiver Programs	✓
	BSS Care Manager	✓
Health Homes		
	Health Homes Manager	✓
	UM Coordinator – HH	✓
QRTP		
	Service Support Facilitator	✓
School Based		
	School Based Health Trainer Consultant	✓
	BSS Out of State Residential Case Reviewer	✓
TBI Waiver		
	TBIW Manager	✓
	TBIW Assessment Coordinator	✓
	TBIW Provider Educator	✓
CSED Waiver and Wraparound Services		

Name/ Function	Position Title	Staff in Place
HH, CSED, QRTP, and TBI Waiver		
	Provider Educator	✓
	Lead Service Support Facilitator	✓
	Service Support Facilitator	✓
Tiered Foster Care		
	Case Reviewer	✓

Table 10. HH, CSED, QRTP, and TBI Waiver Positions

Our HH, CSED, QRTP, and TBI Waiver Team is currently staffed and assigned to WV UM and PA Services

4.3.1.1.6 KEY STAFF QUALIFICATIONS

4.3.1.1.6 Key staff positions, such as Project Manager(s), Assistant Manager (s), Provider Relations Manager(s), Outreach and Communications Manager(s) and other management staff, identified with named individuals and resumes demonstrating a Bachelor degree, licenses, skills and at least two (2) years' experience that qualifies them for their role in this project. The Bachelor degree may be substituted with four (4) years of full-time or equivalent part-time paid Utilization/Prior Authorization Services (UM/PA) experience in addition to the two years already specified. Resumes should be limited to two (2) single-sided pages. The Vendor shall notify the Agency of any key staff vacancies within two (2) business days of the vacancy. The Vendor is to fill key personnel vacancies within sixty (60) calendar days of vacancy.

Key Staff Positions and Resumes

Our key staff positions for the program, which include our core management team, are in-place today and meet the RFP requirements for their position—with each well-equipped for immediate implementation of the new contract as well as the Optional Services. Together these key staff have an average of 15 years of tenure with the contract and thus have built relationships and trust with the Agency and community stakeholders. We include resumes in **Attachment 2** for our key staff that detail their education, licenses, skills, and experience. **Attachment 3** includes copies staff certifications and degrees applicable to this project,

Meet our West Virginia Management Team

As summarized below, our WV Executive Director and 5 Project Managers (currently known as Kepro Directors) are experienced management personnel who are deeply familiar with WV DHHR and the UM and PA Services program.

Nancy Sullivan, MAJ – Executive Director. Nancy has held the Executive Director role for WV DHHR's current contract since 2019 and she will continue to do so under the new contract. Nancy has a master's degree and more than 10 years of related experience. In her role, Nancy delivers optimal clinical performance and results from our WV team who service the contract. Nancy provides daily support to each Project Manager in her role including directing the implementation and management of all deliverables for the various programs while overseeing our WV team of

more than 140 personnel statewide. She also monitors and verifies that all the program functions are performed to established standards and meet or exceed contract requirements and customer expectations. Nancy will continue leveraging her experience and deep familiarity of the UM and PA Services program. **Reporting directly to Nancy are our 5 Project Managers** (Kepro Directors).

"Throughout my career, I have had the privilege to work with some brilliant and dedicated people. I am amazed by the passion and caring our team brings to their job every day. Kepro has provided me the opportunity to grow professionally, while working with people who are dedicated to improving the lives of West Virginia's most vulnerable citizens." – Nancy Sullivan

Melody Cottrell, MSN, APRN, FNP-BC – Project Manager, Long Term Care Services. Melody has 7 years of experience with WV DHHR's contact. Melody holds a Master's degree and numerous licenses and certifications. As the Project Manager (Kepro Director) of Long Term Care Services, Melody provides operational oversight to make sure contract deliverables are met or exceeded for WV DHHR's Nursing Facility Program, Personal Care Program, and Aged and Disabled Waiver Program. Melody develops and maintains operational guidelines as well as provides leadership and supervision to more than 40 personnel. Additionally, she collaborates with the program Leads and Managers to provide support, employee training, process development, and policy implementation. In this role and in her previous role as a Program Manager, Melody has helped enhance the program offerings and efficacy. As an example, Melody developed a Children's Pre-Admission Screening tool for the Personal Care Program utilized by West Virginia. Melody's past performance is also underscored by her success as a nurse, evidenced by her receipt of a Nursing Leadership Award while in a previous role in WV.

"During my 8 years with Kepro, I have worked across 4 programs, and carried 5 different job titles. I am truly an example of an employee who worked my way to an impactful position. Kepro provided tuition assistance to help me obtain both a bachelor's degree (2016) and a master's degree (2022) in Nursing. I use my experiences and knowledge daily to support the Long-Term Care program and West Virginia residents." – Melody Cottrell

Emily Proctor, MA, LPC, AADC, CEAP – Project Manager, Medical, IDD, and Behavioral Health Services. Emily has 22 years of experience with the WV DHHR contract. She holds a Master degree and numerous professional licenses and certifications. As Project Manager (Kepro Director) of Medical, IDD, and Behavioral Health services, Emily provides operational oversight of clinical staff for utilization management and case management functions. She maintains and enhances relationships with WV DHHR Contract Managers, physicians, and corporate staff. She oversees implementation and ongoing management of submission platforms for Medical, SUD, IDD, and Behavioral Health services. Emily has also held other leadership positions with our WV DHHR contract including Behavioral Health Care Manager and Behavioral Team Leader.

"Since joining Kepro in 2001 as a Clinical Assistant, Kepro has supported my personal and professional growth. I have worked with amazing people, witnessed significant changes in WV Medicaid and our healthcare system, expanded my clinical experience and developed long lasting relationships with wonderful people. As a result, my commitment to serving WV has grown and continues to flourish." – Emily Proctor

Amber Murphy – Project Manager, Administrative Services. Amber holds a bachelor's degree and has 18 years of experience with the WV DHHR contract. As the Project Manager (Kepro Director) of Administrative Services, Amber manages administrative processes and Service Center functions, so they operate efficiently and meet both contract requirements and customer expectations. In her 18 years with the contract, Amber has developed a broad knowledge of WV operations, as has led several groups of Customer Service Representatives, including those servicing the IDD Waiver and Aged and Disabled Waiver services. She develops and manages the implementation and maintenance of administrative policies and procedures; manages special projects; leads financial underwriting of new programs; and participates in quality management and quality improvement activities. Additionally, she supervises 8 staff.

"Working at Kepro for 18 years has truly been an amazing experience, enabling my professional growth. It is challenging, exciting, collaborative, positive, and feels like family. Over the years, I have been blessed to work with many individuals who are genuinely dedicated to their jobs and co-workers. I enjoy working with inspiring leaders with a common mission to improve the health of individuals and the communities we serve." – Amber Murphy

Rebecca (Becky) Jamnick, MSW – Project Manager, Information Technology. Becky has more than 22 years of experience with WV DHHR's contact. She holds a Master degree and is certified by the WV Board of Social Work (License Eligible). As the Project Manager (aka Kepro Director) of Information Technology, Becky coordinates and oversees the activities and deliverables for the Bureau for Behavioral Health (BBH) and the contract data and reporting requirements. Reporting requirements include daily, weekly, monthly, and annual reports depending on the program, and as requested by WV DHHR. Becky also works closely with our corporate IT team so that our WV local systems efficiently meet the daily needs of our users.

I began my career working with senior citizens and now, more than 40 years later, I am one! My early experience working with adults with IDD gave me a passion for the people we serve through the State. For the past 22 years at Kepro, I have had the pleasure and challenge of being part of the most talented, hardworking, and committed operations team in the universe. We are serious about our work and making a difference in each life we touch." – Becky Jamnick

Caroline Duckworth MSW, LCSW – Project Manager, HH, CSED, QRTP, and TBI Waiver Services. Caroline has 21 years of experience with WV DHHR's contract. She holds a master's degree and

numerous professional licenses and certifications. As the Project Manager (Kepro Director) of HH, CSED, QRTP and TBI Waiver Services, Caroline currently oversees contract performance and quality assurance in deliverables for the following programs: Health Homes, Traumatic Brain Injury Home and Community Based Waiver, Tiered Foster Care, BSS funded Residential Utilization Management and Review, Children with Serious Emotional Disorder Waiver, Children's Wraparound and Residential Level of Care Assessments. In this position, Caroline supervises 27 staff including Clinical Assessor staff, Managers, Review Assistants, and Customer Service Representatives daily.

"I joined Kepro in 2001 as a behavioral health care manager after working within the Children's System of Care in West Virginia for years. Every encounter with other professionals, peers, parents and especially the children has reinforced my perspective and focus on our mission: make each child's life better, at home with family. Kepro has provided me the means to use my skills and be a part of positive system changes." – Caroline Duckworth

In addition to our key staff roles, we have identified the following roles as essential to the success of the program.

Paul Kuryla, MD – Medical Director. Dr. Kuryla will continue to serve in this role for the new contract. Dr. Kuryla leads the operation on all medical aspects relating to the peer review process, utilization review activities, case management, and other activities requiring clinical leadership and consultation. Additional his responsibilities may include assisting and promoting business development and strategic planning activities. **Dr. Kuryla knows West Virginia Medicaid** – and is known to the Agency, Medicaid Providers, and other Medicaid community stakeholders. As our WV Medical Director since 2019, he will continue to add value to the UM and PA Services program.

Lori McGurty, MS, PMP – Transition Lead. Lori will lead the transition to the new contract to make sure that each activity outlined in the Implementation Plan is addressed thoroughly, timely, and to the State's satisfaction. Lori is a native West Virginian and a Kepro employee of 19 years. She will add value to the transition to the new contract with her project management expertise as well as her in-depth knowledge of the WV DHHR UM and PA program and our corporate implementation support and processes.

Lori previously worked on our West Virginia team for 13 years. She brings a wealth of West Virginia-specific knowledge around the Long-term Care (LTC) programs, as she was the Director of LTC from 2011 through 2017. Lori's career with Kepro began in 2004 and she has held multiple roles as part of our UM and PA Service program in West Virginia including Family Support Educator for the (then-titled) Socially Necessary Services Program, Service Support Facilitator, Provider Educator, Lead Provider Educator, and ultimately the Director of Long-Term Care (2011-2017). In 2017, Lori transitioned to Kepro's Director of Implementations, obtained her Project Management Professional (PMP) certification, and has since successfully supported multiple new State Medicaid project implementations including: Tennessee Application Processing Center, North Carolina

Comprehensive Independent Assessment Agency, California Pre-admission Screening and Resident Review (PASRR), North Carolina COVID, Nebraska PASRR, Pennsylvania Specialized Services and Nursing Home Transition, Colorado Substance Use Disorder, Mississippi State Employees' Life and Health Insurance Program, NY Early Intervention Program Quality Monitoring, and Mississippi Qualified Residential Treatment.

Wayne Bolton, Director, IT Implementation Services has been working with our State clients to implement new programs since 2001. He is known to WV DHHR from his work most recently on the Atrezzo migration. Among other duties, Wayne will provide strategic leadership to all aspects of system development for the UM and PA Services contract throughout the life of the contract.

Lisa Dormann, Sr. Director, Application Services will support implementation leveraging her role at Kepro leading the building of interfaces, modifying the system for new programs, and conducting tests and readiness reviews. Following her role in implementation, she will oversee ongoing maintenance and support of Atrezzo to address issues related to the interfaces between West Virginia's system and other vendor systems.

Key Staff Vacancies

We are committed to providing WV DHHR with consistent service delivery and we are proud of our team's longevity. However, we know that staff vacancies do occur over time. In the event it becomes necessary to replace a key staff member during the term of this contract, we will notify the Agency of planned or unexpected departures.

Regardless of the reason for the vacancy, we will engage our proven recruiting and hiring process to fill key staff positions within 60 calendar days of the vacancy. Our approach to filling key staff vacancies typically includes the following actions:

- Notify the Agency of key staff changes before the change or within two days of the vacancy
- Identify qualified backups to assume responsibilities until a permanent replacement is found
- Engage corporate Human Resources (HR) and our talent acquisition process to begin both internal and external recruiting
- Interview potential candidates
- Consult with the Agency concerning proposed replacement
- Hire and train replacement key staff

4.3.1.1.7 RESUMES OF ALL OTHER NAMED STAFF ASSIGNED TO THE PROJECT

4.3.1.1.7 Resumes of all other named individuals included in the Vendor's proposal, including any temporary staff that may be assigned to the project to provide specific, fixed-length services (e.g., training specialists, implementation staff). Resumes should include licenses, skills, and relevant experience as it pertains to this project. Resumes should be limited to two (2) single-sided pages.

We include resumes, not exceeding 2 pages, for the named staff assigned to the project to provide specific fixed-length services in **Attachment 2** to the proposal. In addition to our key staff roles, we are providing resumes for our additional transition support staff as well as our Medical Director.

Mobilizing Support

In September 2021, when DHHR wanted to improve the health and safety of IDD Waiver members in Intensively Supportive Settings or Group Homes – we stepped up. Kepro's April Goebel, a senior IDD team member, was assigned to lead the successful development and implementation of a new initiative to provide on-site, face-to-face annual reviews, residential interviews, service plan reviews and technical assistance.

4.3.1.1.8 WORK TO BE PERFORMED OFF-SITE

4.3.1.1.8 For any proposed work to be performed off-site, including work of subcontractor(s), the bidder should describe how they will assure confidentiality, quality and timeliness of the work completed off-site or through subcontractors.

We will perform work on the contract from our Charleston, West Virginia office location, except for issues arising that demand corporate-level human resources, executive leadership weighing in, legal-related matters, and other similar support functions. In limited circumstances, we may request to use corporate administrative, or IT resources located outside WV to supplement our WV team in which case we will promptly notify the Agency. Corporate resources are held to the same confidentiality, quality, and timeliness standards as any of our West Virginia on-site staff. We currently do not utilize, and we do not plan to utilize, subcontractor staff to perform contract duties, and we plan to perform the substance of the work under this RFP in West Virginia as we have for the last two decades.

4.3.1.1.9 APPROACH TO STAFF RETENTION AND CONTINUITY OF STAFF

4.3.1.1.9 Approach to staff retention and ensuring continuity of staff.

Our staffing approach is comprehensive: we hire, train, and retain top talent that shares the mission of the work we will be performing in West Virginia and that is reflective of the populations we will be serving under this contract. We have a local presence in West Virginia with over 146 experienced staff in-place today – many who were trained for our original WV DHHR implementation in 2001, demonstrating our history of maintaining continuity of staff. Our decades long relationship with WV DHHR has given the Kepro staff the unique advantage of familiarity and expertise with the State's UM and PA programs.

Our structured staffing approach with well-defined roles is designed to support our adherence to service level commitments. We designed our WV staffing plan to meet RFP requirements and maintain adequate qualified staff throughout the term of the contract. And, as we have demonstrated over the prior twenty years, we are able to efficiently modify our staffing when needed and driven by program changes within the state. Our staffing model provides a team-based

solution to meet contract objectives and exceed the expectations of WV DHHR for meeting all required timelines and deliverables. Our staff members have continued to deliver exceptional customer service in every aspect of work performed. In fact, we average > 90% retention rate companywide exceeding the industry average of 64%. We achieve this by fostering a healthy culture across the organization – one in which every individual can achieve excellence. We hire and retain a highly skilled workforce supported by expert corporate staff experienced in effective contract administration. Our high retention rate contributes to the overall efficiency and effectiveness of our teams. WV DHHR knows firsthand our management team's commitment to and deep level of knowledge of the UM and PA Services program, processes, and applicable federal and state regulations and requirements in this RFP.

West Virginia Staffing Experience

Our 22-year experience hiring, training, and retaining West Virginians; establishing a reputation as an employer of choice in West Virginia; and building relationships across the spectrum of WV DHHR stakeholders means that we are uniquely qualified to provide a seamless transition from servicing the current contract with West Virginians to serving the contract being procured under the RFP with West Virginians.

We hire and retain a highly skilled workforce, supported by corporate staff experienced in effective contract administration. Our staff retention efforts begin with hiring the right staff into each position, training staff thoroughly on their roles and responsibilities, and providing a culture that supports personal growth and job satisfaction. We have a comprehensive hiring/selection process to help hiring managers select the most qualified and skilled applicant for the position. With such an intensive and communicative method, the applicant has a more comprehensive understanding of the company, management style, expectations, and position to help them make the decision to join our team. Additionally, we cross-train staff, where appropriate and relevant, so that there is continuity of service to meet contract deliverables and exceed WV DHHR expectations for quality and service. All staff are knowledgeable of the WV DHHR programs we manage. With this comprehensive hiring and training program, staff have the confidence to perform well and the opportunity to work in other areas if so desired.

Actual staff retention metrics demonstrate the effectiveness of this approach. **The average tenure of our Key Staff is 15+ years in West Virginia and 17+ years with Kepro. On average, our combined staff have over 7 years of tenure.** The average tenure of employees on a national level according to the Bureau of Labor Statistics is 4.1 years as of January 2022. The average tenure of our management team is more than triple this average, demonstrating their commitment to WV DHHR and the valuable goals of this contract.

Retention Strategies

We work internally with our Human Resources team to develop staff retention plans that maintain proper staffing levels throughout both the transition period and the term of the contract. High

retention facilitates long-term relationships, deepening trust, and meaningful engagement. We deploy a proven recruiting and staffing model that provides enough staff to maintain performance and meet contract deliverables. Our standard retention strategy includes:

- Career pathing to foster professional growth
- Work from home program for qualified staff
- Performance and quality-based incentives
- Servant-Leadership attributes within leadership team
- Coaching, mentoring, and training
- Performance and quality audit balance
- Accountability and consistency of practice in our policies and procedures
- Continuous measurement, review, and revision of the recruiting and hiring process
- Clear, consistent, and effective communication practices

> "Kepro's tuition assistance allowed me to obtain both a bachelor's degree (2016) and a master's degree (2022) in Nursing. The direct support from Kepro leadership and my peers helped me advance my career goals, education, and qualifications. I use my experiences and knowledge daily to support our Long-Term Care program and West Virginia residents."
>
> *Melody Cottrell, Project Manager*
> *West Virginia*

We understand the importance of retaining excellent employees. We conduct exit interviews as a best practice to better understand reasons for leaving and to help mitigate such reasons moving forward. Part of our retention strategy includes offering identified and attainable paths to advancement in roles and compensation for new or entry-level workers. We use roles including Clinical Leads, Supervisors, Quality Specialists, and Training Specialists that encourage entry-level workers to increase competency and technical skills that lead to advancement. We offer tuition assistance to help staff obtain relevant degrees, licenses, and certifications. We also provide a structured performance-based incentive program for all line staff. These staff from Specialists up through Clinical Lead levels have defined, role-based goals for quality (measured by quality assurance [QA] scores on their work) and production (measured by completed volumes of assigned work, or timelines when volume goals are not indicated).

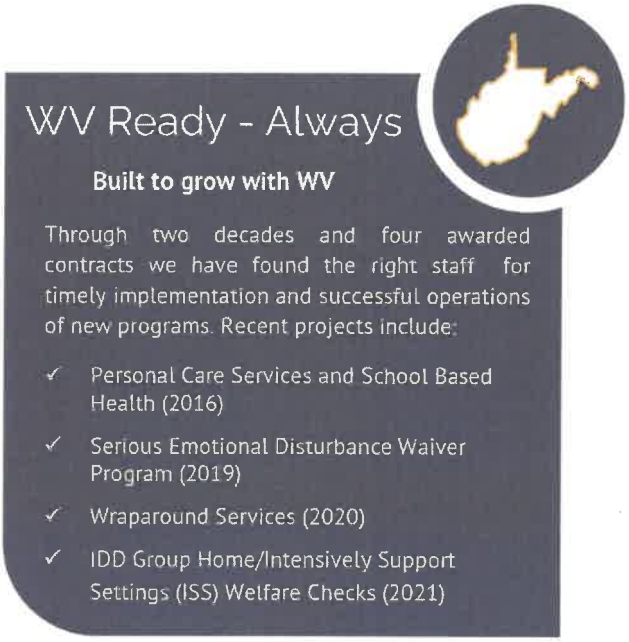
We look forward to using our successful approach to retention to provide our new staff members with the same positive experience as our longest-term employees, to increase their tenure year-to-year through the term of the contract and contribute to the continued success of the program.

4.3.1.1.10 APPROACH TO PERSONNEL MANAGEMENT

4.3.1.1.10 Approach to personnel management.

The foundation of our approach to personnel management is open communication with a strong emphasis on training. Throughout our training and communication processes, we seek to provide excellent customer service and exceed deliverable requirements. Team support is critical, and we encourage it at every level. Staff members learn that we support every position to achieve program goals and objectives, and they are justly proud of their accomplishments.

Our training plan, which has been developed and refined through our years of experience in West Virginia, addresses all staff training requirements to prepare staff to deliver exceptional customer service from the first day of the contract. We consistently provide relevant, dynamic, and engaging training and employee development programs designed to help individuals achieve their highest level of performance, creating the most talented and knowledgeable workforce in the industry. To support this standard, we draw upon our corporate resources dedicated to learning and education across the organization. Our in-house training is unparalleled in supporting the development of our most valuable resource: our people.



Staff Onboarding

We are committed to successfully recruiting and onboarding resources as needed to meet WV DHHR needs. We designed our staffing plan for West Virginia to exceed the requirements and maintain qualified staff throughout the contract term. Our approach includes clearly delineated staff and reporting structures to provide effective administration of all contractual responsibilities.

We understand that a comprehensive recruitment strategy (including talent acquisition) is critical to the continued success of the WV DHHR contract. Our dedicated Human Resources teams have developed a customized recruitment strategy for the West Virginia program utilizing our proven strategies outlined below. **This approach has been successful in recruiting and hiring the 146 staff working on the current West Virginia contract.**

We understand the importance of continual recruitment efforts and are pleased to offer resources dedicated to this work. Our HR team provides support in talent acquisition, onboarding, and retention efforts. This team is committed to the success of every new employee and to our people-first culture. We believe that having a people driven culture allows us to attract and retain the very best talent. Our Vice President, Rose Ungaro, leads this team with over 20 years senior HR experience including 14 years supporting Kepro. These two dedicated teams work in concert to implement the following steps to our recruitment and onboarding process:

- **Talent Attraction.** We do not rely on solely on traditional methods for attracting talent for each job opening, rather we use cutting-edge techniques to find the best talent. Our recruiting team has over 20 years of recruitment experience combined, as well as proven success delivering in high-volume and challenging recruitment scenarios.

- **Screening and Onboarding.** Our screening processes address how we identify candidates who are the right fit both functionally and culturally, and our onboarding process addresses how we introduce them to our organization. Both processes are critical to promote high-performance and retention. This reduces our need to re-hire and re-train, while also delivering highly efficient hires who are effective in achieving their objectives.

Staff Training Program Overview

Our staff training program includes:

- Corporate training expertise for implementation and ongoing training
- A full-time and dedicated individual works with our contract leadership team to monitor quality and provide one-on-one assistance to staff, or group training to address an identified trend
- A WV-approved training plan which identifies the training needs during each operational phase and includes the type of training required, description of the training objectives and content, how training should be delivered, training materials to be developed, and resource and schedule for training activities
- WV-approved internal and external standard operating procedures and educational materials that address the service authorization process, including recorded training sessions and webinars for future reference
- Initial and ongoing training to educate staff on the utilization review process, upcoming changes, and the Atrezzo Care Management (Atrezzo) systems
- A learning management system (LMS) that houses more than 500 video trainings available to staff for on demand training
- Quality monitoring that identifies ongoing training needs

Curriculum Plan

Prior to training and annually thereafter we will obtain WV approval for training sessions. If WV DHHR requests changes, we will resubmit the training material with those changes or notification with the reasons why changes were not incorporated within seven calendar days of receipt of WV DHHR's edits. We further agree to obtain WV approval of all training materials prior to training sessions.

Strategies and Methods

We use a full functioning array of resources including training manuals, operational manuals, policies, procedures, informational materials, webinars, and training evaluation forms. We have an established knowledge repository that is accessible to each employee through their department leadership. Because learning is an individual and social process, we use the following effective methods to deliver training as detailed in **Figure 16 Training Methods**. We continually customize our approach to meet our staff and WV DHHR's specific needs and requirements.

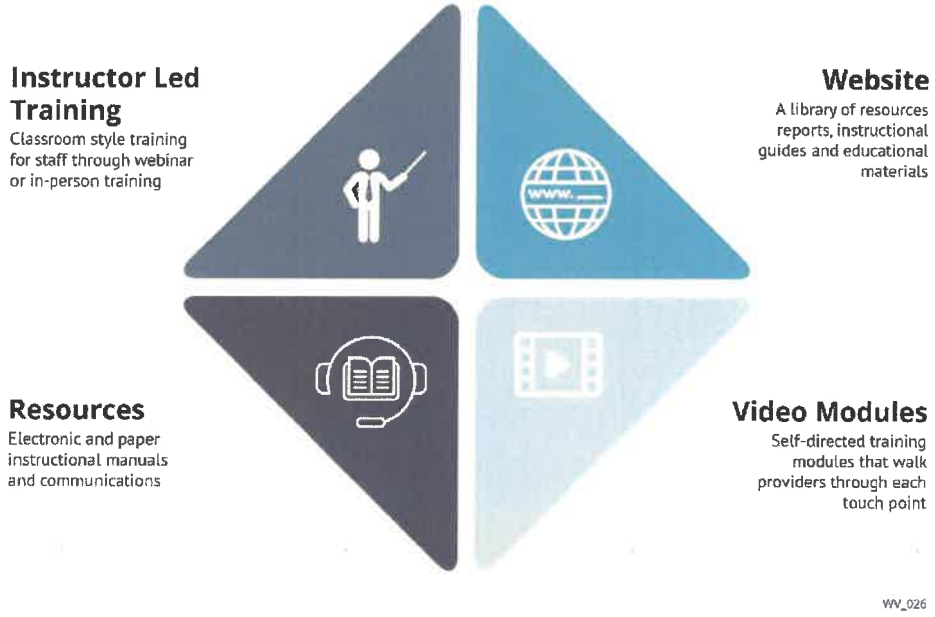


Figure 16. Training Methods

We use multiple, effective methods to deliver training to address individual and group needs.

To maximize the effectiveness of our training, our overall approach to training eliminates lecture-only training because this type of training does not result in acceptable levels of content retention. We also limit reliance on reading as a stand-alone educational method, using it with other methods to achieve greater retention. We use training methods that achieve better retention rates.

We recognize that each learner may have different needs or learning styles to effectively grasp and retain the required information. Throughout the training process, staff are closely monitored and evaluated to identify any learning gaps. Any gaps identified are included in an individual training plan that best meets their unique learning needs to support the individual's learning success.

We have significant experience training staff on our systems as well as West Virginia-specific policies and procedures. Our subject matter experts (SMEs) have already developed and currently deliver comprehensive training and related documentation and materials. They coordinate staff training for our team. Our key staff have the requisite knowledge to train new staff efficiently and appropriately, and we will leverage our existing training modules. We will provide the staff necessary to meet the training-related requirements specified in this RFP.

All staff receive the training shown in **Figure 17 Corporate Compliance and Ethics Training Program Topics** upon hire and annually thereafter.

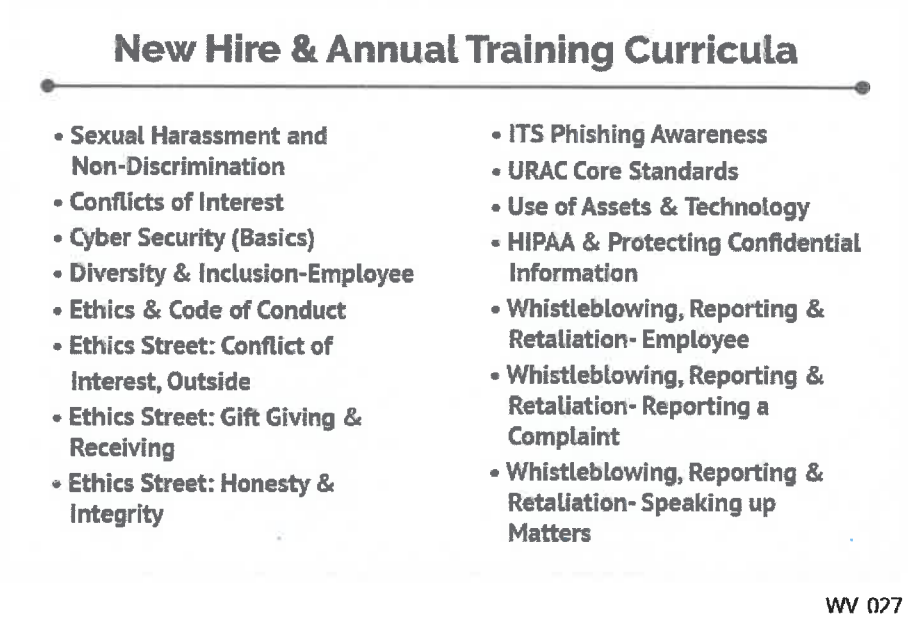


Figure 17. Corporate Compliance and Ethics Training Program Topics
New Hire and Annual training keep our staff up to date on the most critical training areas.

Training Plan

All new staff will undergo orientation and initial training to provide them with the understanding of the requirements under this new contract along with ongoing assessment and review procedures to ensure the staff continue to be aware of and perform to the level of WV DHHR's expectations. Staff are provided with a manual containing our operational and procedural policies and job aids to guide them in their workflow for their duties related to the program.

New staff orientation begins on day one. We tailor orientation to the position and State requirements for total immersion in the job, department, and organization. Corporate orientation leads new staff through our values and mission. We complete onboarding with structured training for processes and systems training through job shadowing, in-person training, and e-learning modules. A detailed new hire orientation checklist guides staff through their orientation and provides consistency and thoroughness in our onboarding and training processes. Our training plan for West Virginia is designed for the following audiences:

- Customer Service Representatives
- Case/Clinical Reviewers
- Quality Specialists/Managers
- Case Managers/Care Coordinators
- Technical and Data Support Leads
- Supervisory Roles

Ongoing Monitoring

Employees who have completed their introductory period continue to receive feedback from the quality monitoring process. Supervisors meet with their staff monthly, and more often as needed, to provide them feedback from their monitoring. Any quality monitoring below the designated threshold will attend remedial training specific to the area in need of improvement.

Customer Service Staff: Project Manager, Administrative Services Amber Murphy will oversee the continual monitoring of Customer Service (call center) staff performance including productivity, quality and call handling techniques, accuracy in call resolution and accuracy in data entry using standards provided by contractual requirements. Four calls per agent received each month are screened for quality control purposes and assigned a quality score. The results are shared with each agent. We require customer service agents to achieve a minimum score of 90% each month. If the results are below 90%, the call center supervisor or manager works with the agent to define an action plan to address the gaps and attain continuous improvement. If it is determined that more calls need to be monitored for a specific representative, or a specific type of call, the Call Center Manager shall handle it accordingly and report updates to WV DHHR accordingly.

Clinical Review Staff: The Quality Assurance (QA) team, under the guidance of the Quality Improvement (QI) Director conducts formal monthly audits of evaluations completed by each Reviewer measuring the quality of the reviews against Key Performance Measures. Each new Clinical Reviewer staff member has an initial probationary period during which their supervisor, or a designated QA Manager, monitors all submitted reviews to identify if the reviewer may benefit from any additional training opportunities. Within the first 30 days of assignment to the role, the QA Manager will conduct an audit of five evaluations completed by the new reviewer. If a reviewer receives an aggregate audit score below the expected performance standard of 90% their supervisor or QA Manager will direct individualized intervention and training. The Clinical Reviewer will continue to have five evaluations audited each month until they receive an aggregate score of 90% or above at which time the number of evaluations that are audited will be reduced to three (3) audits per month. Common issues identified in the audit process will be the basis for group training.

Proficiency Testing and Inter-Rater Reliability

Each month, reviewers will complete a set of test cases to assess reliability and dependability of decisions and knowledge of the review process across reviewers. These test cases are designed to measure the reviewer's proficiency in the following areas:

- Process
- Application of criteria
- Application of workflows

In addition, since all reviewers receive the same sample case, we can analyze the agreement between reviewers (inter-rater reliability). Test cases will be given to all reviewers at the

completion of initial training. Additionally, gold standard cases are assigned to assess reliability on an ongoing basis. With the detailed reporting from our auditing process, we can identify any areas of weakness that may require additional training for a particular reviewer or identify additional training for a specific service type. The proficiency testing is performed monthly, and results are available to the management team for review. Together the Quality team and Management team collaborate to improve the process.

4.3.1.2 RELATED EXPERIENCE AND CAPABILITIES

4.3.1.2. The Vendor should provide detailed evidence of their related experience and capabilities in providing UM/PA Services program, which includes experience with organ transplants, quality management and utilization management in Health Homes services, individualized waiver budgets based on a statistical model, in home assessments and all other services/programs listed in this RFP. Three (3) Vendor references from government entities work within the last five (5) years should be provided.

We have more than 35 years of utilization and prior authorization program experience, 13+ years of Waiver program experience, and expertise that spans the country including our successful partnership with WV DHHR for the past 22 years. Our combination of in-depth West Virginia specific knowledge and experience, reinforced by a national presence to monitor trends and best practices, is a unique differentiator. **Figure 18 Kepro UM and PA Experience** shows a sample of our current contract experience with the scope of services comparable to this RFP.

UM & PA PROGRAM SCOPE EXPERIENCE	WV DHHR	FL AHCA	IL HSF	VA DMAS	ME DHHS	MS DOM	SC DHHS	CO HCPF
YEARS OF SERVICE	22	30	20	16	15	15	10	7
INPATIENT & OUTPATIENT SERVICES	✓	✓	✓	✓	✓	✓	✓	✓
ORGAN TRANSPLANTS	✓					✓	✓	✓
QM/UM HEALTH HOME SERVICES	✓				✓			
INDIVIDUALIZED WAIVER BUDGET REVIEWS	✓	✓	✓		✓			
IN-HOME ASSESSMENTS	✓	✓	✓		✓	✓		
STANDARD & AD HOC REPORTS	✓	✓	✓	✓	✓	✓	✓	✓
CALL CENTER SERVICES	✓	✓	✓	✓	✓	✓	✓	✓
QUALITY ASSURANCE PROCESSES/COMMITTEES	✓	✓	✓	✓	✓	✓	✓	✓
BEHAVIORAL HEALTH SERVICES	✓	✓	✓		✓	✓	✓	✓
WAIVER PROGRAM SERVICES	✓	✓	✓	✓	✓	✓		✓

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Figure 18. Kepro UM and PA Experience
We offer extensive UM and PA s experience from across the nation, including WV DHHR programs

West Virginia Qualifications and Experience

The best evidence of our related experience and capabilities for providing UM and PA services is the work we have performed in partnership with WV DHHR over the past 22 years. We are committed to assisting WV DHHR to meet current and future program challenges with continued flexible, efficient, and customized solutions. Our long-standing record of achievement serving the Agency and our trusted relationship has grown over time.

We implemented the IDD Waiver program in 2006, followed by BBH Charity Care in 2010 and the TBI Waiver in 2011. Within the current contract period, we implemented Medical Fee for Service (FFS) and the Aged and Disabled Waiver in 2009. We completed the Health Homes design and implementation in 2012 and brought previously subcontracted services in-house in 2015. We also implemented Personal Care Services, Nursing Home PAS, Take Me Home, and School-based Health Services in 2015. In addition, all programs have a quality management component including working with the Centers for Medicare and Medicaid Services (CMS) Quality Measures for each of the three Waivers.

We also developed and managed the IDD Waiver Statistical Budget Model based on Dr. Ed Campbell's national model and statistical protocols. Our professionally trained staff conduct in-home assessments in the TBI, ADW, and IDD Waivers. This extensive scope of work goes beyond the traditional UM and PA model to meet the comprehensive needs of the Agency.

Kepro and WV DHHR have cultivated a strong partnership over our 22-year collaboration serving providing UM and PA services and have grown together to successfully adapt to changing member needs. WV DHHR has entrusted our team with numerous program additions and expansions that have produced cost savings for the State and streamlined programs for members. Below is a selection of program accomplishments that have aided WV DHHR in improving member lives:

- ISS/Group Home Welfare Checks – 2021
- Wraparound Services –2020
- West Virginia Children's Health Insurance Program (WVCHIP), QRTP, CSED Waiver –2019
- Quality management and utilization management in Health Homes services– 2015
- Individualized waiver budgets based on a statistical model – 2015
- Organ Transplants – 2010

National Experience

In addition to our two decades of work with WV DHHR, we bring a comprehensive set of national experience with UM, PA, and Waiver services. Since 1985, we have helped Medicaid members lead healthier lives through clinical expertise, with integrity and compassion. We were founded by physicians with continuous physician leadership today including Kepro's CEO, Susan Weaver, MD as well as many of our senior leadership team who have clinical backgrounds. With our current experience serving Medicaid agencies and populations across 34 states covering over 8 million Medicaid FFS members, we are well-qualified to serve WV DHHR, and its most vulnerable

members. We bring WV DHHR over 33 years of utilization management and prior authorization program experience and 13+ years of Waiver program experience and expertise, with a focus on person-centered and wholistic care for the members we serve. Our program solution for WV DHHR is uniquely poised with West Virginia experienced clinical staff, proven processes, and advanced technology to successfully handle any service type and the unique needs of the population.

As indicated in **Figure 18 Kepro UM and PA Experience**, presented earlier in this section, we provide related services in multiple states, including for organ transplants, Health Homes, individualized waiver budgets, and other RFP defined services.

References/Project Managers

Table 11 Kepro Reference Contact Information lists contact information for three Kepro references. Each reference is a government entity and we have performed work for each within the last five years.

Client/Type of Contract	Project Manager Contact Information
Virginia Department of Medical Assistance Services (DMAS) **Type of Contract: UM/PA**	Patricia Arevalo, Manager, Service Authorization Program Operations Division/Service Authorization Unit Virginia Prior Authorization Services Administration 600 East Broad Street, Suite #1300 Richmond, VA 23219 Phone: 804-773-1193 Email: pat.arevalo@dmas.virginia.gov
Florida Agency for Health Care Administration (AHCA) **Type Contract: UM/PA**	John Mattson, Program Administrator 14101 Martin Luther King Hwy Alachua, FL 32615 Phone: 850-412-4033 Email: john.mattson@acha.myflorida.com
Maine Department of Health and Human Services (DHHS) **Type of Contract: UM/PA**	Stephen Turner Director, OMS Contract Management DHHS Office of MaineCare Services 242 State Street, 11 SHS Augusta, ME 04333-0011 Phone: 207-287-3828 Email: Stephen.turner@maine.gov

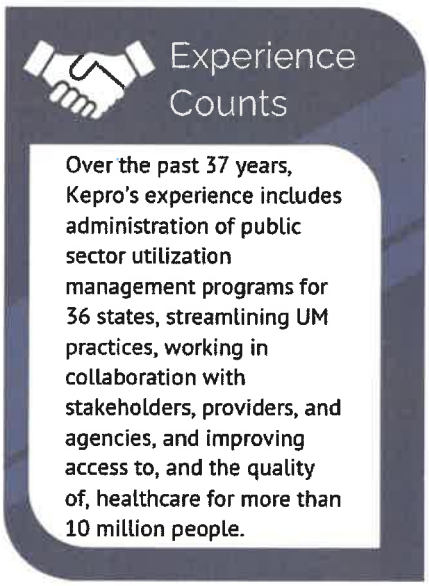
Table 11. **Kepro Reference Contact Information**
We provide services of similar scope and size for each of these contacts

4.3.1.3 QUALITY IMPROVEMENT ORGANIZATION (QIO) / QIO-LIKE UTILIZATION MANAGEMENT/PRIOR AUTHORIZATION SERVICES PROGRAM

4.3.1.3. The Vendor should describe their experience within the last five (5) years' operating a Quality Improvement Organization (QIO) or QIO-like Utilization Management/Prior Authorization Services program(s) for a population similar to that of West Virginia Medicaid, including with the following:

We far exceed the RFP requirement for experience within the last 5 years in operating a Quality Improvement Organization (QIO) or QIO-like Utilization Management/Prior Authorization Services program(s) for a population like that of West Virginia Medicaid, having done so in West Virginia and more than 30 other states.

We are recognized by CMS as a designated QIO entity. In addition, we are approved by CMS as a QIO-like entity. QIO-like entities are required to submit annual attestations statements to CMS, attesting to the following:



- We have a governing body that includes at least one individual who is a representative of health care providers and at least one individual who is representative of consumers under Section 1153 of the Social Security Act (The Act).
- We can perform limited medical and quality review functions required under Section 1154 of the Social Security Act (The Act).
- We are not a health care facility or health care facility affiliate and we do not subcontract with a health care facility to perform any case review activities except the quality of care defined in §475.105.
- We are not a payor organization except as provided in §475.105(a)(3).
- We can demonstrate the ability to perform the functions of a QIO including:
  - Ability to perform case reviews as described in §475.102
  - Ability to actively engage members, families, and consumers, as applicable, in case reviews as described in §475.102, and quality improvement initiatives as described in §475.103
  - Ability to perform the functions of a QIO with objectivity and impartiality in a fair and neutral manner

CMS requires recertification as a QIO-like entity every 5years. Kepro applied for QIO-like entity recertification in February 2019 and was approved and certified effective May 9, 2019, expiring in 2024. To maintain continued certification, Kepro provides an annual assurance statement of continued adherence to certification requirements 30 days prior to the first, second, third, fourth, and fifth anniversary dates of certification. Evidence of our QIO and QIO-like status is shown in **Figure 19 Kepro QIO-like Certification**.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S3-02-01
Baltimore, Maryland 21244-1850

CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CLINICAL STANDARDS & QUALITY

Joel Portice
Chief Executive Officer
Kepro Incorporated
777 East Park Drive
Harrisburg, Pennsylvania 17111

MAY - 9 2019

Dear Mr. Portice:

We have reviewed your application of February 6, 2019 requesting that the Centers for Medicare & Medicaid Services certify Kepro Incorporated as a Quality Improvement Organization (QIO)-like entity for the State of Pennsylvania. As a result of this review, we have determined that Kepro Incorporated of Pennsylvania meets the requirements to be a QIO-like entity, namely:

- It is able to perform limited medical and quality review functions required under Section 1154 of the Act;
- It has one individual who is representative of health care providers and consumers on its governing body under section 1152 of the Act; and
- It is not a health care facility, health care facility affiliate, or payor organization as defined in 42 CFR 475.105.

This certification designates Kepro Incorporated of Pennsylvania as a QIO-like entity eligible to fully operate in Pennsylvania. Kepro Incorporated of Pennsylvania may also operate in other states with the exception of performing Medicare medical reviews. For the conduct of Medicare medical review work, a QIO-like entity must meet the requirement that the QIO-like entity have access to or agreements with peer reviewers in the state in question.

If the QIO-like entity determines to conduct Medicare medical review work in a state other than the state for which it has submitted a list of medical reviewers, this criterion must be met and submitted for approval by CMS before such work can be undertaken.

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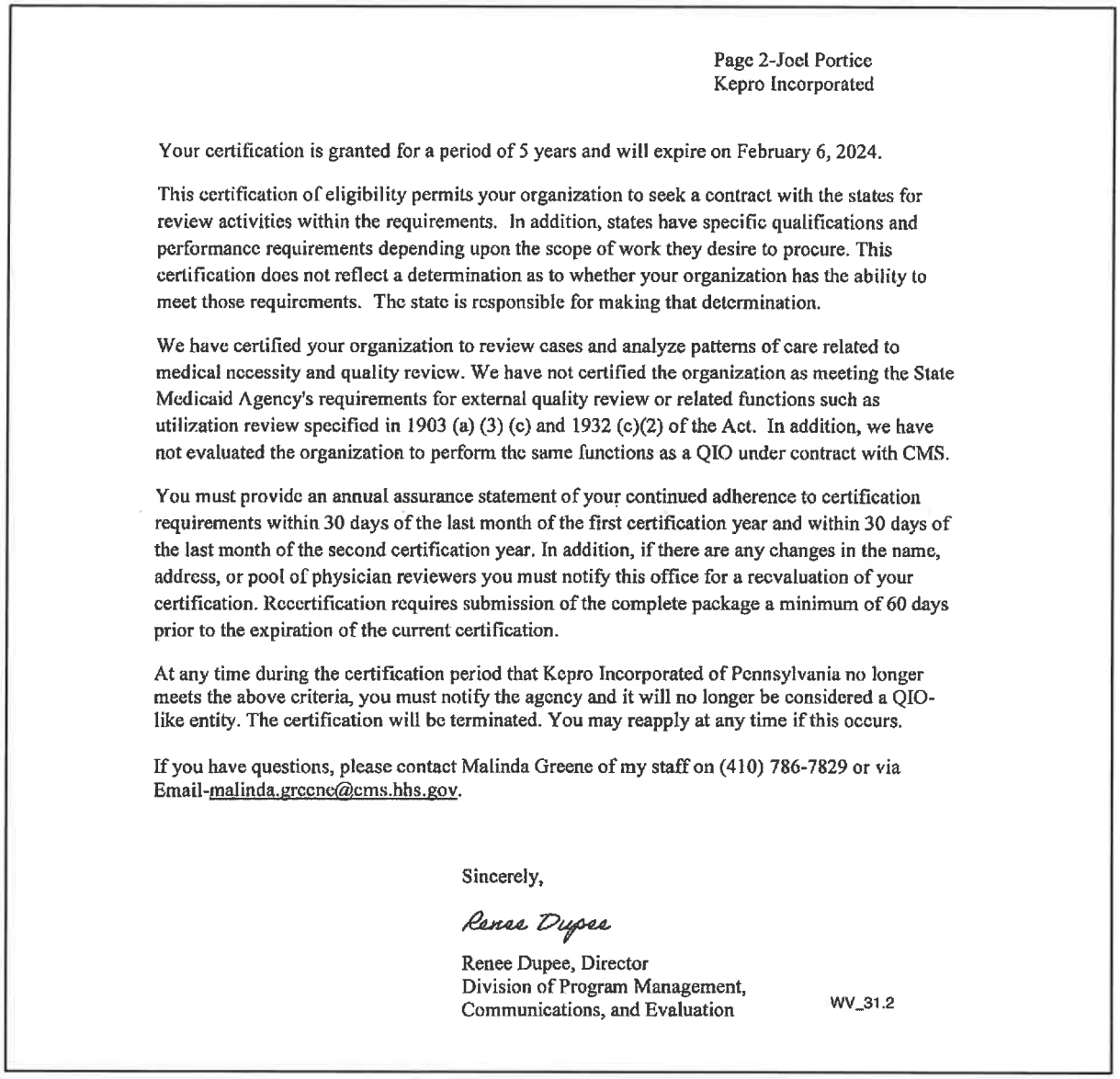

Page 2-Joel Portice
Kepro Incorporated

Your certification is granted for a period of 5 years and will expire on February 6, 2024.

This certification of eligibility permits your organization to seek a contract with the states for review activities within the requirements. In addition, states have specific qualifications and performance requirements depending upon the scope of work they desire to procure. This certification does not reflect a determination as to whether your organization has the ability to meet those requirements. The state is responsible for making that determination.

We have certified your organization to review cases and analyze patterns of care related to medical necessity and quality review. We have not certified the organization as meeting the State Medicaid Agency's requirements for external quality review or related functions such as utilization review specified in 1903 (a) (3) (c) and 1932 (c)(2) of the Act. In addition, we have not evaluated the organization to perform the same functions as a QIO under contract with CMS.

You must provide an annual assurance statement of your continued adherence to certification requirements within 30 days of the last month of the first certification year and within 30 days of the last month of the second certification year. In addition, if there are any changes in the name, address, or pool of physician reviewers you must notify this office for a recvaluation of your certification. Recertification requires submission of the complete package a minimum of 60 days prior to the expiration of the current certification.

At any time during the certification period that Kepro Incorporated of Pennsylvania no longer meets the above criteria, you must notify the agency and it will no longer be considered a QIO-like entity. The certification will be terminated. You may reapply at any time if this occurs.

If you have questions, please contact Malinda Greene of my staff on (410) 786-7829 or via Email-malinda.greene@cms.hhs.gov.

Sincerely,

Renee Dupee

Renee Dupee, Director
Division of Program Management,
Communications, and Evaluation

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Figure 19. Kepro QIO-like Certification

CMS provided the certification letter above in 2019; we will be required to re-certify in 2024.

As a quality-driven organization with both QIO and QIO-like designations, reliable and consistent quality assurance practices and credentials are essential to Kepro's Clinical Review programs. We have gained decades of quality utilization review and program monitoring experience as a trusted QIO partner to the CMS on our Beneficiary Family Centered Care (BFCC) contract, providing quality reviews of UM determinations in 29 states. Our performance history with WV DHHR demonstrates our commitment to quality across West Virginia:

- Over 15 years of continuous URAC reaccreditation, including our Health Utilization Management and Case Management programs relative to the scope of this RFP

- 98% organization-wide compliance on internal audit results for six consecutive years
- 100% compliance on timeliness of SLAs across all Kepro contracts held today

Additionally, our multiple URAC accreditations, as shown in **Figure 20 Kepro URAC Accreditations**, as well as our two decades of experience working with WV DHHR, underscores our commitment to providing excellent programs and services that meet or exceed national benchmarking standards. Our adoption of state-of-the-art business processes to promote quality and accountability for our clients is validated by URAC awarding Kepro the following accreditations:

- Health Utilization Management was first awarded in 2005; reaccreditation in 2024
- Disease Management was first awarded in 2012; reaccreditation in 2023
- Independent Review Organization: Internal/External awarded in 1999; reaccreditation in 2024
- Case Management was first awarded in 2007; reaccreditation in 2024

Figure 20. Kepro URAC Accreditations
Our URAC accreditations demonstrate our corporate culture of quality improvement.

4.3.1.3.1 EXPERIENCE WITH STATE MEDICAID AND OTHER GOVERNMENT PROGRAMS

4.3.1.3.1 State Medicaid and/or other governmental utilization/prior authorization programs

Our results in other state and federal programs are evidence that we know how to drive real change. We support WV DHHR to maximize healthcare quality and efficiency across the healthcare continuum by applying best practices and bringing valuable industry knowledge. West Virginia's UM and PA services require a partner that is well-versed and experienced in all aspects of utilization management. After working in the Medicaid utilization management, Home and Community Based Services (HCBS) waiver and quality oversight program space for decades, we know how to deliver optimal results.

Our experience goes beyond those requirements to include state and national responsibilities for utilization and quality management for Medicaid, state-funded, and other government-funded services. Our average contract term is over 10 years, demonstrating our ability to maintain long-term and positive relationships with clients and stakeholders. Our background translates into

stability, continuity, and consistent improvement of systems and methods to meet the needs of our clients with flexible, responsive, and efficient services. This experience substantiates our capabilities for the Scope of Work in the current RFP.

Table 12 UM and PA Experience by State within Past 5 Years represents a summary of current and past Medicaid programs where we provided UM and PA services over the past five years through contracts directly with Medicaid state agencies.

Agency /Location	Type of Contract, Scope, Goals, and Objectives
State of West Virginia 22 Years of Service	• UM/PA of inpatient and outpatient services for physical and behavioral health care • Hospice reviews • Discharge planning and Care Transition Management • Medical case management for select populations and high-cost medication review • Provision of clinical consultation and development assistance of policies and clinical criteria where no nationally recognized criteria exist for Physical, Behavioral Health and Socially Necessary Services • Provider reviews/training for behavioral health, SUD Waiver, and medical providers • Retrospective Medical Necessity and Medicaid compliance reviews of Behavioral Health and IDD providers • Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) of Physical and Behavioral Health Services • Operational agency for IDD Waiver program including waitlist management, slot allocations, assessments, implementation of budgetary model, provider reviews, and CMS reporting • Incident Management, Quality Assurance and Data Analysis for Group Home population of the IDD Waiver Program • Operational agency for TBI Waiver program including waitlist management, slot allocation, assessments, incident investigations, provider reviews, and CMS reporting • Operational agency for CSED Waiver program including waitlist management, slot allocation, assessments, provider reviews, and CMS reporting • Health Homes Eligibility and Provider Certifications • Documentation reviews of School Based Health Medicaid Programs • Psychiatric Residential Treatment Facility (PRTF)and Provider On-Site Reviews • Treatment Foster Care Level of Care Determinations • Training/educational services for SUD Waiver, Serious Emotional Disturbance (SED) Waiver, Intellectual/Development Disability (IDD) Waiver, Aged and Disabled (AD) Waiver, Traumatic Brain Injury (TBI) Waiver programs, Socially Necessary Services (SNS), and Behavioral Health Service Providers • Nursing Home I Reviews and Level II Coordination • Level of Care/Eligibility determinations for Personal Care Services, ADW, TBI and IDD applicants and annual redeterminations of members
State of Florida 30	• UM/PA of inpatient and outpatient services for physical and behavioral health care • Enhanced Care Coordination for Medical Fragile Children • Administrative Support and Clinical Testimony for Fair Hearing Office

Agency /Location	Type of Contract, Scope, Goals, and Objectives
Years of Service	• NICU Care Management and Discharge Planning Support • Monitoring and Validation of Healthcare Acquired Conditions (HAC) • Hospice reviews • Implementation and Management of a Multi-Disciplinary Team Behavioral Analysis Program • Prior authorization review for individuals enrolled in Florida's Medicaid Waiver programs, HCBS, Consumer Directed Care Plus (CDC Plus), Family and Supported Living (FSL), for the DD/ID population through Florida's Agency for Persons with Disabilities. • PASRR Level 1 screenings and Level II reviews for individuals with serious mental illness (SMI) and individuals with ID/RC
State of Illinois 20 Years of Service	• UM/PA of inpatient and outpatient services for physical and behavioral health care • Discharge planning and Care Transition Coordination • Internal and Independent Review Organization (IRO) appeals processing • Retrospective claims review • Case management of high cost/risk members • Quality of Care and Provider Compliance Reviews for Medically Complex Populations • Program monitoring and support for the Children's Mental Health Act • Home and Community Based Waiver Authorizations and Quality Management • Management of the Family Support Program for Child and Adolescent Mental Health
Commonwealth of Virginia 16 Years of Service	• UM/PA of inpatient and outpatient services for physical and behavioral healthcare • Care coordination and educational services for various HCBS Waiver programs • Appeals • Elderly or Disabled with Consumer-Direction (EDCD) Waiver Program reviews • EPSDT authorization reviews • Assistive Technology Personal and Dependent Care • Durable Medical Equipment (DME) reviews • PRTF Level of Care reviews
State of Mississippi 15 Years of Service	• UM/PA of inpatient and outpatient services for physical and behavioral health care • Imaging Services authorization review • Administrative Support and Clinical Testimony for Appeals • Retrospective claims review including APR-DRG validation • HCBS Waiver Program Management • Children and youth with Serious Emotional Disturbance (SED) Provision of Peer Review Panels and Specialty Medical Consultation
State of Maine 15 Years of Service	• UM/PA of inpatient and outpatient services for physical and behavioral health care • Katie Beckett Waiver and the IDD/A&D/BH Waivers • Eligibility verification, prior authorization, utilization review, and retrospective review for children and adults who are eligible for and receiving Medicaid mental health and substance abuse program services. • PRTF quality oversight
State of South Carolina	• UM/PA of inpatient and outpatient services for physical and behavioral health care • Discharge planning and Care Transition Coordination • DME authorization reviews

Agency /Location	Type of Contract, Scope, Goals, and Objectives
11 Years of Service	• Home Health authorization reviews • Hospice services authorization reviews • Retrospective claims reviews • PRTF Level of Care Reviews
State of Minnesota 8 Years of Service	• UM/PA of inpatient and outpatient services for physical and behavioral health care • Appeals and Fair Hearings processing
State of Colorado 8 Years of Service	• UM/PA for both inpatient and outpatient services for physical health care • Retrospective review of inpatient admissions for outlier payments; random reviews; billing/claims; short stays; admissions; readmissions; quality of care and diagnostic-related group (DRG) accuracy • Discharge Planning and Care Transition coordination • Provision of the Client Over-Utilization Program • Provision and management of the statewide Nurse Advice Line • Management of the Hospital Back-Up Unit Program • Eligibility Review for the Children's Extended Services Program and Children's Home and Community Based Waiver Services Program • Management of the Over-Cost Containment Program • Preassessment and Resident Review Program for Skilled Nursing Facility Admissions • Administrative Support and Provision of Clinical Testimony for Appeals • Provision of clinical consultation and development of policies and clinical criteria where no nationally recognized criteria exist
State of Arkansas 4 Years of Service	• Discharge planning and Care Transition coordination • Case Management of high cost/risk members • Retrospective Claims Reviews • Foster Care Program • Provision of support for clients with developmental disabilities and behavioral health needs • PRTF Level of Care reviews
State of North Dakota 3 Years of Service	• UM/PA of inpatient and outpatient services for physical health care • Retrospective review of inpatient admissions for outlier payments; random reviews; billing/claims; short stays; admissions; readmissions; quality of care and DRG accuracy • Reviewing and validating shared client files
State of Nebraska 2 Years of Service	• UM/PA of inpatient and outpatient services for physical health care • Retrospective Claims Review • Cost Outlier Review and Management • Continued Stay Reviews for Service Intensity Payment and Special Needs Facilities • Administrative Support and Clinical Testimony for Appeals • Provision of Expert Medical Consultation • PASRR LI screenings and LII evaluations and determinations

Table 12. UM and PA Experience by State within Past 5 Years

We have long standing customer relationships and decades of UM and PA experience with similar scope

4.3.1.3.2 EXPERIENCE PROVIDING UTILIZATION / PRIOR AUTHORIZATION SERVICES

4.3.1.3.2 Providing Utilization/Prior Authorization Services

We began utilization and prior authorization review functions decades ago to help states manage access to medical and other services. Beginning with the Peer Review Organization program in 1984, we built our methodology and approach on the foundation established by the CMS for reviews. Our experience with utilization management and prior authorization extends back to these beginnings, a depth of experience that demonstrates our approach to meet RFP requirements aligns with CMS expectations.

Utilization/Prior Authorization Expertise

- ✓ **West Virginia – 22 years**
- ✓ Florida – 30 years
- ✓ Illinois – 20 years
- ✓ Virginia – 16 years
- ✓ Maine – 15 years
- ✓ Mississippi – 15 years
- ✓ South Carolina – 10 years
- ✓ Colorado – 7 years

With our large network of Medicaid clients across **34 states covering over 8 million Medicaid FFS beneficiaries**, we are well-versed in serving diverse organizations with a wide range of population sizes. As such, our systems and programs are uniquely poised to successfully handle any service type and population size. Some of our largest Medicaid populations outside of West Virginia include the states of Florida, California, and Pennsylvania, as illustrated in **Figure 21 Kepro's Current State Clients**.

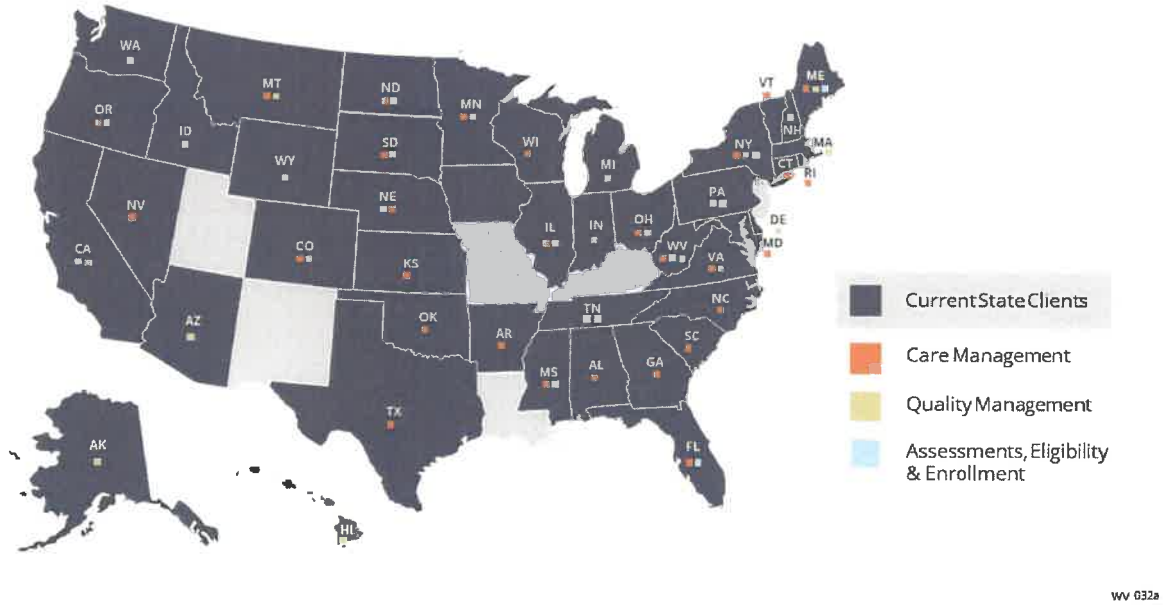

Figure 21. Kepro's Current State Clients
The extent and depth of our program expertise benefits every client.

With a focus on person-centered and wholistic care for the members we serve, and partnering with Department to optimize the care each individual receives, we bring to the Department 33 years of utilization management and prior authorization program experience including 20+ years of experience with behavioral health utilization review and 13+ years of Waiver program experience and expertise. Our program solution for WV DHHR is uniquely poised with expert West Virginia experienced clinical staff, proven processes, and advanced technology to successfully handle any service type and the unique needs of the population.

Given our extensive UM and PA services national footprint and years of experience, we bring a unique comprehensive perspective and set of best practices that already benefits the WV DHHR programs. We draw upon best practices from across the breadth of our experience to serve West Virginia members. With our years of partnership and commitment to continual improvement, the Agency can expect us to continue delivering the highest level of UM and PA services for the program and its providers and members.

4.3.1.3.3 EXPERIENCE HIRING PROVIDERS FOR UM AND PA REVIEW SERVICES

4.3.1.3.3 Hiring Providers to perform Utilization/Prior Authorization review services

We have more than three decades of experience hiring qualified licensed Providers to perform UM and PA review services. As an organization performing over 6 million time-sensitive utilization reviews annually, we understand it is imperative to maintain fully staffed clinical review teams within our UM and PA programs - and our proven ability to do so is evident in the decades we have maintained the appropriate number, licensure, and skill set of our review staff in our current WV DHHR UM and PA Services program. The advantage of choosing us to continue providing your UM and PA services is that today we employ the necessary number of qualified review staff to seamlessly continue performing the UM and PA review services. Our impressive roster of currently employed or contracted review staff includes the following:

- WV-based licensed and board-certified Medical Director, Dr. Paul Kuryla, along with 16 other FTE Medical Directors
- 19 WV-based Master's level assessors
- Provider Panel consisting of over 3,000 licensed and contracted Physicians and Allied Practitioners across 104 specialties

Additionally, our experienced Human Resource team will continue to successfully support the recruitment, hiring, and onboarding of new program employees to ensure quick ramp up of new services or projects and the long-term retention of our WV-based staff. Our established policies and procedures for recruiting, interviewing, credentialing (including primary source verification for education, training, and licensure) provide the governance for our WV UM and PA program staffing activities. A process that has proven to be effective through government and accreditation audits conducted in our existing contract.

Our hiring process, based on decades of national experience, has proven to be best-in-class time and time again. In fact, for our most recent **UM and PA implementations across 6 states (Alabama, California, Colorado, Minnesota, Mississippi, and North Dakota) we were fully staffed with qualified and licensed Review staff in less than the 90-day Implementation period defined by the contract.**

Talent Attraction

Our Talent Attraction Strategy can be further broken down into the following mechanisms:

- **Define Staffing Objectives:** Collaboration between talent acquisition and program teams to identify functional and soft skills for each hire, target audience, target location and timeline.
- **Tailored Job Postings:** Our extensive job posting library in combination with creative content strategy creates impactful and unique job postings for each position to attract top talent.
- **Customized Outreach Plan:** Extensive in-house recruitment experience, network, and partnerships create detailed outreach plan and detailed timeline for execution of objectives.
- **Cutting Edge Recruitment Tactics:** Use modern, innovative sourcing techniques to fill tough positions. This includes passive sourcing, utilizing artificial intelligence, social media outreach, and capitalizing on our existing networks to source talent. We do not rely solely on job postings to fill our positions. We also aggressively source talent using these techniques. Our two-prong approach allows us to deliver top quality hires with a shortened time to fill for even the toughest positions.
- **Marketing Support:** Provides support to create targeted messaging that is effective to appeal to all audiences, which helps increase diversity among hires.

4.3.1.3.4 Staffing a Utilization/Prior Authorization Services customer service in- house call center.

We have over three decades of experience operating toll-free information lines and call centers. Our experience operating call centers includes handling over **2 million calls annually with a 30-second answer rate across 18 current Medicaid programs in 16 states**. We focus exclusively on clinical customer service and support in each of the 15 call center locations that we operate across our portfolio, including in our current customer services staff in West Virginia. We adhere to a person-centered model and believe the person receiving the services is the priority when determining the services and support they need.

Evidence of our successful call center experience is found in our ninety-five percent (95%) customer satisfaction rate measured by annual Member and Provider Surveys. By providing high levels of customer service, we minimize disruption, complaints, and appeals. A sample of our Medicaid State contracts with in-house Call Center operations that align with the scope of this RFP are represented below in **Figure 22 Kepro Call Center Experience.**

	WV DHHR	CMS BFCC	FL AHCA	VA DMAS	TN Tenn-Care	ME DHHS	SC DHHS
YEARS OF SERVICE	22	30	29	15	14	14	10
ANNUAL CALL VOLUME (INBOUND)	62k	350k	60k	14k	260k	45k	60k
INFORMATION SERVICES	✓	✓	✓	✓	✓	✓	✓
MEMBER SUPPORT	✓	✓	✓	✓	✓	✓	✓
APPEALS SUPPORT	✓	✓	✓	✓	✓		✓
365/24/7 ACCESS	✓	✓	✓	✓	✓	✓	✓
DOCUMENT SERVICES	✓	✓	✓	✓	✓	✓	✓
PROVIDER TECHNICAL SUPPORT	✓	✓	✓	✓	✓	✓	✓
FAX PROCESSING	✓	✓	✓	✓	✓	✓	✓

WV_135

Figure 22. Kepro Call Center Experience
Our extensive Call Center experience gives us the resources to provide efficient services.

Our expertise combines functionality and flexibility, as we use time-tested standard processes but are agile and adaptable to meet individual contract needs. Our Call Center services display the broad of capabilities we offer our clients:

- **Information Services**—Our Call Center information services prioritize providing information and connecting members and their families to the resources they need. This can include providing information about Medicaid financial eligibility, and/or connecting members to other services.
- **Member Support Services**—Our Call Center member support services help members with tasks such as scheduling and rescheduling face-to-face level of care assessments or providing updates on the status of reviews. The quick and effortless way in which we respond to these requests helps members get the support they need over the phone.
- **Appeals Support**—Our appeals process is supported by our Call Center, where both appeals coordination and appeals status communication requests are fielded. This helps bring continuity to our appeals process through ease of communication.
- **24/7/365 Access**—Our flexibility extends to our 24/7/365 access—we are here for our members and their families. Our Automated Call Distributor (ACD) features an easy-to-follow menu, and our staff conducts live answering of Inbound Calls from members and providers during business hours with voicemail capabilities for afterhours messages and return calls.
- **Document Services**—We offer comprehensive document processing services. We can mail notifications and information to both members and providers, as well as processing fax and hard copy submissions.

- **Provider Technical Support**—Through our robust technical support, we assist Providers with support related to our UM and PA services and processes and using the Atrezzo portal.

In West Virginia, most callers are providers or provider offices. Our Call Center acts as a central point of communication and help for both service-related and technical services. Our call center platform has been traditionally based on Evolve IP, including our WV DHHR call center as well as for all the contracts listed in Table X above. After an extensive evaluation of competitive alternatives, we selected the Genesys call center platform for its superior reliability, ease of use, and advanced features.

We staff the Call Center with administrative and clinical staff members to provide a "one call" response and resolution for every call. This operational expertise informs our staffing approach, so we have sufficient staffing to meet contract requirements and exceed our customers' expectations for service. The capabilities of our Customer Service Representatives illustrate our capacity and performance, demonstrated in our WV experience over the past 5 years in **Table 13 WV Call Volume Over the Past 5 Years**.

Metric	Result
Calls Received	337,607
Calls Answered	320,825
Calls Transferred	56
Average Speed to Answer	30 seconds
Average Wait Time	26 seconds
Average Hold Time	6 seconds

Table 13. WV Call Volume Over the Past 5 Years
We provide significant capability and resources for call response.

We maintain toll-free numbers for specific programs to facilitate the ability of providers to reach program staff efficiently. Additionally, we staff the WV Call Center with an effective combination of administrative, technical, and clinical staff, all of whom have training on use of the Call Center system to answer, transfer, and manage call volume with exemplary customer service. Our staffing volumes and credentials enable us to respond to provider questions and concerns on a timely basis. Additionally, administrative and waiver staff are available for member calls to provide a prompt, culturally and linguistically appropriate response to calls.

4.3.1.3.4 UM / PA DATABASE, REPORTING AND ANALYSIS

4.3.1.3.5 Developing and managing a utilization/prior authorization database, including reporting and service utilization analysis activities.

Our Atrezzo platform was specifically designed to manage UM and PA services and produce meaningful reporting and analysis activities for the individual Medicaid clients and programs we serve. The Atrezzo platform includes a comprehensive database structure that provides access to all utilization management and prior authorization data for all WV DHHR programs. Our analysts access this database to conduct analyses for monthly, quarterly, annual, and ad hoc reports.

Our highly qualified Master-level and PhD-level healthcare analytics experts use the latest in reporting and analytics software to produce custom and ad hoc reports, automatically generate program dashboards, and perform quantitative analysis. By utilizing tools such as SQL, Excel, Tableau, PowerBI, SAS, and Python in combination with various data models and analytic methods, we track program progress as well as identify and mitigate potential risks to keep the program well informed. We will leverage this data, alongside our clinical expertise, in our pursuit and commitment of continuous quality improvement for the DHHR UM and PA Services program.

Our Data Lake allows us to provide a true 360° view of available data and the members we serve. We can see trends and develop operational strategies to address those trends. An example dashboard report using sample data can be seen in **Figure 23 Care Management Dashboard.**

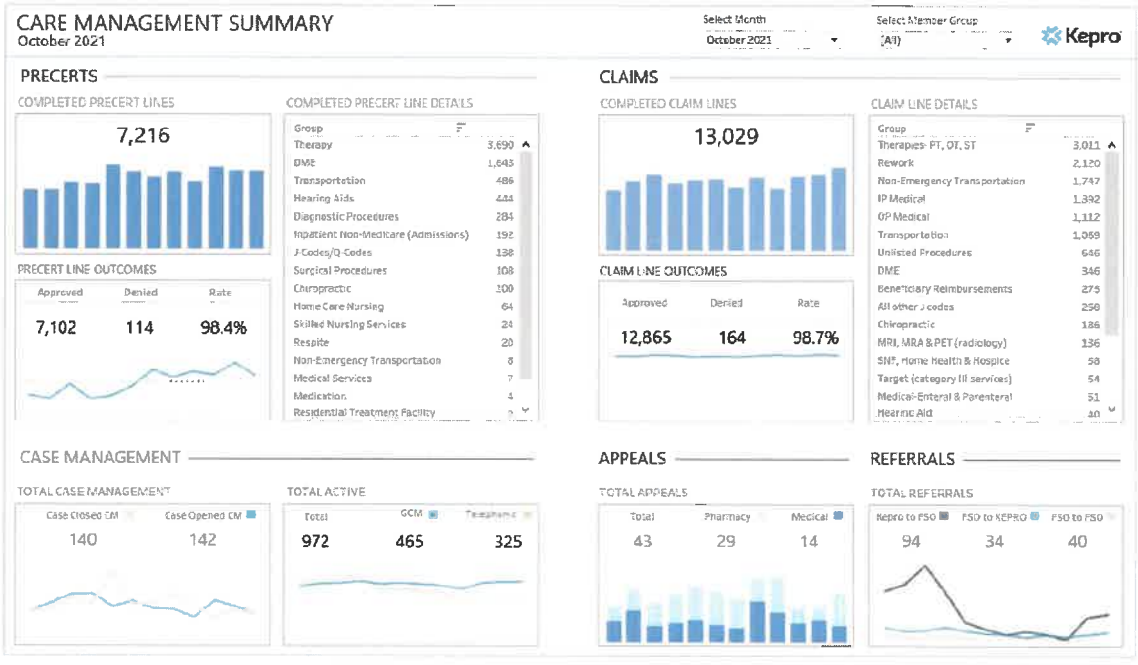

Figure 23. Care Management Dashboard

Dashboards can be configured specifically for the WV DHHR UM and PA Services program to show a 360 view of the members we serve.

4.3.2 Mandatory Qualification/Experience Requirements

4.3.2. Mandatory Qualification/Experience Requirements - The following mandatory qualification/experience requirements must be met by the Vendor as a part of its submitted proposal. Vendor should describe how it meets the mandatory requirements and include any areas where it exceeds the mandatory requirements. Failure to comply with mandatory requirements will lead to disqualification, but areas where the mandatory requirements are exceeded will be included in technical scores where appropriate. The mandatory qualifications/experience requirements are listed below.

In this section, we provide our response to the Mandatory Qualifications/Experience Requirements as an experienced Vendor in West Virginia and across the nation. Building on 22 years of successful contract performance for the Agency, we understand the unique needs of the Agency, the stakeholder community, and the population served . **Figure 24 Kepro's Mandatory Qualifications and Experience** summarizes our experience with the mandatory requirements.

In West Virginia alone we exceed all the services that comprise the mandatory qualification and experience requirements (Figure 24).

MANDATORY REQUIREMENTS	MEETS IN WV	EXCEEDS IN WV	EXCEEDS IN OTHER JURISDICTIONS
5 years operating a PA/UM program size/scope of WV	✓	✓	✓
3 years waiver individualized budget implementation	✓	✓	✓
3 years services for children covered by BSS	✓	✓	✓
3 years UM and PA for BHS, Health Homes, and Waiver Programs	✓	✓	✓
3 years ICFIID experience and knowledge	✓	✓	✓
3 years experience making eligibility determinations for ICFIID and ICFIID facilities	✓	✓	✓

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Figure 24. **Kepro's Mandatory Qualifications and Experience**
We exceed the qualification and experience requirements for each category.

Our existing WV-based team and our knowledgeable corporate team have the combined expertise and experience to effectively deliver the requirements of the RFP today – with no learning curve, resulting in the successful program operations and member outcomes the Agency expects.

Our experience, expertise, and understanding coupled with our knowledge of best practice drive our success in delivering the WV DHHR requirements of the RFP. In the subsections that follow, we confirm our ability to meet the specific mandatory requirements.

4.3.2.1 EXPERIENCE OPERATING UM / PA PROGRAMS

4.3.2.1. The Vendor shall have at least five (5) years' experience operating a utilization management and prior authorization program comparable to the size and scope of the program outlined in this RFP.

Kepro exceeds this mandatory requirement in West Virginia. We have provided utilization management (UM) and prior authorization (PA) services for the State of West Virginia since 2000, exceeding this mandatory requirement by providing the services for **more than 22 years.**

We far exceed this mandatory requirement by also providing utilization management and prior authorization for the following states:

- Florida—30 years
- Illinois—20 years
- Virginia—16 years
- Mississippi—15 years
- Maine—15 years

4.3.2.2 EXPERIENCE WITH WAIVER INDIVIDUALIZED BUDGET IMPLEMENTATION

4.3.2.2. The Vendor shall have at three (3) years' experience with waiver individualized budget implementation.

Kepro exceeds this mandatory requirement in West Virginia. We have provided waiver individualized budget implementation for the state of West Virginia for **more than 7 years.**

We also exceed this mandatory requirement by providing waiver individualized budget implementation for self-direct Medicaid services in Florida for more than 19 years.

4.3.2.3 EXPERIENCE WITH THE BSS-COVERED SERVICES FOR CHILDREN

4.3.2.3. The Vendor shall have at least three (3) years' experience with the services for children covered by BSS as listed in 4.2.1.25.

Kepro exceeds this mandatory requirement in West Virginia. We have UM and PA experience with the services for children covered by BSS for the State of West Virginia for **more than 19 years.**

We also far exceed this mandatory requirement by providing UM and PA reviews for BSS-covered services for children (which include the special medical card, psychiatric residential facilities outside state borders, out-of-state residential provider reviews, qualified residential treatment programs independent program assessments, special psychological evaluations, and the therapeutic foster care program) for the following states:

- Florida—30 years
- Illinois—20 years
- Maine—15 years
- Oregon 7 years

4.3.2.4 EXPERIENCE WITH BEHAVIORAL HEALTH, HEALTH HOMES, AND WAIVER PROGRAMS

4.3.2.4. The Vendor shall have at least three (3) years' experience providing utilization management and prior authorization services for Behavioral Healthcare Services, Health Homes, and Waiver Programs.

Kepro exceeds this mandatory requirement in West Virginia. We have provided utilization management and prior authorization for **Behavioral Healthcare Services (BHS), Health Homes, and Waiver Programs for the State of West Virginia for more than 7 years**. Individually we have provided UM and PA for BHS since 2000; Health Homes since 2015, and Waiver Programs since 2003.

We also exceed this mandatory requirement providing utilization management and prior authorization for BHS, Health Homes, and/or Waiver Programs in the following jurisdictions:

- Florida—30 years
- Illinois—20 years
- Mississippi—15 years
- Maine—15 years
- South Carolina – 11 years

Did You Know?

Today we provide Medicaid Behavioral Health program services across 17 states including: California, Colorado, Florida, Illinois, Arkansas, Oregon, Mississippi, Minnesota, Nebraska, Maine, South Carolina, West Virginia, Tennessee, North Dakota, North Carolina, and New Hampshire.

4.3.2.5 EXPERIENCE WITH INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID)

4.3.2.5. The Vendor shall have three (3) years' experience and knowledge of the State, Federal and local Agency rules and regulations pertaining to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

Kepro exceeds this mandatory requirement in West Virginia. We have **more than 22 years** of West Virginia experience and knowledge of the State, Federal and local agency rules and regulations pertaining to Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFIID).

We also far exceed this mandatory requirement with ICFIID experience and knowledge of the State, Federal and local Agency rules and regulations gained through our work in the following jurisdictions:

- Illinois—20 years
- Florida—14 years
- Oregon—7 years
- New Hampshire –6 years
- Pennsylvania –4 years
- California – 4 years

4.3.2.6 EXPERIENCE WITH ELIGIBILITY DETERMINATION FOR ICF/IID FACILITIES

4.3.2.6. The Vendor shall have three (3) years' experience in making eligibility determinations for the ICF/IID, including ICF/IID facilities.

Kepro exceeds this mandatory requirement in West Virginia. We have more than 22 years of experience making eligibility determinations for ICF/IID, including ICF/IID facilities in West Virginia.

We also exceed this mandatory requirement through our ICFIID experience in the following jurisdictions:

- Illinois—20 years
- Florida—14 years
- Oregon—7 years
- New Hampshire –6 years
- Pennsylvania –4 years
- California – 4 years

Appendix 1: BMS/WVCHIP Detailed Specifications

BUREAU FOR MEDICAL SERVICES PRIOR AUTHORIZATION REQUIREMENTS

BUREAU FOR MEDICAL SERVICES PRIOR AUTHORIZATION REQUIREMENTS
Policies for the Medicaid program can be found at:
https:lldhhr.wv.gov/bms/Pages/Manuals.aspx

A1.1. Agency Technical Requirements (Medicaid)

This section describes the requirements for the development, implementation, and operation of a Utilization Management (UM) program to include:

a. Inpatient Medical/Surgical Services;
b. Organ Transplant Services
c. Hospice Services
d. Durable Medical Equipment, Supplies, and Orthotics and Prosthetics
e. Vision Services
f. Audiology Services
g. Outpatient Physical Therapy, Occupational Therapy and Speech Therapy
h. Physician and Non-Physician Practitioner Services
i. Home Health Services
j. Private Duty Nursing Services
k. Diagnostic Imaging/Radiology Services
l. Nursing Home Eligibility and Pre-Admission Screening and Resident Review (PASRR) Eligibility
m. Traumatic Brain Injury (TBI) Waiver Services
n. Intellectual/Developmental Disabilities Waiver (IDDW) Services
o. Children with Serious Emotional Disorder (CSED) Waiver Services
p. Personal Care Services
q. Aged and Disabled Waiver (ADW) Services
r. Take Me Home (TMH) Services
s. Lab/Genetics Services
t. Out-of-Network (OON) Services
u. Cardiac rehabilitation
v. General and Acute Care Inpatient Hospital Admission and Continued Stay Review
w. Pulmonary Rehabilitation
x. Chiropractic Services
y. Podiatry Services
z. Case Management
aa. Expanded EPSDT Services and Criteria Development
bb. Health Home Services
cc. Long-Term Acute Care (LTAC)
dd. School-Based Health Services
ee. Inpatient Rehabilitation Services
ff. Specialty Medications/Physician Administered Drug Services
gg. Applied Behavioral Analysis (ABA) Services
hh. General Authorization for all programs (Please note: This section is not included in the pricing page)

A1.1.a. Inpatient Medical/Surgical Services

1. The Agency covers inpatient medical/surgical services for all eligible members. As a condition for reimbursement, the Agency requires that all inpatient hospital admissions receive prior authorization.

Kepro has over 30 years of experience performing prior authorization of -- Medical/Surgical services. We currently perform these reviews for Medicaid clients in 17 states including West Virginia. We have been contracted with West Virginia Department of Health and Human Resources (WV DHHR) to provide these services since 2010. In 2022, under our current contract with WV DHHR, we conducted approximately 1,300 prior authorization reviews for inpatient hospital admissions.

Did You Know?

Kepro performs over 7 million UM/PA reviews annually with the same scope of services outlined in the RFP.

We understand the critical role of the prior authorization review process and its necessity for ensuring all inpatient hospital admissions are medically necessary and appropriate before costs are realized. Our prior authorization processes are streamlined and in full alignment with State requirements that member needs are met with the appropriate level of care. To accomplish this, our prior authorization review of Inpatient Medical/Surgical services is managed in our Atrezzo system using the review process outlined in **Figure 25 Prior Authorization Review Process.**

Prior Authorization Process

Our Atrezzo Care Management (Atrezzo) system is configured to determine when an authorization for inpatient hospital admission requires clinical review. Our clinical reviewers receive these requests automatically and in real-time via Atrezzo. The reviewers examine the clinical information based on the appropriate criteria and client-required rules. if the request for services meets medical necessity, the clinical reviewer documents the approval for inpatient prior authorization and authorizes an initial number of certified days, previously determined in collaboration with BMS, and the provider receives real-time notification via the Provider Portal.

All decisions made by the clinical reviewer to authorize, modify, or deny a given request are based on medical necessity, as well as program policy criteria. For our WV DHHR Utilization Management (UM) and Prior Authorization (PA) Services program today we use InterQual® criteria in addition to contract, State, and CMS required guidelines for authorizations of inpatient and outpatient services and items to determine whether the requested services are clinically appropriate and medically necessary.

We bring to WV DHHR over 2 decades of experience as the incumbent providing optimal services and performance by our WV-based seasoned team combined with our national experience providing these same services across multiple state programs – *allowing us to share meaningful trends, challenges, and opportunities for improvement experienced nationally that may benefit the Agency's program.* In the following **Figure 25 Prior Authorization Review Process**, provides an

overview of our prior authorization review process including key decision points and associated actions.

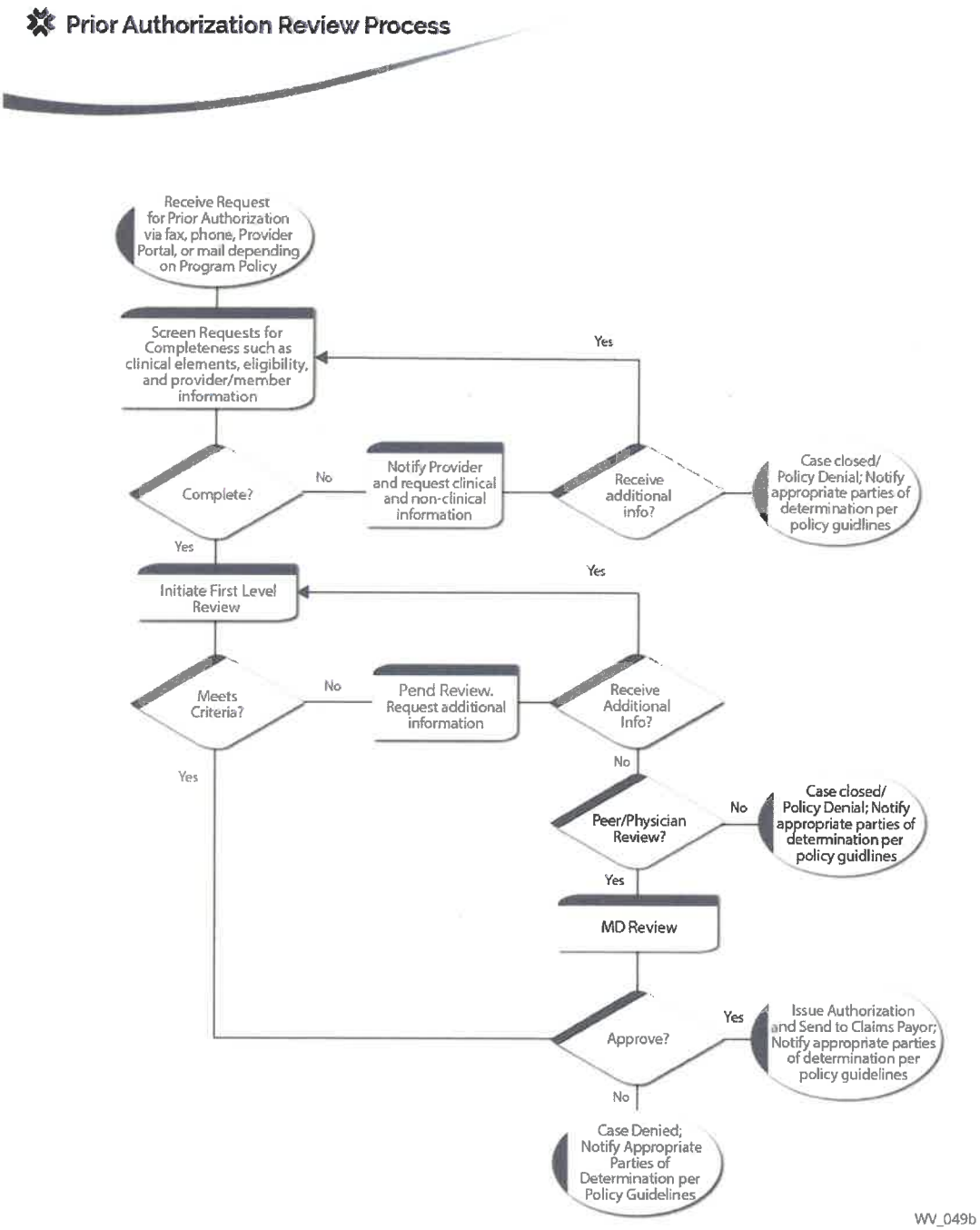


Figure 25. Prior Authorization Review Process

Our Prior Authorization review process is configurable to accommodate WV DHHR's program-specific needs.

The PA review process begins upon receipt of the request for services. The process follows the steps outlined below:

- The clinical reviewer receives the request automatically in real-time via Atrezzo and reviews the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR program policy. Using these criteria will identify whether the services and items requested are consistent with the provisions of appropriate care.
  - If InterQual® guidelines are not available for a specific service, we maintain a library of local evidence-based policies that can be adapted for WV DHHR's consideration.
- If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo. The provider receives real-time notification via the Provider Portal.
- If clinical information is not sufficient, the clinical reviewer pends the PA request, and a notice is automatically sent to the provider requesting additional clinical information.
  - If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification of the approval via the Provider Portal.
  - If additional information received does not meet criteria or additional information is not received, the request is forwarded to the physician reviewer to review all available documentation against criteria and medical expertise.
    - The physician reviewer reviews the case, documents the determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via United States Postal Service (USPS).

Receipt of Prior Authorization Requests

Depending on program policy, Kepro offers providers flexibility with convenient options for submitting prior authorization requests via multiple modalities including the Atrezzo portal, telephone, fax, and mail. **Figure 26 Process for Receiving and Processing Prior Authorization Requests** outlines the initial PA request process in Atrezzo, whether the request is submitted through the portal or staff enter it into the system.

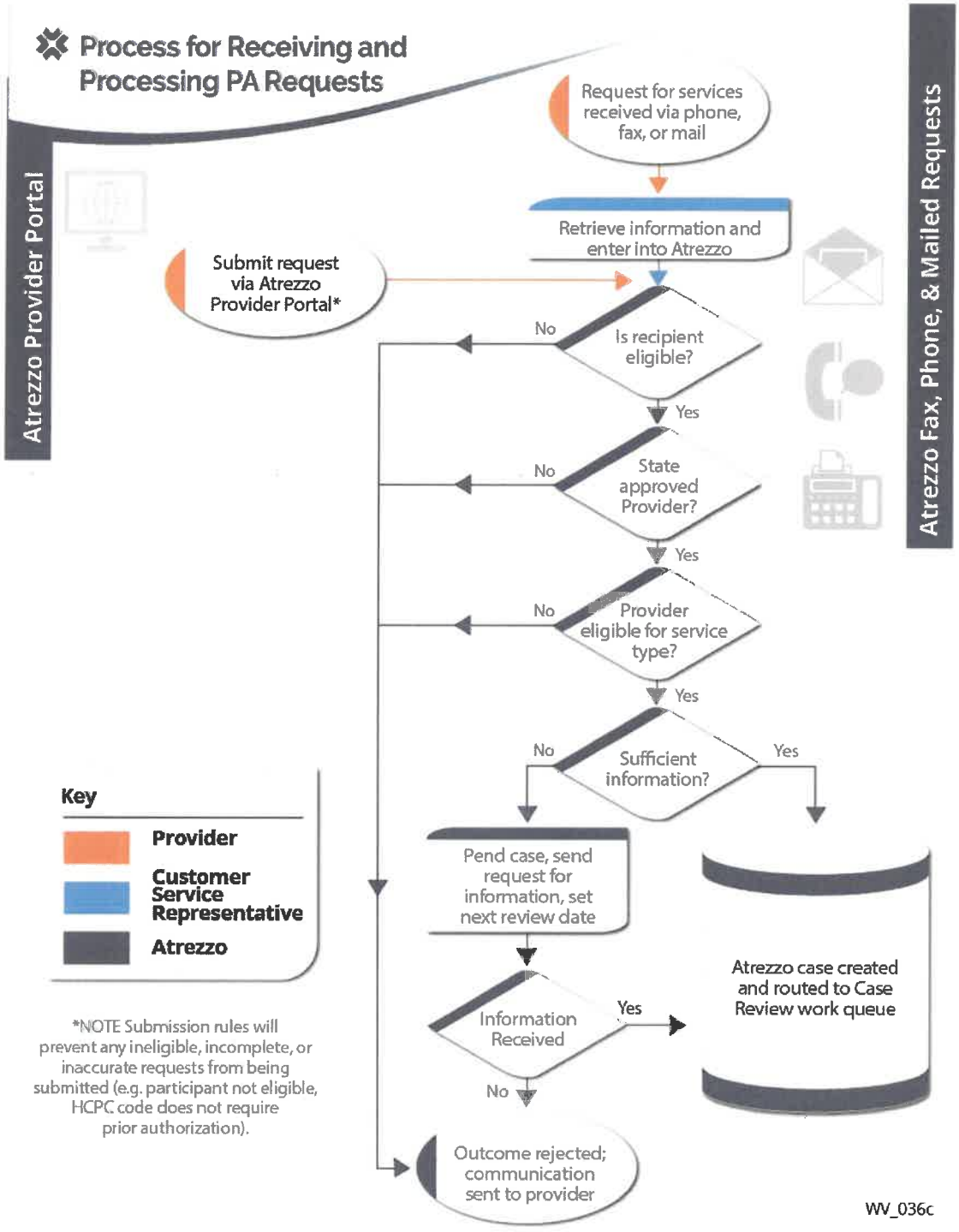


Figure 26. Process for Receiving and Processing Prior Authorization Requests

Kepro's Atrezzo system provides a provider-friendly and efficient process for submitting and processing requests.

When a PA request is submitted via fax, telephone, or mail our Customer Service Representative (CSR) retrieves the intake information and enters relevant details into Atrezzo. The CSR records the date of receipt as the date a mailed, telephonic, or faxed request was received (except for requests received after business hours). For requests received after business hours, the date of receipt is recorded as the next business day. **Atrezzo then automates the remainder of the process, including verifying Medicaid eligibility, member benefits, and sending automated communication to the provider**. If the request requires clinical review, the request is automatically routed via Atrezzo workflows to the appropriate clinical review work queue.

We follow BMS guidelines relating to policy denials. If it is determined that administrative requirements are not met, the clinical reviewer will document the adverse determination in Atrezzo, and an automated notification is sent to the provider via the Provider Portal. **For all adverse determinations, the member receives the denial notification including the fair hearing form.**

Did You Know?

In the first quarter of 2022, 90.6% service authorization requests for our Virginia client were submitted via the Atrezzo Provider Portal.

If administrative requirements are met, but the clinical reviewer cannot approve the request due to lack of clinical information, the clinical reviewer pends the case with notification to the provider via the Provider Portal requesting additional information. If the provider does not fulfill the request for additional information within the allotted timeframe, or, following review of additional information the clinical reviewer cannot approve the case based on medical necessity, the case is routed to a physician reviewer for review.

The physician reviewer employs medical expertise and best practice when reviewing and rendering a determination. The physician reviewer documents the determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. **For all adverse determinations, the member receives the denial notification via United States Postal Service (USPS).**

Concurrent Review

We complete Concurrent Reviews on inpatient care requests following receipt of all pertinent medical information. Upon receipt of a complete Concurrent Review request, we follow our standard prior authorization process as noted in **Figure 25 Prior Authorization Review Process**. Prior to termination of the initial number of authorized days, the facility will contact us if the member remains hospitalized to request authorization for additional days.

Concurrent Reviews of continued hospital stays allow our clinical reviewer to closely monitor the member's progress, treatment goals, discharge plan, and other objectives established during the inpatient hospitalization stay. It serves to monitor the utilization and quality of services rendered, decreases retrospective denials, and promotes adherence to member-centered clinically appropriate length of stay. During the review we verify that daily documentation is specific to

treatment goals and objectives, anticipated length of stay, and discharge planning activities for each day of hospitalization. Significant to this review, we identify whether the discharge plan is person-centered and adequately addresses the member's needs upon discharge. Subsequent concurrent reviews are completed as requested until the member is discharged. Additionally, **we built a step into both the elective and emergency process flows to reach out to the providing hospital one day before the current end date to send additional documents needed and to determine whether a concurrent review is needed.**

Retrospective Review

Kepro performs Retrospective Reviews based on retroactive Medicaid eligibility and admissions occurring on weekends, holidays, or times when the UM/PA review process is unavailable. Retrospective reviews must be requested within 12 months of the discharge date. When a retrospective review request is received, a review of the initial admission and continued stay information is completed to validate that all information provided is consistent with the medical record documentation and other information provided by the facility and supports the length of stay in an acute hospital. We review daily documentation specific to treatment goals and objectives, anticipated length of stay and discharge planning activities to verify it is completed for each day of the member's hospitalization. We also review the plan of care for consistency with WV DHHR policy.

For retrospective reviews of inpatient services post discharge and prior to billing for services, the hospital will submit a request for review. Our Retrospective Review Process is illustrated in **Figure 27 Retrospective Review Process**.

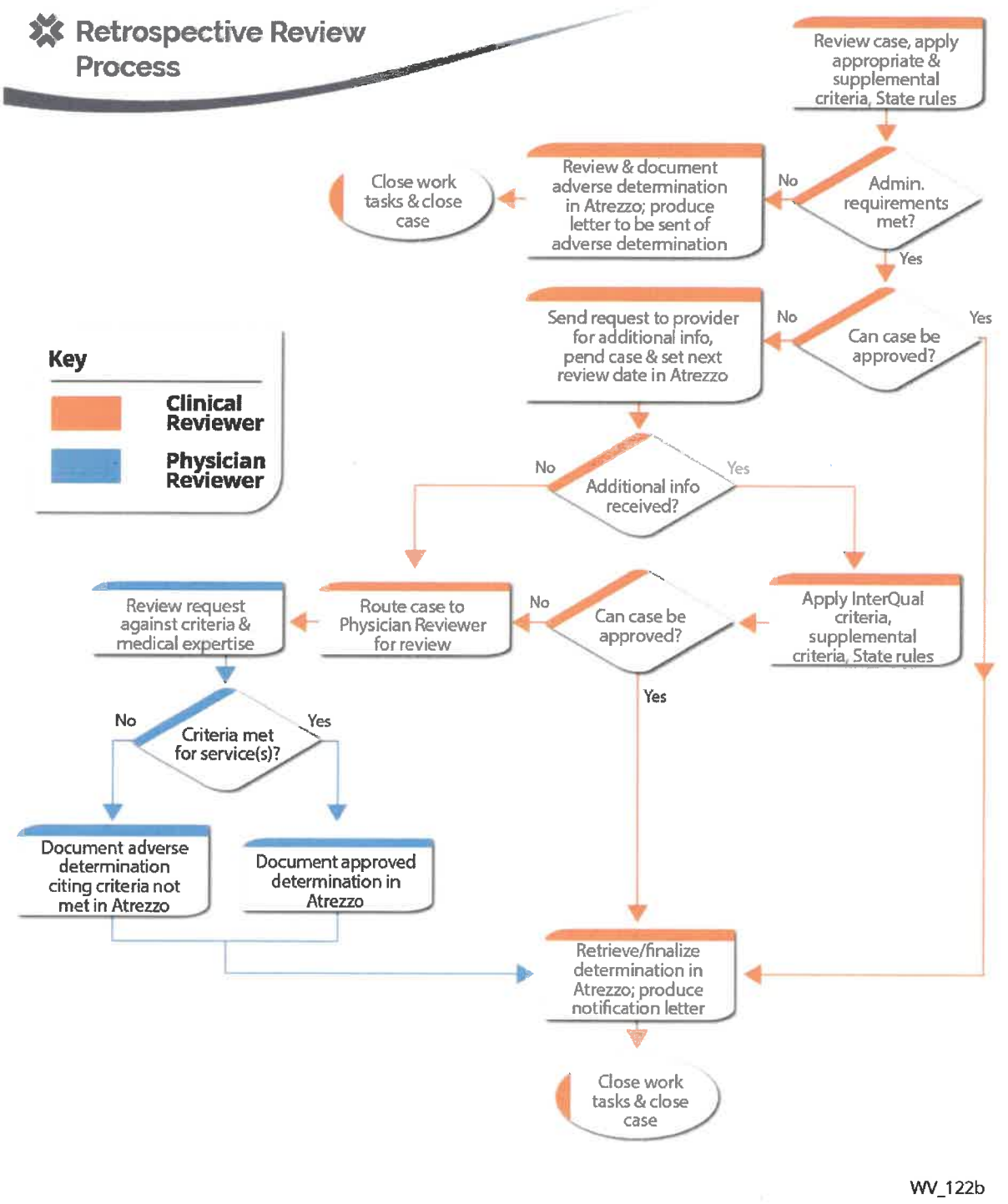


Figure 27. Retrospective Review Process

Kepro Reviewers are experts in conducting thorough retrospective reviews of services rendered to support person-centered and clinically appropriate care for the members we serve.

Our Retrospective Review process follows the steps below through completion of the request.

- Our clinical reviewer begins the retrospective review by evaluating the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR program rules. Using these criteria, we verify whether services and items planned are consistent with the provisions of appropriate care.
  - If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification via the Provider Portal.
  - If the clinical information provided is not sufficient to determine appropriateness of services, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information.
    - If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.
    - If additional information received does not meet criteria or additional information is not received, the request is forwarded to the physician reviewer. The physician reviewer reviews the case, documents the determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via United States Postal Service (USPS).

We complete retrospective reviews within 48 hours of the request. We conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services. If a hospital admission or days were not appropriately pre-authorized, We will deny the admission or days in question. We will not review any medical record for admission which has not been preauthorized prior to the admission and concurrent review completed. This excludes retrospective eligibility cases.

If pre-admission review is not documented, the clinical reviewer will consult with the physician reviewer for a denial, as appropriate, the admission or days which required preauthorization but were not preauthorized. The medical record review will also include a review of each emergency admission. Preauthorization requirements include:

- Applies to all medical inpatient admissions except for those related to maternity services (labor and delivery).
- Services rendered by an eligible provider must be:
  - Covered and authorized
  - Rendered by a West Virginia Medicaid enrolled provider
  - Within the scope of the provider's license
  - In accordance with all state and federal requirements

A1.1.b. Organ Transplant Services

1. The Agency covers organ transplant services for all eligible members. Organ transplant services are covered when considered safe, effective, and medically necessary and no alternative medical treatment as recognized by the medical community is available. The intended transplant must be performed to manage a disease consistent with recognized standards in the medical community. Investigational, research, or experimental procedures are not covered.
2. As a condition for reimbursement, the Agency requires that heart, lung, liver, small bowel, bone marrow, kidney, pancreas, and corneal transplants receive prior authorization. The Agency reserves the right to change the list of covered organ transplants at the discretion of the Agency. Reimbursement for the hospital admission in which the transplant is performed is standard Diagnosis-related group (DRG) reimbursement. Additionally, the hospital will be reimbursed the organ procurement cost at the Center for Organ Recovery & Education (CORE) standard organ procurement cost for each category of organ plus any additional transportation cost associated with the organ acquisition. Donor cost, if not reimbursed by the donor's insurance, may be reimbursed by the Agency Program under the Agency eligible members identification (ID) number.
3. Transplants are not covered when two (2) are performed together, except under the following circumstances:
a. If the primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process.
b. If the damage to the second organ will compromise the outcome of the transplant of the primary organ, multiple organ transplantation may be considered.
4. The Vendor shall determine the medical necessity of transplant applications and requests for extension of benefits for eligible members utilizing the Agency-approved criteria and policies. The Vendor shall ensure determinations transplant applications and requests for extensions of benefits are in accordance with current policies. The Vendor shall have the capability and established procedures to verify the transplant facility is Medicare approved and to determine the existence of other available financial resources.
5. The Vendor shall establish and maintain a procedure for the attending/ordering/referring physician to contact the Vendor's Medical Director to discuss transplant cases that have been denied, modified, or considered for denial. Time frames for notification to the Agency of review outcomes for prior authorization, requests for extensions and retrospective review of transplant services shall be in accordance with current policies.
6. Member selection criteria are based on critical medical need for transplantation and a successful clinical outcome. All other medical and surgical therapies that might be expected to affect short-and long-term survival must have been tried or considered. At a minimum, member selection criteria include the following:
a. Current medical therapy has failed, and the member has failed to respond to appropriate therapeutic management.
b. The member is not in an irreversible terminal state.
c. The transplant is likely to prolong life and restore a range of physical and social function to activities of daily living.

In 2022, we conducted over 150 organ transplant reviews for WV DHHR's UM and PA Services program. Careful oversight is imperative to the delivery of organ transplant services to verify they are medical necessary and, in turn, reduce the burden on the Medicaid budget. Prior authorization with case management follow-up of these cases assists BMS in containing cost and delivering medically necessary transplants in the appropriate setting, in the most cost-effective manner.

Prior authorization is required for all transplants, and we use a case management (CM) trigger in Atrezzo to flag for transplant patients for review. We currently review requests for prior authorization, which covers the following types of transplants:

- Heart Transplant
- Pancreas/Kidney Transplant
- Bone Marrow Transplant
- Lung Transplant – single and double
- Adult Liver Transplant
- Heart/Lung Transplant
- Pediatric Liver Transplant
- Small Intestine Transplant
- Kidney Transplant
- Cornea

Transplants do not receive coverage when two occur together, except if the:

- Primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process
- Damage to the second organ will compromise the outcome of the transplant of the primary organ, in this case multiple organ transplantation may be appropriate

Prior Authorization Process - Organ Transplants

The clinical review of organ transplant services occurs within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**. Our timeframes for notification to the Agency of review outcomes for prior authorization, requests for extensions, and retrospective review of transplant services meet current policies.

A case manager will review the request for medical necessity and appropriateness by applying WV Medicaid approved criteria and policies such as InterQual®, BMS Manual Chapter 510, and other approved guidelines. We review medical necessity and appropriateness using InterQual® criteria for those transplants covered by WV Medicaid. If a Medicaid covered transplant does not have an InterQual® criteria set, we use Medicare guidelines or other Medicaid approved criteria. Due to the documentation requirements, labor intensity, and necessary clinical follow-up, medical case management follows these cases. Per BMS Manual Chapter 510: Organ Transplants:

- WV Medicaid covers certain types of organ transplants performed in a Medicare-approved transplant facility.
- Medicaid covers organ transplant services when generally considered safe, effective, and medically necessary and when no alternative medical treatment as recognized by the medical community is available. The intended transplant must be to manage a disease consistent with recognized standards in the medical community. Investigational, research, or experimental procedures are not covered.
- Member selection criteria rely on critical medical need for transplantation and a maximum likelihood of successful clinical outcome. All other possible medical and surgical therapies

expected to affect short-and long-term survival must have been tried or considered. At a minimum, member selection criteria include the following:

- Current medical therapy has failed, and the member has failed to respond to appropriate therapeutic management
- The member is not in an irreversible terminal state
- The transplant is likely to prolong life and restore a range of physical and social function to activities of daily living

Hospital admission reimbursement for transplant surgery is standard DRG reimbursement with a maximum or cap of $75,000. Additionally, the hospital will receive reimbursement for the organ procurement at the CORE standard organ procurement cost for each category of organ and any additional transportation cost associated with the organ acquisition. The Medicaid program, under the Medicaid-eligible member identifying number may reimburse donor cost, if donor insurance does not cover.

If approved, Atrezzo automatically exports the authorization number to the claims payor via daily file transfer; it is available in the system record and reports tab for referring and servicing providers. providers who are unable to access the online system and have notified us of their inability to do so receive information by fax or telephone.

All organ transplants are referred to a physician reviewer for determination of approval or denial. Due to the critical nature of organ transplant service, if the initial physician reviewer denies the request, we will expedite the reconsideration by sending the request and all information to a second physician reviewer for a determination. If the second reviewer disagrees with the initial review and approves the request, we will notify all parties of an approval.

We will only deny a request due to lack of medical necessity when two physician reviewers agree to a denial determination. We will attach denial notices to the provider and referring practitioner in Atrezzo – this notification includes the policies, criteria not met, and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals. We will communicate the determination and applicable payor limits on requests for an organ transplant to the client or legal representative as well as to the requesting party within 48 hours of receipt of all necessary information.

Peer to Peer Process

Our West Virginia Medical Director, Dr. Paul Kuryla, as well as our physician reviewers, are available to discuss Medical Necessity denial determinations with physicians via Peer-to-Peer discussion. This process is straightforward (**Figure 28 Peer-to-Peer Process**) and prioritizes support for providers.

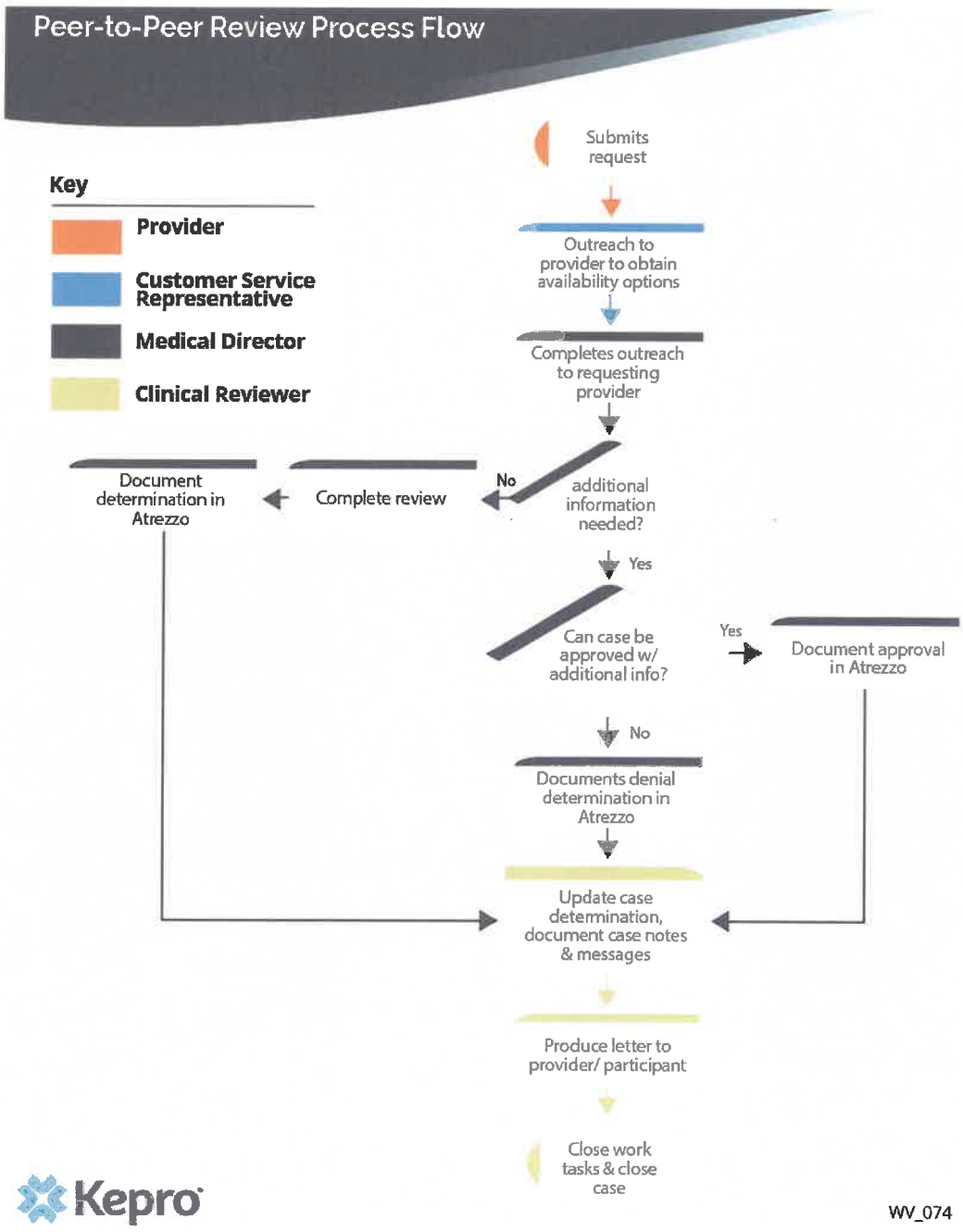


Figure 28. Peer-to-Peer Process

Kepro builds support for providers into our process to promote effective communication.

Per URAC guidelines, upon notification of a denial determination for inpatient services, a Peer-to-Peer discussion is offered to the referring provider. Peer-to-Peer discussions can also be requested for other service types via the Atrezzo Provider Portal as well as through our Call Center. Our

clinical reviewer assists in scheduling Peer-to-Peer discussions by first obtaining the requesting provider's full name, office and/or mobile number, and three available dates/times to meet.

The clinical reviewer or Customer Service Representative (if the request was submitted via the call center) sends the Medical Director or physician reviewer a message or notification via secure portal and/or a secure email marked as "high importance" with:

- The requesting provider's full name and office and/or mobile number.
- The requesting provider's preferred dates and times for the Peer-to-Peer Conversation.
- Patient name and Case ID#

As an example: "Dr. John Doe has requested a Peer-to-Peer with our Medical Director. She is available on Wednesday, 03/28/23 before 3:00pm or Thursday, 03/29/23 between 2:00pm and 4:00pm at 240-555-9999. Member: Initials Only and the Case ID#"

The clinical reviewer then reviews Atrezzo system notes on the Case to confirm that any additional information received prior to the Peer-to-Peer Conversation process is entered into the Case. The reviewer subsequently enters a summary statement in Atrezzo under reviewer notes regarding the requested Peer-to-Peer Conversation, which must include:

- Services being requested
- Guidelines used to review the case
- Reason the case does not meet Medical Necessity requirements per the associated guidelines

The Peer-to-Peer task is generated in Atrezzo and assigned to the identified physician reviewer or Medical Director. Following the meeting and the Kepro team member's review of any additional documentation, the reviewer enters a note in Atrezzo documenting the results of the peer-to-peer conversation. If the denial is upheld, the clinical reviewer does not change the Detail line in Atrezzo showing the denial status on the case but will document the results in the Reviewer Notes section of Atrezzo. If the result of the peer-to-peer conversation is to reverse the denial, the clinical reviewer updates the Detail line in Atrezzo, reflecting the new decision as Approved and reason as "Peer-to-Peer Approval." The clinical reviewer also documents the Approval in the Reviewer Notes section in Atrezzo.

Retrospective Review

Our Retrospective Review process follows a similar process to our Prior Authorization review process. The retrospective review includes reviewing the member's medical record that corresponds with the date of initial service and subsequent treatment to validate medical necessity throughout the member's length of stay in the inpatient setting. We will review the plan of care for consistency with WV DHHR policy and that daily documentation specific to treatment goals and objectives, anticipated LOS and discharge planning activities is clearly documented for each day of hospitalization. For inpatient reviews after discharge and prior to billing, the hospital will submit a

request for processing. Our Retrospective Review Process is illustrated in **Figure 27 Retrospective Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**

Our Retrospective Review process follows the steps below through completion of the request.

- Our clinical reviewer begins the retrospective review by evaluating the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR program rules. Using these criteria, we verify whether services and items planned are consistent with the provisions of appropriate care.
  - If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification via the Provider Portal.
  - If the clinical information provided is not sufficient to determine appropriateness of services, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information.
    - If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.
    - If additional information received does not meet criteria or additional information is not received, the request is forwarded to the physician reviewer. The physician reviewer reviews the case, documents the determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via United States Postal Service (USPS).

We complete retrospective reviews within 48 hours based only on the policy approved by the Bureau for Medical Services.

A1.1.c. Hospice Services

The Vendor shall administer prior authorization services for hospice services for eligible members certified as being terminally ill. According to the Patient Protection and Affordable Care Act for Hospice, children under the age of 21 may receive hospice benefits including curative treatment upon the election of the hospice benefit without foregoing any other service to which the child is entitled. Members enrolled in Home and Community-Based (HCBS) Waiver programs cannot receive hospice benefits simultaneously that duplicate HCBS Waiver services. As a condition for reimbursement, the Agency requires that hospice services receive authorization. If the member is receiving any other Agency service, the Waiver service is considered primary. Authorization may occur before or after admission to hospice services. Authorization(s) must be specific to the member, provider agency, service code, units, start and end date. The units, start and end dates in the authorizations may subsequently be modified/edited as necessary.
2. The Vendor shall have established procedures and sufficient capacity to receive review requests, required forms, the member's medical history and physical examinations, additional medical documentation and other forms or documentation required for prior authorization of hospice services.

3. The Vendor shall determine the medical necessity of certification and recertification requests for eligible only members, as well as admission and continued stay reviews for dual eligible (Medicare/Medicaid) members electing hospice services to eligible members utilizing the Agency approved criteria and policies. The Vendor shall also determine medical necessity and approval processes for members receiving hospice services while residing in a nursing facility.
a. Authorization Requests (Medicaid Only Members): The Vendor shall have the capability and established procedures to receive certification reviews for the initiation of a hospice enrollment period for a member with Medicaid only benefits. The Vendor shall ensure determinations for certification requests are completed in accordance with current policies.
b. Admission Reviews (Dual Eligible Members): Dual Eligible Members are defined as members who have both Medicare and Medicaid. The Vendor shall have the capability and established procedures to receive admission reviews for the initiation of a hospice enrollment period for a member with Medicare and Medicaid benefits. The Vendor shall ensure determinations for admission reviews are in accordance with current policies.
c. Recertification Requests (Medicaid Only Members and Dual Eligible Members): The Vendor shall have the capability and established procedures to receive subsequent review requests to determine if continuation of a hospice benefit period is medically necessary. The Vendor shall ensure determinations for recertification requests are completed in accordance with current policies.
4. The Vendor shall have the capability to develop educational trainings and provide technical assistance, at no additional cost to the Agency, regarding policies, available services, service delivery models, and any other information requested by the Agency for members, families, provider agencies, stakeholders and the general community via email, telephone, webinars etc., at no additional cost. To include but not limited to:
a. Plan, advertise and produce statewide trainings and webinars at the request of the Agency.
b. Communicate program announcements to providers, members, and other stakeholders as necessary, at no additional cost to the Agency.
c. Participate in conference calls at the request of the Agency.
d. Offer Continuing Education Units (CEUs) for Nurses, Counselors and Licensed Social Workers that attend attending training sessions.
5. The Vendor will enroll the Medicaid/Medicare Member in Case Management as needed based on length of stay in Hospice program.
6. The Vendor will notify the Agency weekly and the member's Case Manager upon authorization of members who receive services from a waiver program or the personal care program who are also receiving hospice services.
7. The Vendor will collect and report data regarding the utilization and quality of Hospice services as required by the Agency.
2. The Vendor shall have established procedures and sufficient capacity to receive review requests, required forms, the member's medical history and
6. The Vendor will notify the Agency weekly and the member's Case Manager upon authorization of members who receive services from a waiver program or the personal care program who are also receiving hospice services.
7. The Vendor will collect and report data regarding the utilization and quality of Hospice services as required by the Agency.

We have 10 years of experience performing hospice reviews. We conduct Hospice reviews for several states, including West Virginia, where we conducted nearly 3,000 reviews in 2022 alone. We conduct medical record reviews of Medicaid members continuously enrolled Long Term Hospice care in West Virginia, Alabama, Minnesota, and South Carolina and additionally for our commercial contracts with National Elevator Industry Benefit Plans, Mississippi State Employees, and the United Mine Workers of America. In West Virginia, We currently review and authorize Hospice requests for Routine Home Care; Continuous Home Care; Inpatient Respite Care, and General Inpatient Care. We apply our extensive experience to the Hospice review processes, policies, and procedures. We understand the specific requirements of WV DHHR's hospice benefit.

Atrezzo is equipped to incorporate any additional supporting guidance in the review, such as the health plan's own benefit rules/structure, internally developed criteria, and/or specialty society criteria.

Hospice Clinical Review

Kepro performs clinical review of hospice services requests pursuant to the criteria established in the West Virginia Medicaid Manual Chapter 509 and Local Medical Policies (LMPs). For a hospice records review, our clinical reviewer first verifies that all applicable policies and program and administrative requirements are met and then evaluates the clinical information submitted by the provider along with any supporting documentation. Upon submission, clinical reviewers verify that the member is in fact eligible for the benefit, that all data elements are completed on the form and are signed by the physician. The clinical reviewer compares the information to the applicable first level review clinical decision support tools, such as InterQual®, which also indicates appropriate length of stay and triggers for continued stay based on the member's medical status.

Prior to seeking authorization for hospice services within the community, the member will have active Medicaid eligibility and be included in Gainwell eligibility file in Atrezzo. A Medicaid eligible enrolled hospice provider accepts the referral from the member's physician who has completed the Hospice Election Form (HEF1) and the Certification of Terminal Illness (CTI) as indicated in West Virginia Medicaid Chapter 509.5.1.

Prior to seeking authorization for hospice services within the nursing home, the member must have active Medicaid coverage and the claims payor and BMS will have been notified via the Notification of Contribution of Cost of Care (DFA-NH-3) as outlined in the WV Medicaid Chapter 509.11.1. A Medicaid eligible enrolled provider accepts the referral from the member's physician and care team. The physician and care team complete the Hospice Election Form (HEF1) and the Certification of Terminal Illness (CTI) as indicated in West Virginia Medicaid Chapter 509.3.4.

We evaluate requests for members with Medicaid-only coverage as well as for individuals with dual Medicaid/Medicare coverage. As the current vendor, we have established processes in place that identify requests made for hospice services for members who are also participating in HCBS Waiver programs. Once the requests are identified, we evaluate them to verify any hospice services do not duplicate HCBS Waiver services.

Our clinical review process for Hospice is outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

Our Hospice review process includes the following 6 key steps.

Step 1: Verification of Medicaid coverage and service eligibility. This step is automated through Atrezzo using the standard system verification workflow described throughout this proposal. Verification of provider Medicaid status also takes place during this stage of the process, where

prior authorization requests are only accepted from providers enrolled in the WV Medicaid program.

If the requestor is not a participating Medicaid provider, we will contact the provider within one working day and inform them we cannot process the request before establishing their participation status in the program. Verification of other payor sources, coverage status of the service, and service limitations also take part during this first step.

Step 2: Determine if the request is complete. If the request does not Include the required information, we suspend the request and place it in a pending status. Following verification of covered service status and completeness,

Step 3: Evaluate the request to determine if the service is medically necessary and clinically appropriate. Documentation reviewed for medical necessity includes certification of terminal illness (CTI), hospice election form (HEF1), and the Palliative Performance Score (PPS).

Step 4: System export of the authorization number. If the request Is approved, the authorization number is exported to the claims payor in a daily file.

Step 5: Admission review and approval decision. If the admission request requires physician review, the review Is completed within 24 hours. of request. If it is approved by the physician reviewer, our team would then follow the same process described in step four. Alternatively, step six addresses the process if the request is denied after the physician review.

Step 6: Denial decision. If the request is denied following the physician review, the denial notice is attached to the provider, referring practitioner, and servicing provider in Atrezzo and accessible via the Provider Portal. This notification includes the policies and criteria that were not met, and we will send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

Figure 29 Reconsideration Process outlines our reconsideration process.

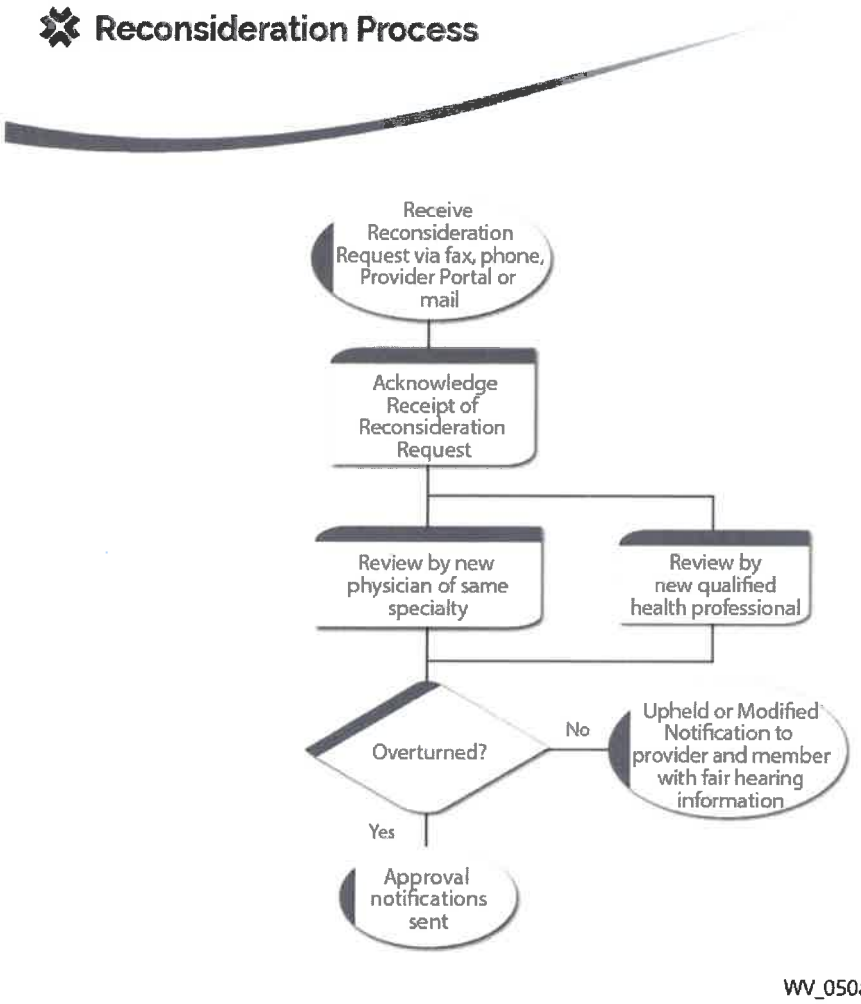
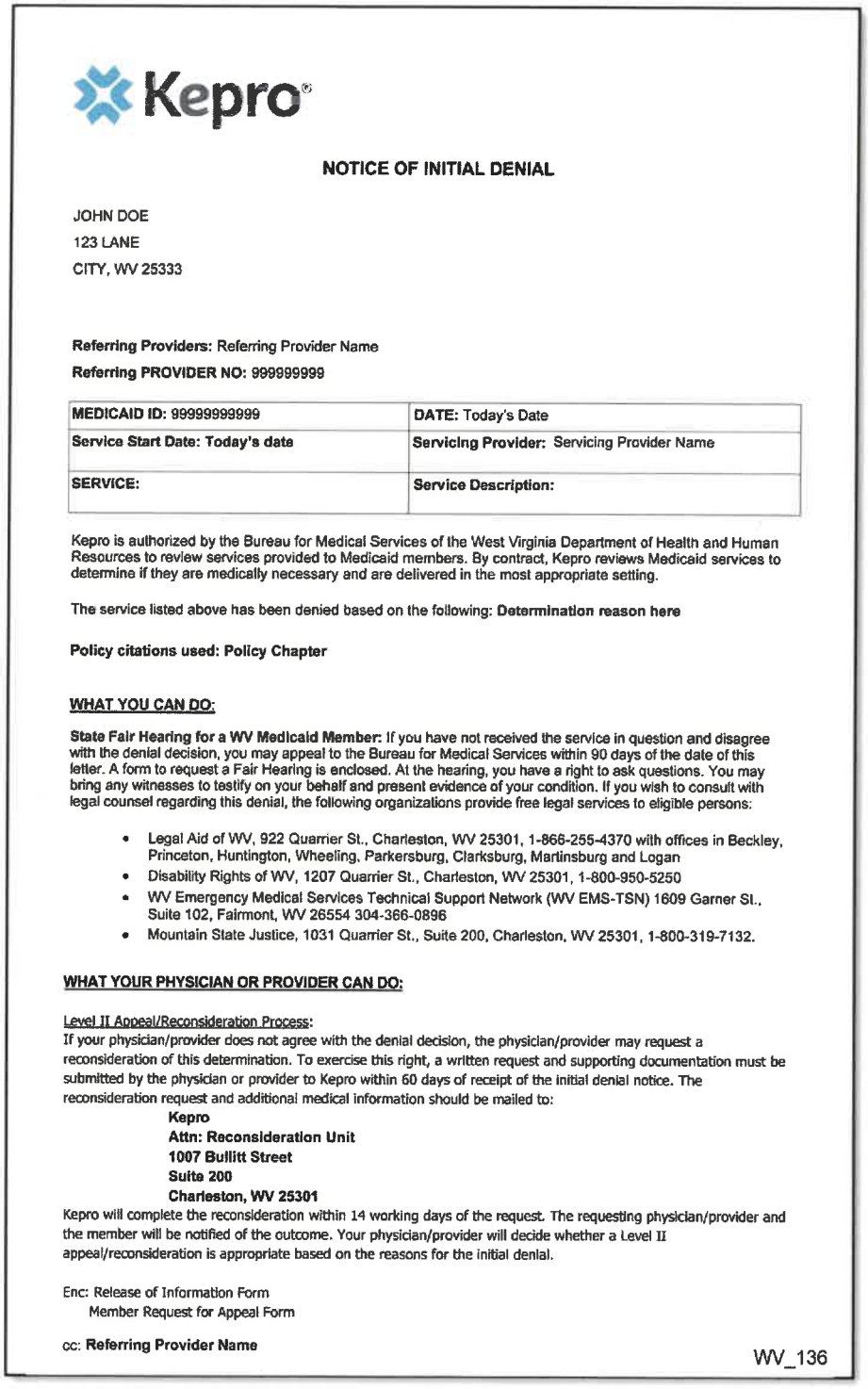


Figure 29. Reconsideration Process

Kepro's reconsideration process efficiently accommodates WV DHHR timeframe requirements.

Providers may request reconsideration of an initial denial within 60 days of the denial notification, and our response to reconsideration requests are completed within 7 calendar days for expedited requests and 15 calendar days for non-urgent requests. We send reconsideration determination notices to the provider and referring practitioner. If the physician reviewer reverses the initial decision, we send the approval decision to the MMIS, and members may request an appeal of a denial of services not yet provided. We prepare the documentation to process the member's appeal.

We perform clinical determinations within five business days of receipt. The availability of qualified clinical reviewer is the most critical aspect of achieving timeliness. All records reviews are conducted by licensed clinical staff with a scope of practice that is relevant to the clinical areas addressed. Our clinical staff use InterQual® Medical Necessity Review Criteria and/or WV DHHR-required Medical Necessity Review Criteria when conducting utilization reviews. **Figure 30 Sample Denial Notice for Member** shows a sample West Virginia member communication.



Kepro®

NOTICE OF INITIAL DENIAL

JOHN DOE
123 LANE
CITY, WV 25333

Referring Providers: Referring Provider Name
Referring PROVIDER NO: 999999999

MEDICAID ID: 99999999999	**DATE:** Today's Date
Service Start Date: Today's date	**Servicing Provider:** Servicing Provider Name
SERVICE:	**Service Description:**

Kepro is authorized by the Bureau for Medical Services of the West Virginia Department of Health and Human Resources to review services provided to Medicaid members. By contract, Kepro reviews Medicaid services to determine if they are medically necessary and are delivered in the most appropriate setting.

The service listed above has been denied based on the following: **Determination reason here**

Policy citations used: Policy Chapter

WHAT YOU CAN DO:

State Fair Hearing for a WV Medicaid Member: If you have not received the service in question and disagree with the denial decision, you may appeal to the Bureau for Medical Services within 90 days of the date of this letter. A form to request a Fair Hearing is enclosed. At the hearing, you have a right to ask questions. You may bring any witnesses to testify on your behalf and present evidence of your condition. If you wish to consult with legal counsel regarding this denial, the following organizations provide free legal services to eligible persons:

- Legal Aid of WV, 922 Quarrier St., Charleston, WV 25301, 1-866-255-4370 with offices in Beckley, Princeton, Huntington, Wheeling, Parkersburg, Clarksburg, Martinsburg and Logan
- Disability Rights of WV, 1207 Quarrier St., Charleston, WV 25301, 1-800-950-5250
- WV Emergency Medical Services Technical Support Network (WV EMS-TSN) 1609 Garner St., Suite 102, Fairmont, WV 26554 304-366-0896
- Mountain State Justice, 1031 Quarrier St., Suite 200, Charleston, WV 25301, 1-800-319-7132.

WHAT YOUR PHYSICIAN OR PROVIDER CAN DO:

Level II Appeal/Reconsideration Process:
If your physician/provider does not agree with the denial decision, the physician/provider may request a reconsideration of this determination. To exercise this right, a written request and supporting documentation must be submitted by the physician or provider to Kepro within 60 days of receipt of the initial denial notice. The reconsideration request and additional medical information should be mailed to:

Kepro
Attn: Reconsideration Unit
1007 Bullitt Street
Suite 200
Charleston, WV 25301

Kepro will complete the reconsideration within 14 working days of the request. The requesting physician/provider and the member will be notified of the outcome. Your physician/provider will decide whether a Level II appeal/reconsideration is appropriate based on the reasons for the initial denial.

Enc: Release of Information Form
Member Request for Appeal Form

cc: **Referring Provider Name**

WV_136

Figure 30. Sample Denial Notice for Member

Kepro's automated communications include all relevant stakeholders to streamline notification processes.

We recognize the importance of enrolling dual eligible hospice members in Case Management services. This expands continuity of care opportunities for some of the most vulnerable WV Medicaid members. Our case management functions include weekly notification to the provider agencies, including recognition of hospice members also receiving personal care or Waiver services to minimize potential duplication of services. We will notify BMS and the members' case manager upon authorization of members also receiving HCBS waiver or personal care services.

Atrezzo automation enables timely and efficient review of hospice records. Atrezzo has a core functionality of providing status updates, alerts, and status tracking capabilities to relevant users. Atrezzo delivers the capability to automatically create notifications and alerts, make those notifications and alerts visible to all relevant personnel, and track those notifications and alerts as the review moves through the Atrezzo workflow. Alerts can be added either through automated rules or manually, and the status – either "Pending," "Active Review" or "Completed" – are visible to all users. These status indicators help Atrezzo manage and keep WV DHHR informed as to the current volumes and turnaround times for review completion ensuring we are meeting or exceeding your requirements for timeliness.

Our current data reporting for hospice services occurs weekly to BMS, identifying member hospice admissions and discharges. We look forward to continuing this process and further discussion on any other reporting parameters requested by BMS.

Hospice Level of Care reviews

We will follow a standard prospective clinical review process for Hospice Level of Care (LOC) reviews; however, prior to closing the case, the clinical reviewer will schedule the case for reassessment. **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services** outlines the process to be used for Hospice LOC reviews with the exception that the clinical reviewer will create a task in Atrezzo for 90/60 calendar days before current end date to remind the provider to send documents for reassessment.

We will perform a reassessment or extension of LOC cases after initial approval every 90 or 60 calendar days (additional 60 calendar days if hospice care is appropriately outlined and in accordance with WV-Medicaid BMS Manual Chapter 509). Additionally, our process can accommodate reassessment of hospice benefit periods lasting two, 90-day periods or an additional 60-day period that lasts until revocation or termination for other reasons such as ineligibility or death.

Training and Technical Assistance

Additionally, we have developed educational trainings for hospice providers regarding policy, available services, service delivery models, and any other topics requested by the Bureau for Medical Services. We will provide continuing education units (CEUs) for Registered Nurses (RNs), counselors and Licensed Social Workers developed in conjunction with the Bureau for Medical

Services. We use RNs to assist in developing topic specific CEUs, which are also in compliance with Boards of Nursing, Licensed Professional Counselors, and Social Work requirements.

We provide technical assistance as requested by individual providers or to all hospice providers when changes in policy or updates in the system occur. We plan, advertise, and conduct statewide training and webinars and communicate providers announcements. We will participate in and conduct training for members and other stakeholders as requested.

A1.1.d. Durable Medical Equipment, Prosthetics, Orthotics and Supplies

1. The Agency covers medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for all eligible members. As a condition for reimbursement, the Agency requires that DMEPOS identified in the Agency Policy.

We have 30 years of experience performing prior authorization for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) across nine states, including West Virginia, Alabama, Colorado, South Carolina, Virginia, North Dakota, Illinois, Florida, and Pennsylvania. In 2022, we conducted nearly 23,000 DMEPOS reviews for the state of West Virginia. Our breadth of experience leaves our teams uniquely qualified to apply best practices learned in those programs within WV DHHR's UM and PA program, enabling WV DHHR to reap the advantages of tried and tested processes.

BMS' policy to provide the most cost-effective equipment that meets the members' need coupled with InterQual screening criteria for medical necessity is successful for cost containment in the current UM contract. There are local medical policies approved for some services based on the requirements of Chapter 506. Our clinical reviewers will continue to work with BMS in the new contract to refine DMEPOS criteria and validate that this program continues to be both cost effective and efficient.

We will also continue to work with BMS to identify areas for additional cost savings. We take care to consistently add value to our clients' programs in this and other ways. In West Virginia we have worked closely with BMS and providers to educate them on a variety of cost saving measures regarding DME requests; education topics have included:

- High cost DMEPOS equipment
- Enrolling members in our Care Management system to follow and track their services
- Obtaining Certificates of Medical Necessity
- Prescriptions
- Explanation of Benefits
- Cost calculation and invoice forms
- Verifying DME credential in Gainwell and Atrezzo systems

We have also provided extensive training for providers in submitting prior authorization requests and medical reviews. Trainings conducted focused on every aspect of the submittal process, including the documentation needed for submission and review and using our systems effectively.

Our highly flexible system and its configurable rules engine further allow us to customize criteria to WV DHHR needs. During the prior authorization review of services, our system can use InterQual® criteria, federal regulations, and any State policies. We use InterQual® Criteria as the baseline of our review. If InterQual® criteria are not available for a specific item or services, we have a large library of local medical policies that can be adapted to specific contracts. Our customizable platform guarantees continual alignment with potential WV DHHR updates to applicable policies.

We perform prior authorization of designated DMEPOS to determine if the service is medically necessary and clinically appropriate as outlined in Chapter 506. We can attach prior authorization check lists to the Provider Portal, which uses an alert system to verify all required information is submitted with each DME request. We will use the process outlined in **Figure 31 DMEPOS Prior Authorization Review Process** to perform prior authorizations of DMEPOS.

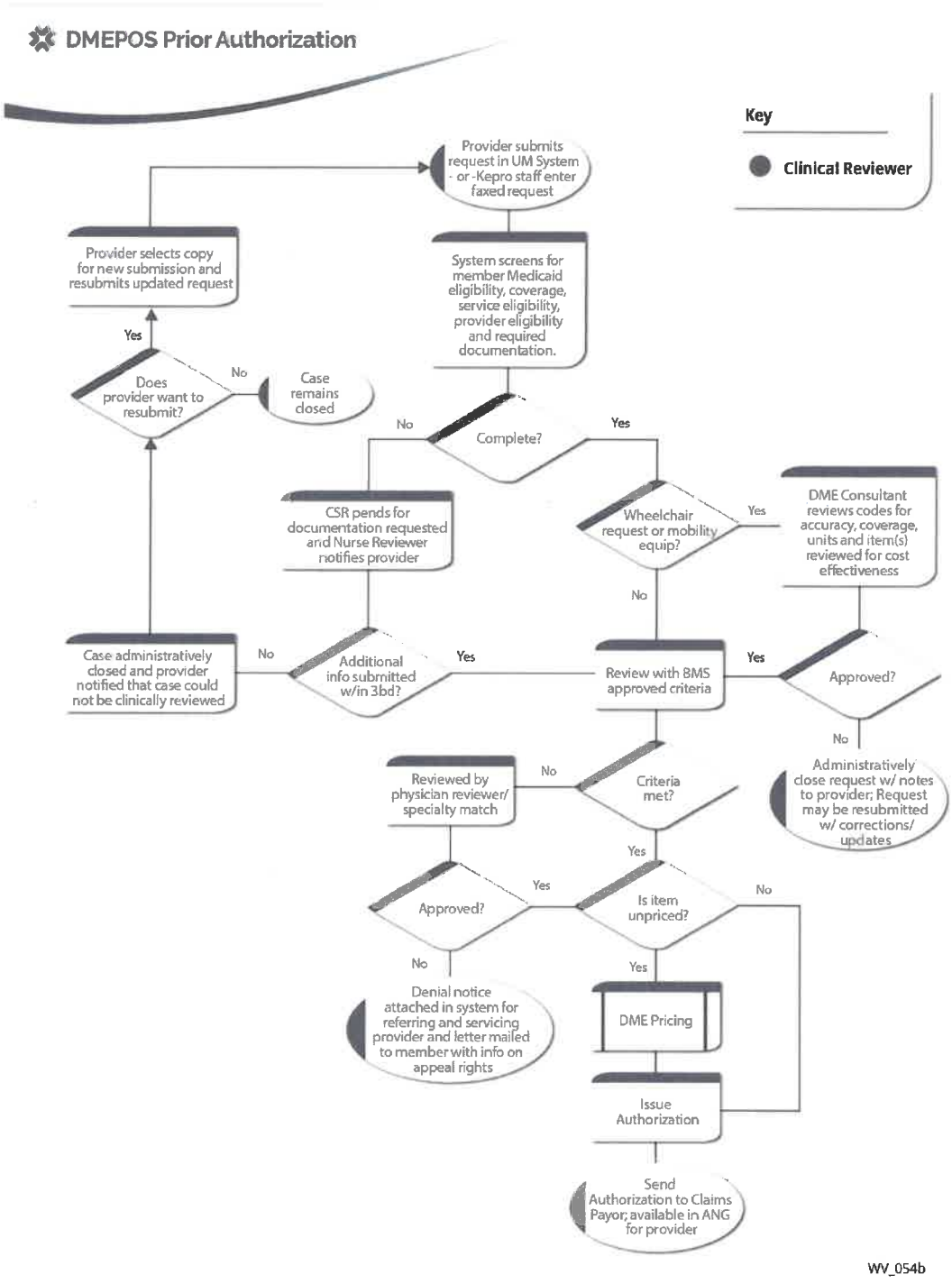


Figure 31. DMEPOS Prior Authorization Process

Our DMEPOS processes are built on decades of clinical experience performing these services.

The prior authorization process begins upon receipt of the prior authorization request for DMEPOS. First, Atrezzo verifies of the following:

- Member Medicaid eligibility, coverage, service eligibility
- Provider Medicaid status—we only accept prior authorization requests from providers enrolled in the WV Medicaid program. We use the provider file received from the Bureau's MMIS vendor to verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, we contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see **Section A1.1.t Out-of-Network Services**, for more details on this process.)
- Other payor sources—our review staff use the MMIS system, as well as information gathered during the review process to establish whether an alternative payor may be responsible for the services requested. If we can establish an alternative payor, we notify the provider through messaging on the request.
- The service requested is a covered service—Atrezzo has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. Our staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see **Section A1.1.aa Expanded EPSDT Services and Criteria Development** for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine it is a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.
- Service limitations—our team verifies that the request is within any service limitations attached to the coverage at the time of the request.

Upon eligibility verification, our clinical reviewer receives the request automatically and in real-time via Atrezzo and reviews the clinical information based on the appropriate criteria and BMS rules. Our systems automate vital aspects of the DME review process to help reviewers achieve efficiency and accuracy. An example is Atrezzo's ability to check for duplication of services, which may include:

- Either the same service or equipment is provided by more than one provider during the same timeframe.
- A specific DME item that is only authorized periodically. For example, electric wheelchairs may be authorized for members only every five years. Reviewers check the system for claims to determine whether this same equipment was authorized and delivered to the member within the designated timeframe. If there is evidence of prior authorization, reviewers contact providers to determine the need for this repeat request. Replacement or repairs will be processed in accordance with WV DHHR policy and regulations.

- Our reviewers have significant experience in evaluating repair compared to replacement and renting compared to purchase of DME. Repairs are not authorized if the cost of the repair equals or exceeds the purchase price of the item. However, they also consider the cost associated with renting a replacement item during the estimated period of repair when making a determination. They also determine the cost of renting equipment for the estimated required period of time compared to the cost of purchasing the same equipment.

When a clinical reviewer pulls a DMEPOS case from queue, they will first determine if the request is complete. If a request is incomplete (i.e., does not have all the required information), we suspend the request and place it in a pending status documentation requested. The provider receives a message in the system and contacted within one business day to obtain the necessary additional information and/or correct errors. If we do not receive additional information within three business days, we close the request administratively. The provider may resubmit the request by selecting copy for new submission and updating the request or by resubmitting the request by fax with the additional information. If the clinical reviewer is still unable to approve the request after receipt of additional information, we refer the review to a physician with all available information.

If administrative requirements are met, but the clinical reviewer cannot approve the request due to lack of clinical information, the clinical reviewer pends the request with automatic notification to the provider via the Provider Portal requesting additional information. If the provider does not fulfill the request for additional information within the allotted timeframe, or, following review of additional information the clinical reviewer cannot approve the case based on medical necessity, the case is routed to a physician reviewer for review. The physician reviewer documents the determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via mail.

After administrative requirements are verified, the clinical reviewer will determine if the service is medically necessary and appropriate. Currently, we use InterQual® DME criteria as approved by the Bureau for Medical Services. There are also local medical policies for some items and supplies. Additionally, if the request is for a wheelchair or other mobility equipment, a DME Consultant reviews the request for accuracy, coverage, units, appropriate coding and verifies that the item is the most cost effective for the member's needs.

If approved by the clinical reviewer, Atrezzo exports the authorization number to the claims payor in a daily file. It is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified Kepro of their inability to do so by fax or telephone.

If denied after physician review determination, we attach denial notices to the provider, referring practitioner and servicing provider in Atrezzo. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to

the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

DMEPOS Pricing

During the prior authorization process, if an item requested does not have an associated cost, our team calculates pricing for the DME using the process outlined in **Figure 32 DMEPOS Pricing**.

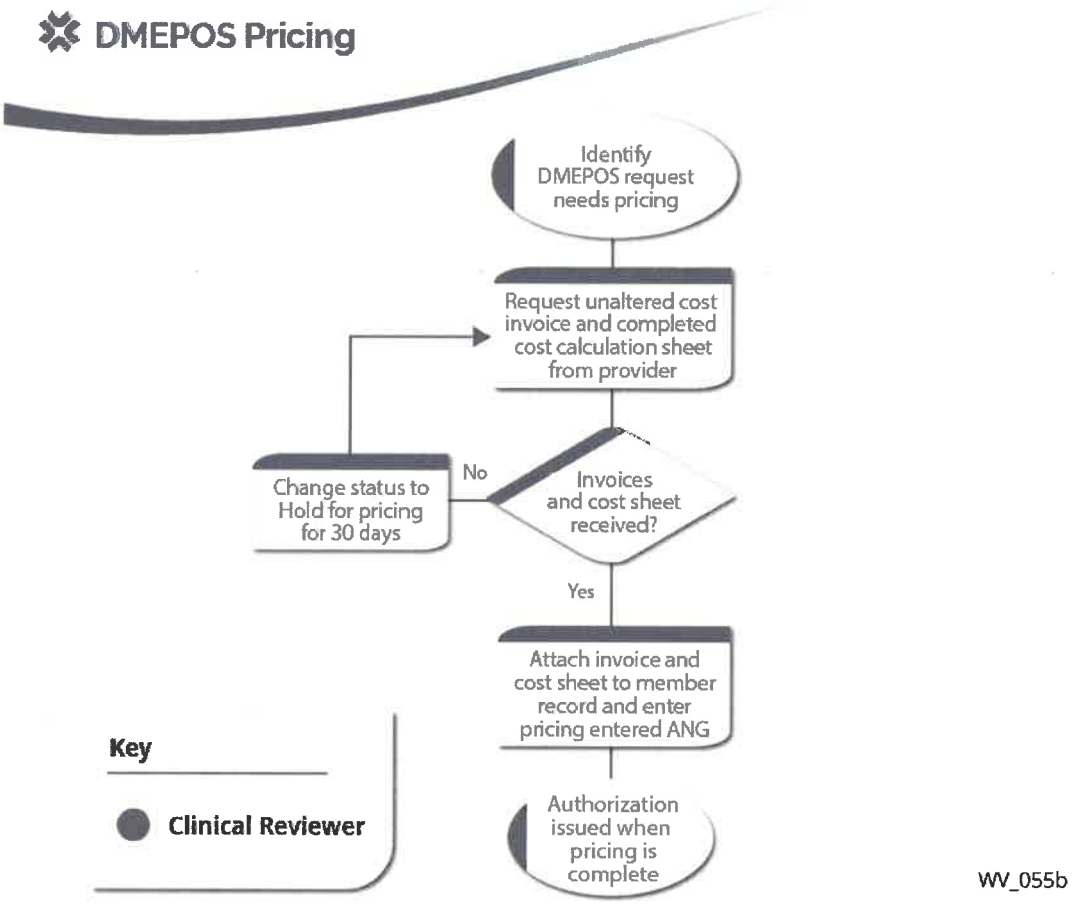


Figure 32. DMEPOS Pricing
Kepro's clinical reviewers complete authorization requests within 30 days of request receipt.

When it is identified that DMEPOS pricing is required, our clinical reviewer will request an unaltered cost invoice and completed cost calculation sheet from the provider. We do not release the authorization until the provider submits the cost invoice. Cases awaiting pricing are in a hold for pricing status for 30 days. The system prompts the provider at multiple points to send the invoice. Vendors cannot place equipment without authorization.

Upon receipt, the clinical reviewer will attach the invoice and cost sheet to the member record and enter the pricing into Atrezzo. After the pricing is completed, an authorization number is issued. If

the required documentation is not received from the provider after 30 days, the clinical reviewer will send a second request for the required documentation to complete pricing.

DMEPOS Reconsiderations

Providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration request, and additional information to another board-certified MD/DO with specialty match for a final determination.

Response to reconsideration requests: We review reconsideration requests within two business days of the request and send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative receives notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the right to fair hearing, with instructions on how to proceed.

Reconsiderations resulting in reversals: If we reverse the initial decision, we send the approval decision to the MMIS. The process for reconsideration is in the workflow in **Figure 29 Reconsideration Process in Section A1.1.c Hospice Services**.

Obtaining an appeal: Members may request an appeal of a denial of services not yet provided. We will prepare documentation necessary to process the member's appeal.

A1.1.e. Vision Services

1. The Agency covers vision care services for the examination, diagnosis, treatment, and management of ocular and adnexal pathology. This includes diagnostic testing, treatment of eye disease or infection, specialist consultations and referral, comprehensive ophthalmologic evaluations, and eye surgery (but not cosmetic surgery). Visual examinations to determine the need for eyeglasses are covered for members under 21 only. Full vision care benefits are available for members under 21 years of age. limited vision care benefits are available for members 21 years and older. There is no coverage for cosmetic purposes.

Under our current UM and PA Services contract, we complete prior authorization services for many outpatient procedures involving vision related conditions (example, blepharoplasties, repairs for entropion and ectropion disorders, and lagophthalmos corrections). InterQual® has criteria for a number of these surgical procedures and we use them to review these requests. However, some procedures do not have specific criteria. In these instances, we use the specifications of Chapter 525 and a board-certified ophthalmologist reviews the request. We understand the coverage differences for vision care benefits between members 20 and under and those 21 and over.

In 2022, we did not receive any vision services review requests. The clinical review of vision services process occurs within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

Following verification of covered service status and completeness, the clinical reviewer evaluates the request to determine if the requested service is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use InterQual® Criteria sets (InterQual Adult & Pediatric; InterQual Procedures & Acute) as previously approved by the Bureau for Medical Services. Services for which there are no InterQual criteria available go directly to physician review.

If approved by the clinical reviewer, Atrezzo exports the authorization number to the claims payor in a daily file. It is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability by fax or telephone.

If physician review is required, we will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, Atrezzo exports the authorization number to the claims payor in a daily file as described above.

If a PA request is denied after a physician review determination, we will attach denial notices to the provider, referring practitioner and servicing provider in Atrezzo. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

A1.1.f. Audiology Services

1. The Agency covers medically necessary audiology services to members under 21 years of age. Services provided on or after the 21st birthday are not eligible for reimbursement. Audiology covered services include mandatory newborn hearing screens, one (1) initial evaluation per calendar year to determine hearing capability, two (2) re-evaluations per calendar year, diagnostic audiology testing, Cochlear implants, hearing aids and batteries. Replacement of Cochlear implants, hearing aids and/or accessories require prior authorization.

We conduct prior authorization reviews of speech, language, and audiology services to include hearing aids, speech generating devices and cochlear implants for BMS under their current contract and will continue to provide this service subject to BMS approval. We have designed the Provider Portal to clearly assist both speech and audiology providers by reflecting the current audiology services requiring prior authorization as outlined in the BMS provider Manual-Chapter 530 Speech and Audiology Services. Included in the review process for this area are licensed speech therapists and audiologists who conduct reviews to support compliance with BMS policy for these services.

Prior authorization requests may be entered directly into the submission portal by the provider. If a prior authorization request is submitted via fax, telephone, or mail our Customer Service Representative (CSR) retrieves the intake information and enters relevant details into Atrezzo. The CSR will record the date of receipt as the date a mailed, telephonic, or faxed request was received except for requests received after business hours. For requests received after business hours, the date of receipt will be recorded as the next business day. Atrezzo will then automate the remainder of the eligibility process, including Medicaid eligibility checks and sending communications to the

provider automatically. If the request requires clinical review, the request is automatically routed via Atrezzo workflows to the appropriate clinical review work queue.

Atrezzo also assists our staff in provider enrollment verification. We receive a provider enrollment file from the fiscal agent, which contains data for active and credentialed, or enrolled, providers with WV Medicaid and WVCHIP. The enrollment file allows our staff to quickly and efficiently verify that a provider is appropriately enrolled.

In 2022, we conducted a total of 6 audiology reviews. The clinical review of audiology services process will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

When determining if the service requested is a covered service, Atrezzo has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, Atrezzo configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. We verify that the request is within any service limitations attached to the coverage at the time of the request.

Our staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see **Section A1.1.aa Expanded EPSDT Services and Criteria Development** for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

If a request is incomplete, as in it does not have all the required information, we will suspend the request and place it in a pending status documentation requested. The provider receives a message via the Provider Portal within one business day to obtain the necessary additional information and/or correct errors. If we do not receive additional information within three business days, we close the request administratively. The provider may resubmit the request by selecting copy for new submission and updating the request or by resubmitting the request by fax with the additional information. If the clinical reviewer is still unable to approve the request after receipt of additional information, we refer the review to a physician with all available information.

Following verification of covered service status and completeness, a clinical reviewer evaluates the request to determine if the service requested is medically necessary and appropriate, and if the service should be approved or referred to physician review. We use BMS/Medicaid criteria with consultant review; Speech Generating Device (SGD) InterQual Criteria; InterQual Hearing Aid criteria (with local edits); Cochlear implants BMS criteria and InterQual criteria.

If the audiology consultant reviewer approves the request, Atrezzo exports the authorization number to the claims payor in a daily file; it is available in the system record and reports tab for

the referring and servicing provider. We inform providers who are unable to access the online system and have notified Kepro of their inability by fax or telephone.

After referral from the audiology consultant level for physician review, we complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system exports the authorization number to the claims payor in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability to do so.

If the request is denied after physician review determination, we attach denial notices to the provider, referring practitioner and servicing provider in Atrezzo. This notice includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

A1.1.g. Outpatient Physical Therapy, Occupational Therapy and Speech Therapy

1. The Agency covers outpatient physical, occupational, and speech therapy services for all eligible members.

We began providing outpatient physical therapy, occupational therapy, and speech therapy for WV DHHR in 2010. Since that time, we have worked with the State to streamline our approach and maximize efficiency in our processes and program offerings to ensure we have sufficient resources to address contract deliverables and WV DHHR needs. Our commitment to successfully delivering contract requirements is further underscored by our consistently timeliness. We provide a monthly report card of service activities and remained timely for this service level agreement 95% of the time in 2022.

High volumes are a particular focus. In 2022, we conducted over 3,500 outpatient physical therapy, occupational therapy, and speech therapy reviews for West Virginia. We were able to accomplish this volume of work because of our commitment to streamlining and continual improvement. In 2022, we migrated outpatient physical therapy and occupational therapy initial assessments to our innovative technology solution, Atrezzo, which now adjudicates these assessments.

Occupational and physical therapy now have a combined limit of 20 visits per calendar year. A prior authorization is required for the initial visits but does not require clinical review. Atrezzo captures these visits as initial visits, and we administratively approve them on the date of receipt by our team. Visits beyond 20 in a calendar year require clinical review. We capture these visits as established, and subject them to nurse review and physician review, if necessary, to determine medical necessity. We can modify the threshold for the number of initial visits allowed to accommodate any changes in Chapter 515 Occupational/Physical Therapy once current policy remediation efforts are complete.

Recent policy updates have separated speech services from the 20-visit combination with PT/OT through the creation of Chapter 530-Speech and Audiology Services. Atrezzo reflects the new limits for both Chapter 515 Occupational/Physical Therapy as well as Chapter 530 Speech and Audiology Services.

The prior authorization of physical, occupational, and speech process occurs within Atrezzo using the prior authorization process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

Prior authorization requests entered by the provider via the portal are automatically uploaded to Atrezzo. When a prior authorization request is submitted via fax, telephone, or mail our Customer Service Representative (CSR) retrieves the intake information and enters relevant details into Atrezzo. The CSR records the date of receipt as the date we received the mailed, telephone, or faxed request, except for requests received after business hours. Atrezzo then automates the remainder of the eligibility process, including Medicaid eligibility checks and sending communications to the provider. If the request requires clinical review, the request is automatically routed via Atrezzo workflows to the appropriate clinical review work queue.

For each prior authorization request, the clinical reviewer pulls the case from the clinical review queue and determines first if the request is complete. If a request is incomplete, we suspend the request and place it in a pending status documentation requested. The provider receives a message in the system and contacted within one business day to obtain the necessary additional information and/or correct errors. If we do not receive additional information within three business days, we close the request administratively. The provider may resubmit the request by selecting copy for new submission and updating the request or by resubmitting the request by fax with the additional information. If the clinical reviewer is still unable to approve the request after receipt of additional information, we refer the review to a physician with all available information.

Physical and Occupational Therapy

Occupational and physical therapy now have a combined limit of 20 visits per calendar year. A prior authorization is required for the initial visits but does not require clinical review. Atrezzo captures these visits as initial visits, and we administratively approve them on the date of receipt by our team. Visits beyond 20 in a calendar year require clinical review. We capture these visits as established, and subject them to RN review and physician review, if necessary, to determine medical necessity. We can modify the threshold for the number of initial visits allowed to accommodate any changes in Chapter 515 Occupational/Physical Therapy once current policy remediation efforts are complete.

When we receive an initial physical or occupational therapy PA request, we automatically review the request. This information is also available in the system record and reports tab for the referring and servicing provider.

If the request is an established request, the clinical reviewer determines if the service is medically necessary and appropriate. Following verification of covered service status and completeness, the clinical reviewer evaluates the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. For physical and occupational therapy reviews, we utilize InterQual Criteria sets (InterQual Adult & Pediatric PT/OT), BMS criteria, and Chapter 515 to determine medical necessity as approved by the Bureau for Medical Services.

If the PA request is approved by the clinical reviewer after clinical review, Atrezzo exports the authorization number to the claims payor in a daily file as described above.

We complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payor in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability to do so by fax or telephone.

If denied after physician review determination, the clinical reviewer attaches denial notices to the provider, referring practitioner and servicing provider in Atrezzo. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

Speech and Language Services

We authorize speech and language services in conformance with BMS Manual Chapter 530 Speech and Audiology Services. Speech therapy services require prior authorization from the initial service and are no longer subject to limits in conjunction with occupational and physical therapy. Licensed speech therapists conduct reviews of speech therapy requests to ensure compliance with BMS policy for these services.

When a speech and language services PA request is received, the clinical reviewer first determines if the service is medically necessary and appropriate. Following verification of covered service status and completeness, the clinical reviewer evaluates the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use BMS/Medicaid criteria with consultant review and Chapter 530 for the review of these services.

If approved by the speech and language therapy consultant reviewer, Atrezzo exports the authorization number to the claims payor in a daily file, and the approval is also available in the Atrezzo record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability by fax or telephone.

After referral for speech and language therapy for physician review, we complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payor in a daily file; it is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability to do so by fax or telephone.

If denied after physician review determination, we attach denial notices to the provider, referring practitioner and servicing provider in Atrezzo. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

A1.1.h. Physician and Non-Physician Practitioner Services

1. The Agency requires Prior Authorization for all hospital admissions, and specific surgeries performed in defined places of service, to be authorized in accordance with current policies. No surgical procedure may be covered on an inpatient basis if the procedure can be performed appropriately and safely in a physician's office or other outpatient setting. If the surgery is authorized by the UM, separate prior authorization numbers for the surgeon and the outpatient facility are assigned. In addition, specific practitioner services and all unlisted codes for procedures/services require Prior Authorization.

As part of our commitment to providing quality assurance in utilization management, ensuring medical necessity is essential to our daily work with clients and providers. As such, we incorporate WV DHHR's priorities, including requiring prior authorization for all hospital admissions and elective surgeries as outlined in the RFP above, into our UM processes to ensure an integrated and seamless implementation of the State's policies and procedures. Our processes are essential to effectively managing high volumes, such as in 2022, when we conducted close to 4,200 Physician and Non-Physician Service reviews for West Virginia.

BMS Policy Chapter 519, was known as Physician and Non-Physician Practitioner Services, and BMS revised it as part of current policy remediation. The current Chapter 519 Practitioner Services includes outpatient surgery services requiring prior authorization as well as a separate section on outpatient surgical bariatric procedures (Policy 519.4). We conduct prior authorization of elective outpatient surgery cases under its existing contract with BMS. We understand that this review helps to ensure medical necessity for elective surgery performed for West Virginia's Medicaid members.

The prior authorization of physician and non-physician services occurs within Atrezzo using the utilization review process outlined **in Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

A1.1.i. Home Health Services

1. The Vendor shall have established procedures and sufficient capacity to receive requests, physician's orders, plans of care, assessments, and other forms or documentation required for the Home Health provider to register for the initial 60 visits.
2. The Vendor shall have the capability and established procedures for determining the medical necessity of requested authorization requests for Home Health services that exceed the initial 60 visits. Authorization(s) must be specific to the member, provider agency, service code, units, start and end date. The units, start and end dates in the authorizations may subsequently be modified/edited as necessary.
a. Authorization Reviews: The Vendor shall have the capability and established procedures to ensure determinations for authorization reviews are completed in accordance with current policies.
b. Continued Stay Reviews: The Vendor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed in accordance with current policies.
c. Retrospective Reviews: The Vendor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed in accordance with current policies.
3. The Vendor shall have the capability to develop educational trainings and provide technical assistance, at no additional cost to the Agency, about policies, available services, and any other information requested by the Agency for members, families, provider agencies, stakeholders and the general community via email, telephone, webinars etc. at no additional cost to include but not limited to:
a. Plan, advertise and produce statewide trainings and webinars at the request of the Agency.
b. Communicate program announcements to providers, members, and other stakeholders as necessary, at no additional cost to the Agency.
c. Participate in conference calls at the request of the Agency.
d. Offer Continuing Education Units (CEUs) to nurses, counselors and Licensed Social Workers attending training sessions.
4. The Vendor will enroll the Agency Member in Case Management to monitor and assist when the needs required if necessary.
5. The Vendor will notify the Agency weekly and the members' Case Managers upon issuing authorization(s) for members who receive services from a waiver program or the personal care program who are also receiving home health services.
6. The Vendor will collect and report data regarding the utilization and quality of Home Health services as required by the Agency.

We understand the importance of a complete and thorough review, as we have 17 years of experience performing Home Health services. In 2022, we conducted a total of nearly 3,000 Home Health reviews for West Virginia. As part of the review process, clinical reviewers evaluate each request to ensure the beneficiary does not have existing services with another provider, that all required clinical documentation has been submitted and is completed in its entirety. The clinical reviewer will also take note of any previous visits authorized due to the service limits set forth by WV DHHR. If a request is submitted for authorization that will exceed the 60-visit annual limit, the clinical reviewer will ensure that the request is medically necessary and work with the Agency for final approval of the services.

Online Training

Kepro holds regular Home Health refresher trainings on initial requests. As Kepro provides these trainings online, our individuals statewide can receive instruction.

Our understanding of the unique needs of WV DHHR's Home Health program is based on our review of Chapter 508. These requirements are incorporated into our systems and prior

authorization processes to ensure compliance with WV DHHR regulations. We verify that services provided fall within the scope of practice of home health providers and that services are covered under the home health benefit. Our reviewers are practiced in raising concerns, should there be any indication that the plan of care includes services that are outside of that scope.

We understand that Home Health services are intended to be short term in duration, and that an important goal of these services is to educate members and their families on self-care principles. As such, our personnel verify that the home health care plan addresses educational needs and increase the member and their families' health literacy. We validate that, for established requests that are clinically reviewed, covered home health services are prescribed and supervised by a physician, Advanced Practice Registered Nurse (APRN), or a Physician Assistant, as stated in the applicable regulation. Services provided will follow a written plan of care to help the member to receive medically necessary and reasonable care. Additionally, we enroll the member in Case Management to monitor and assist if needed.

In performing this work, we have gained invaluable best practices that we bring to WV DHHR vulnerable population:

- **Monitor for duplication of services.** Clinical reviewers check past authorizations (or claims if available) to determine if requested services are currently being provided by another provider.
- **Importance of knowing benefit limits.** We know that members initially are permitted up to 60 visits per year, depending on medical necessity, for any combination of skilled nursing, speech/language, occupational and physical therapy(ies). We understand the importance of tracking the initial visits and their role in DHHR's efforts pertaining to Electronic Visit Verifications (EVV). We will continue to further track established Home Health requests along with reviewing for medical necessity. All initial and established requests for home health services are entered into the Atrezzo system to assist with EVV. We also recognize benefit changes between coverage types. Home Health Alternative Benefit members have a 100-visit cap, while traditional members for Home Health, occupational, physical and speech therapy benefits do not have a cap for established requests; Alternative Benefit plan members have a 30-visit maximum. Enrolling members in case management monitor services to provide quality of care yet conserve visits for future needs. Clinical reviewers evaluate the plan of care and requested visits, including the number of visits, and compare against designated medical necessity review criteria and potentially consult with our physician reviewers before authorizing the number of visits. Receipt of requests beginning with in initial visits, and including established patients, in a calendar year supports the need to determine whether the member is making progress; if the individual has not made progress, they must again consult with our medical director and – in some cases - the treating provider/ordering physician to discuss the best course of treatment.

Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services, outlines the process that will be used to make a prior authorization determination.

The prior authorization process begins upon receipt of the PA request for Home Health services. The clinical reviewer receives the request automatically and in real-time via Atrezzo and reviews the clinical information based on the appropriate criteria and client-required rules. If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo, and automated notification is sent to the provider in real-time via the Provider Portal. If it is determined that administrative requirements are not met, the clinical reviewer documents the adverse determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via mail.

If administrative requirements are met, but the clinical reviewer cannot approve the request due to lack of clinical information, the clinical reviewer pends the request with automatic notification to the provider via the Provider Portal requesting additional information. If the provider does not fulfill the request for additional information within the allotted timeframe, or, following review of additional information the clinical reviewer cannot approve the case based on medical necessity, the case is routed to a physician reviewer for review. The physician reviewer documents the determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via mail.

Continued Stay Review

To ensure beneficiaries move through the continuum of care appropriately based on medical need criteria, Continued Stay Reviews are provided throughout all levels of care. We have provided Continued Stay Review Management for decades. Our extensive experience in Continued Stay Review Management includes contracts in Maine, West Virginia, South Carolina, Minnesota, and Florida. As such, we are confident that we can provide Continued Stay Review to support WV DHHR as required. We will conduct Continued Stay Reviews within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

A nurse conducts reviews of medical record information to determine if the need for continued stay and to provide notice and/or reconsideration for denied participants. Additionally, this review ensures quality assurance and multidisciplinary team requirements pursuant to state requirements.

Using an algorithm based on approved criteria, we assess the medical necessity and appropriateness of the recipient's continued stay. Where the medical record documentation does not substantiate the need for continued stay, the attending physician and/or direct care staff is contacted and requested to supply additional documentation in the recipient's record to justify the continued stay.

Retrospective Review

Our Retrospective Review process follows a similar process to prior authorization review. The retrospective review includes reviewing the member's medical record that corresponds with the date of initial service and subsequent treatment to validate medical necessity throughout the member's length of stay. We verify that the plan of care is consistent with WV DHHR policy. Daily documentation specific to treatment goals and objectives, anticipated LOS and discharge planning activities must be evident for each day of hospitalization. For inpatient reviews after discharge and prior to billing, the hospital will submit a request for processing to us. Our Retrospective Review Process is illustrated in **Figure 27 –Retrospective Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

Our clinical reviewer begins the retrospective review by evaluating the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR required rules. Using these criteria verifies that services and items planned are consistent with the provisions of appropriate care. If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to a physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo, and notification is automatically sent to the provider via the Provider Portal and/or notification is autogenerated via Atrezzo. For all adverse determinations, the member receives the denial notification.

We complete retrospective reviews within 48 hours. We conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services.

Training and Technical Assistance

Additionally, we have developed educational training for Home Health providers regarding policy, available services, service delivery models, and any other topics requested by the Bureau for Medical Services. We provide CEUs for RNs, counselors and Licensed Social Workers developed in conjunction with the Bureau for Medical Services. We use RNs to assist in developing topic specific CEUs, which are also in compliance with Board of Nursing and Social Work education requirements.

We provide technical assistance as requested by individual providers or to all Home Health providers when changes in policy or updates in the system occur. We plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We participate in and conduct training for members and other stakeholders as requested by the Agency. We also participate in conference calls at the request of the Agency.

A1.1.j. Private Duty Nursing Services

1. The Agency covers private duty nursing (PDN) services for eligible members through age 20 who require more individual and continuous care than is available under the home health benefit. As a condition for reimbursement, the Agency requires that all PDN services receive prior authorization. Authorization(s) must be specific to the member, provider agency, service code, units, start and end date. The units, start and end dates in the authorizations may subsequently be modified/edited as necessary.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, assessments, and other forms or documentation required for prior authorization and eligibility review of PDN services.
3. The Vendor shall determine the medical necessity of the requested authorization, concurrent stay, and retrospective reviews utilizing the Agency approved criteria and policies for PDN services to eligible members.
a. Authorization Reviews: The Vendor shall ensure determinations for authorization reviews are completed in accordance with current policies.
b. Continued Stay Reviews: The Vendor shall ensure determinations for continued stay reviews completed in accordance with current policies.
c. Retrospective Reviews: The Vendor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed in accordance with current policies.
4. The Vendor shall have the capability to develop educational trainings and provide technical assistance, at no additional cost to the Agency, about policies, available services, and any other information requested by the Agency for members, families, Agencies, stakeholders and the general community via email, telephone, webinars etc., including but not limited to:
a. Plan, advertise and produce statewide trainings and webinars at the request of the Agency.
b. Communicate program announcements to providers, members, and other stakeholders as necessary, at no additional cost to the Agency.
c. Participate in conference calls at the request of the Agency.
d. Offer Continuing Education Units (CEUs) to nurses, counsellors and Licensed Social Workers attending training sessions.
5. The Vendor will enroll Members in Case Management to follow throughout the PDN Authorizations and longer if need is indicated.
6. The Vendor will notify the Agency weekly and the member's Case Manager upon authorization of members who receive services from a waiver program or the personal care program who are also receiving private duty nursing services.
7. The Vendor will collect and report data regarding the utilization and quality of Private Duty Nursing services as required by the Agency.

We recognize that Private Duty Nursing (PDN) is a critical component of the care already provided to an individual by the individual's family, foster parents, and/or delegated caregivers. As such Kepro takes pride in our contribution to this program over the last 12 years, building a relationship with PDN providers and members. In 2022, we conducted nearly 300 PDN reviews for West Virginia, underscoring the importance of our role for enrolled waiver members.

Alongside our excellent and steadfast performance in conducting PDN reviews for the state, we have proven its value innumerable times over the course of our partnership. In one notable example, we followed through on our commitment to discover and eliminate fraud, waste, and abuse in our provider network. We accomplished this by our strict adherence to our thorough review processes. While conducting a review, we identified a PDN agency that was sent to the Fraud, Waste, and Abuse unit. We reported the Agency to ensure the appropriate stakeholders were involved in further investigation of the entity. Our involvement assisted the state in maintaining integrity in its wide network of stakeholders.

Process

Our medical staff review and prior authorize all private duty nursing requests within guidelines established by BMS. The prior authorization of Private Duty Nursing services occurs within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

Following verification of covered service status and completeness, a clinical reviewer evaluates the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use the BMS Manual including the medical and psychosocial grid as well as policy requirements for the service, as approved by the Bureau for Medical Services. After the initial request is received, the case is pended for 30 days to allow sufficient time for provider submission of the signed 485 or Plan of Care, if not already provided. If the PDN service is authorized, medical case management is invoked to monitor service utilization, possible duplication of service, and member outcomes.

Case Management

Additionally, we began enrolling PDN members in Case Management in 2011. PDN member enrollment in Case Management allows us to monitor and confirm that member needs are met regarding PDN and any other service the member receives, based on BMS recommendations. Case Management is offered and tracked through our Atrezzo system, which will integrate with UM episodes of care. Members and staff benefit from this integrated system as individuals.

Our Atrezzo Case Management system supports members engaged in different programs and services to receive the care they need by coordinating different program receipts. Atrezzo users viewing member records will be able to see all cases listed for a particular member using the "Consumer Summary" function within the system. Users can also select the "Cases" option for a member, which will also display the member's cases.

Continued Stay Review

To help beneficiaries move through the continuum of care appropriately based on medical need criteria, we conduct Continued Stay Reviews throughout all levels of care. We have provided Continued Stay Review Management for decades. Our extensive experience in Continued Stay

Review Management includes contracts in Maine, West Virginia, South Carolina, Minnesota, and Florida. As such, we can provide Continued Stay Review to support WV DHHR as required. We will conduct Continued Stay Reviews within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

A nurse reviews medical record information to determine the need for continued stay and to provide notice and/or reconsideration for denied participants. Additionally, this review ensures quality assurance and multidisciplinary team requirements pursuant to state requirements.

Using an algorithm based on approved criteria, we assess the medical necessity and appropriateness of the recipient's continued stay. Where the medical record documentation does not substantiate the need for continued stay, the attending physician and/or direct care staff is contacted and requested to supply additional documentation in the recipient's record to justify the continued stay.

Retrospective Review

Our Retrospective Review process follows a similar process to prior authorization review. The retrospective review includes reviewing the member's medical record that corresponds with the date of initial service and subsequent treatment to validate medical necessity throughout the member's length of stay in the inpatient setting. We will ensure the plan of care is consistent with WV DHHR policy. Daily documentation specific to treatment goals and objectives, anticipated LOS and discharge planning activities must be evident for each day of hospitalization. Our Retrospective Review Process is illustrated in **Figure 27 –Retrospective Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

Our clinical reviewer begins the retrospective review by evaluating the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR required rules. Using these criteria will ensure that services and items planned are consistent with the provisions of appropriate care. If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to a physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo, and notification is automatically sent to the provider via the Provider Portal and/or

notification is autogenerated via Atrezzo. For all adverse determinations, the member receives the denial notification by mail.

We complete retrospective reviews within 48 hours. We conduct review of retrospective requests only in compliance with the policy approved by the Bureau for Medical Services.

Training and Technical Assistance

We have a proven history of providing training and education services to WV Medicaid providers, members, and community stakeholders. Throughout our work in WV, we are accustomed to scheduling and leading training sessions for a wide range of populations. We provide training in a variety of formats including email and recorded presentations made available on our website to all providers. Each review type has a dedicated web training for Atrezzo submissions. This training is recorded and available on our website for providers to access at any time.

Additionally, we will develop educational trainings to PDN providers regarding policy, available services, service delivery models, and any other topics requested by the Bureau for Medical Services. We will provide CEUs for RNs, counselors and Licensed Social Workers developed in conjunction with the Bureau for Medical Services. We use RNs to assist in developing topic specific CEUs, which are also in compliance with Board of Nursing and Social Work education requirements.

We provide technical assistance as requested by individual providers or to all PDN providers when changes in policy or updates in the system occur. We plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicates announcement of the training to providers. We participate in and conduct training for members and other stakeholders as requested by the Agency. We also participate in conference calls at the request of the Agency.

We will leverage our current relationship with PDN providers and further expand to include weekly communications in the event members are enrolled in Personal Care and other waiver programs simultaneously. This is an added benefit as we provide the internal coordination needed to oversee the member's involvement in two or more programs.

Collecting and Reporting Data

We provide regular and ad hoc reporting on Private Duty Nursing, monitoring both utilization and quality. We use data collected to analyze program trends of specialty care to note areas of high need and high utilization. Our regular utilization reporting includes:

- Active PDN Members
- Utilization Management Activity and Timeliness
- UM Retrospective Report
- UM Reconsideration Report
- UM Appeals Report
- UM OON Report
- UM Activity Year-to-Date
- UM Denials

We also provide an annual report that summarizes key trends and data across and within all the programs we service under the current contract. In addition to reporting on volume and timeliness of deliverables, ongoing quality activities include monthly monitoring of clinical staff (RNs and physician reviewers), inter-rater activities for eligibility and administrative staff (letters and keying requests) as well as other quality measures.

A1.1.k. Diagnostic Imaging/Radiology Services

1. The Vendor shall develop, implement, and maintain a UM program, which includes prior authorization for all non-emergency advanced imaging studies provided in outpatient settings (including but not limited to Independent Diagnostic Testing Facilities (IDTF), hospital outpatient, and private physician offices. These include, but are not limited to:
a. Computerized Tomography (CT) scans.
b. Magnetic Resonance Images (MRI).
c. Magnetic Resonance Angiograms (MRA).
d. Positron Emission Tomography (PET) scans.
e. Nuclear Cardiology.
f. Radiopharmaceutical's.
g. Any other identified imaging service or over utilized and/or high-cost Diagnostic Imaging/Radiology services.
2. The Agency reserves the right to modify the list, through either addition or deletion, of imaging study procedures subject to prior authorization over the term of the contract.
3. In performing medical necessity determinations, the Vendor shall use nationally recognized, research based, standardized, clinical criteria in reviewing each prior authorization and eligibility review request. If not nationally accredited, researched based criteria exist, the Vendor shall develop criteria based on current research available. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all Diagnostic Imaging/Radiology and imaging services reviewed under the contract.
a. The Vendor shall maintain the capability to update the review criteria for Diagnostic Imaging/Radiology services reviewed under the resulting contract. The Vendor shall make recommendations to the Agency annually or as needed, regarding what, if any, changes should be made to the criteria that is currently being used or will be used for the following the calendar year. The recommendations shall be included in the Vendor's annual report and communicated to the Agency.
b. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria annually.
c. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the resulting contract.
d. The Vendor is responsible for any cost associated with the purchase of any review criteria.
4. In performing medical policy coverage recommendations, the Vendor shall use nationally accredited, research-based standards of care in determining recommendations. If not nationally accredited, research based, standards of care exist; the Vendor shall develop recommendations based on current research available. Policy recommendations shall take into consideration, the WV State Plan, any applicable federal regulations, and comparisons of other State Agency policies.

We will continue our work, which began in 2010, providing prior authorization of elective outpatient, high-cost imaging studies to ensure that these services are medically necessary and the most cost-effective service for the member. In 2022 alone we conducted close to 7,000 diagnostic imaging and radiology service reviews for West Virginia, covering services such as computerized

topographies (CT), positron emission tomography (PET), magnetic resonance imaging (MRI) and angiography (MRA), as a method to control costs in the West Virginia Medicaid program. We understand that these tests do not require prior authorization when provided in an emergency room, to avoid delaying emergency treatment for members. We will also include any other identified imaging service or over utilized and/or high-cost diagnostic imaging/radiology services, as requested by BMS.

When InterQual criteria are not available we provide recommendations to the Bureau for medical services based on research of clinically sound and research-based criteria that have been endorsed by our Medical Director and physicians in the specialty of the criteria under review. It is possible to edit these criteria to create local medical policies (LMPs) that conform to BMS specific policies. BMS may also develop local medical policies for existing criteria, based on updated policy or clinical practices changes. The Bureau for Medical Services receives recommendations for approval, and once BMS approves, we implement the policies. We update providers regarding criteria changes and if the criteria are not proprietary, they are available to providers unless otherwise specified by BMS. Publishers do not release proprietary criteria, such as InterQual; however, we can provide "SmartSheets" for many review areas that at BMS' request.

We will continue to update the review criteria annually, and alert BMS to any changes in the criteria. Any recommended changes in criteria will be included in the annual report provided to the Agency. Since InterQual criteria is utilized in several review areas it is not within the purview of Kepro or BMS to make major modifications to the proprietary criteria set- however, recommendations will be made to the Agency for any additions or edits that may need to be approved to conform to BMS policies. For all other policies, we will present recommended changes to the Agency for consideration. The Bureau may reject current or recommended criteria and specify use of different criteria. We will provide the Agency with access to a complete set of materials associated with the criteria annually. We are responsible for the purchase of InterQual review materials, and any other criteria adopted that are not public domain.

The prior authorization of diagnostic imaging and radiology services is conducted using InterQual®, local medical policies, and BMS Manual Chapter 528. PA of diagnostic imaging and radiology will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

Provider Education and Stakeholder Engagement

We have, and will continue to, develop educational trainings for imaging stakeholders on topics requested by the Bureau for Medical Services. We provide technical assistance as requested by individual providers or to all imaging providers when changes in policy or updates in the system occur. We plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcements of the training to providers. We will provide the following services to the Bureau for Medical Services to ensure appropriate utilization management of imaging services:

- Participate in conference calls at the request of the Agency.
- Develop a reference manual for providers.
- Maintain updated imaging/radiology information, instructions, updates, code lists, bulletins, links to other information and sites, and announcements of new information on the website.
- Hold initial orientations to the Atrezzo portal with key stakeholders, as requested by the Agency.
- Provide support to the Agency related to stakeholder inquires, including but not limited to members, providers, facilities, legislators, and/or other government offices or officials.
- Provide a toll-free line for providers and members for inquiries regarding service coverage, prior authorization status or to answer questions regarding issues or problems with a prior authorization request.
- Make recommendations or develop forms upon request of the Agency.
- Represent the Agency regarding UM and/or Agency policies, guidelines and/or other criteria at meetings, conferences, or educational seminars, as needed.
- We will also coordinate with Gainwell, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. We will monitor over- and under- utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

A1.1.l. Nursing Home Eligibility and Pre-Admission Screening and Resident Review Eligibility

1. West Virginia reimburses for Nursing Facility Services for individuals who need direct nursing care 24 hours a day, 7 days a week. The Agency has designed a tool that is used in part for the Medical determination process. As a condition for reimbursement, the Agency requires that Nursing Facility services receive a prior authorization approval on each individual seeking admission to a nursing facility known as a Pre-Admission Screening (PAS). Authorization must occur before admission to a nursing facility.
2. The Vendor shall be able to receive requests submitted according to the prescribed format identified as the State designated long-term care eligibility pre-admission assessment (PAS) instrument.
3. The Vendor shall be able to review decisions and must be able to communicate to the requesting party in writing, fax, mail, or e-mail within 48 hours of receipt of a request, at no additional cost to the Agency.
4. The Vendor shall establish procedures and sufficient capacity to receive review requests, required forms, history and physical, additional medical documentation and other forms or documentation required for prior authorization of nursing facility services.
5. The Vendor shall provide a first level review conducted by a complement of qualified staff, which must include registered nurses.

a. The Vendor shall be able to demonstrate the ability to request additional information if a decision cannot be made by the RN reviewer within 24 hours of the original request. If the RN reviewer requires additional information, a decision of eligibility, at the RN level, should be made within 24 hours after receipt of the requested additional information.

b. The Vendor shall be able to demonstrate the ability to have a physician review the request if the RN is still unable to make decision after the additional information has been received. The physician approval/denial must be made within 24 hours after the referral to the physician.

c. The Vendor shall be able to demonstrate the ability to show when PAS requests are received. Requests received after 12:00 pm on Friday, or a day preceding a holiday, must be accepted upon the first working day following the holiday or weekend.

6. As part of the medical determination process, the Vendor shall review the information submitted to identify possible presence for individuals with intellectual disabilities (110), developmental disability, and/or associated condition, or major mental illness.
7. If as part of the medial necessity determination, the Vendor identifies the presence of, or there is a need to rule out mental illness, 110, an associated condition, or a developmental disability diagnosis, the referring party, whether a hospital, physician, or other Agency, will be notified of that determination. It will be the responsibility of the referring party to initiate the Level II PASRR.
8. All notices, approval or denial shall come from the Vendor and shall be transmitted to the referring party.
9. The Vendor shall be able to identify criteria which were deemed not met in the review process and advise provider/member/legal representative. The member/legal representative is also notified of their right of an appeal and should be provided the appeal form from the Vendor.
10. The Vendor shall demonstrate the ability to request additional information from the provider as credible evidence (i.e., Minimum Data Set (MDS) Section "G", Activities of Daily living (ADL sheets, care plan notes, physician progress notes, nurses' notes, and any other pertinent needed information) within ten (10) business days to be reviewed during the appeal hearing.
11. The Vendor shall demonstrate the ability to support, review, and identify, during the hearing process, the documentation that provides supporting/ contradiction information.

We have worked to keep the Pre-Admission Screening and Resident Review (PASRR) process nimble and responsive to WV DHHR needs. Introduction of our innovative and efficient Atrezzo system has allowed our team to be flexible in the face of unprecedented challenges, including high volumes such as in 2022, when we conducted over 24,000 PASRR Level I reviews for West Virginia.

BMS requires all individuals placed in a nursing facility, or transferring between facilities, to have a medical necessity assessment completed, submitted, and reviewed in accordance with BMS policy. BMS utilizes the Pre-Admission Screening (PAS) assessment instrument, PAS-2000, as the basis for conducting the medical necessity review. We have managed the work to conduct NH/PASRR reviews for BMS since 2009. This effort has helped to ensure that individuals seeking placement in a nursing facility meet BMS' medical eligibility requirements for this level of care as well as whether an alternative placement is appropriate. We review over 20,000 submissions each year. Kepro continues to meet all timelines and expectations set forth by BMS including all turnaround times for conducting each stage of the review process. **Figure 33 PASRR Level I Review Process** provides an overview of the nursing home review process that we will conduct.

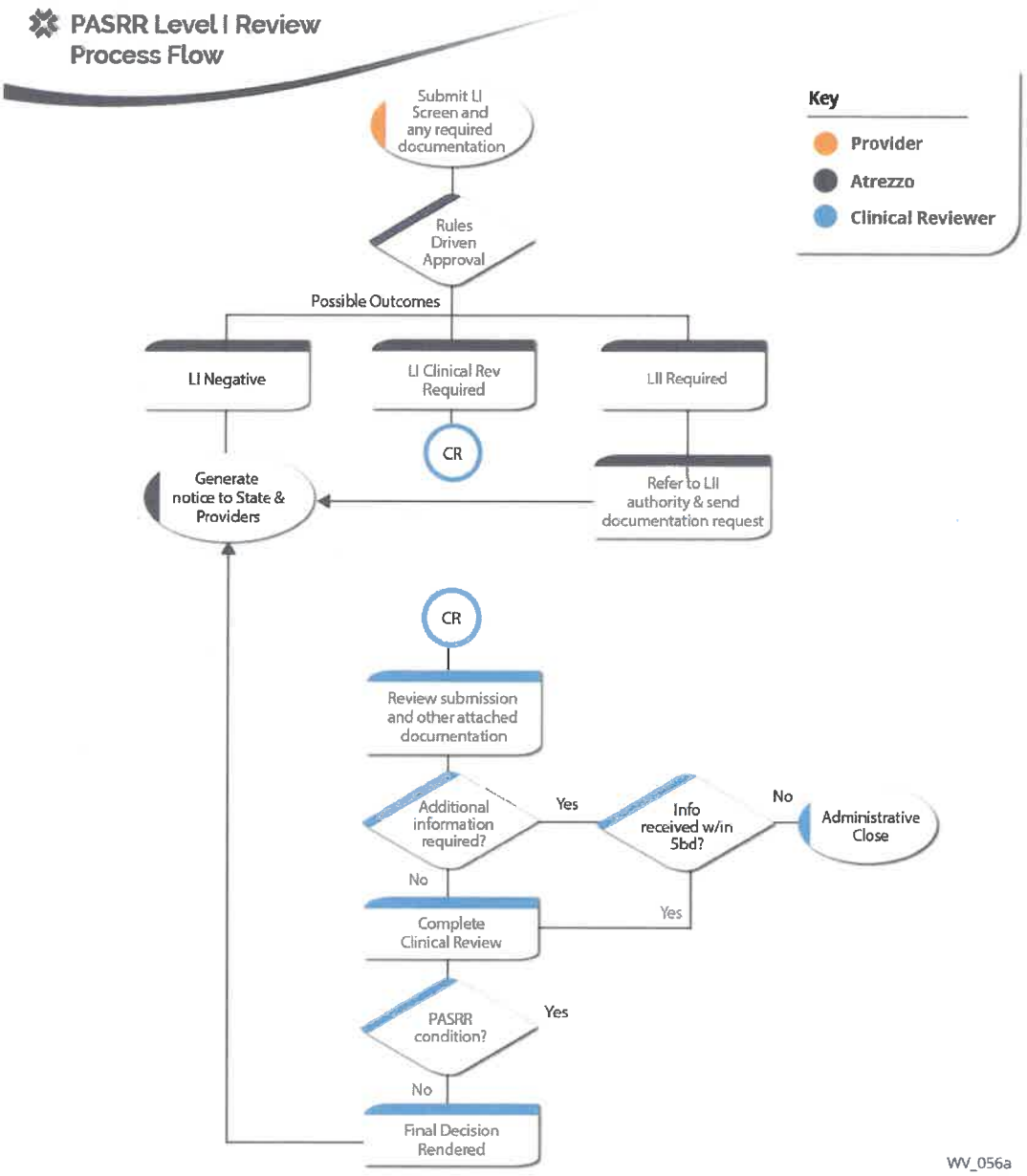


Figure 33. PASRR Level I Review Process

Kepro's approach to PASRR evaluations ensures individuals receive the care they need in the most optimal setting.

Hospitals and physicians' offices submit the completed Pre-Admission Screening (PAS) to Kepro by fax, email, or through direct entry into the Provider Portal. This approach allows providers to enter demographics and other information, then submit requests electronically. It also allows providers to check the status of their referrals or reviews at any time 24 hours a day, 7 days a week.

If the provider does not enter the PAS data directly in Atrezzo, Kepro staff will enter the PAS for clinical review. Atrezzo uses proven algorithms to auto-process PASRR Level I Screens and identify records that meet positive triggers, as well as identify records that require clinical review if the system cannot confirm the screen as negative.

If the PAS submission meets a positive trigger, Atrezzo notifies the clinical reviewer that additional information and further review is necessary. Additional information from providers is requested by the clinical review nurse through fax, email, and within Atrezzo. We will base the determination of the need for a PASRR on submitted information indicating the presence of intellectual disability, developmental disability and/or an associated condition, or major mental illness. Once we identify such a condition, the referring facility will be responsible for initiating the Level II PASRR process.

We will process all reviews submitted and issue a determination within 48 hours of receipt of the request. If screening criteria for Level II is not met, Atrezzo issues a determination immediately after submission. Providers have five business days to submit additional information if requested. Once Kepro receives the additional information, a determination is issued within 24 hours.

If the clinical review nurse is unable to decide at the nurse level, they will make a referral to physician review within 24 hours of receipt of the original request. The physician reviewer will make an approval/denial determination within 24 hours of the referral. If physician reviewers require additional information, they will make the request within 24 hours. Kepro transmits the physician review determination to the originating facility within 24 hours of receipt of the additional information.

WV PASRR providers receive instant notification on all PASRR results along with a printable copy of the PASRR Level I and notification letter reflecting outcomes and next steps if applicable in Atrezzo. For all denials, we will also notify the individual and referring entity by mail and/or fax of the determination. The denial letter will include the criteria not met during the review process, as well as appeal rights. The denial packet will also include a Hearing Request form, with instructions for completion.

To receive approval for Nursing Facility benefits with WV Medicaid, the individual must have at least five deficits. The computerized algorithm in Atrezzo ensures consistency and accuracy of the reviews consistent with BMS policy, within the scope of work, and across the long-term care continuum.

If a member requests a fair hearing as part of the appeal process, Kepro receives a notice of hearing scheduling and participates by requesting additional information within five days of notice receipt. Additional information can include a Minimum Data Set (MDS) section "G," Activities of Daily Living (ADL) sheets, care plan, and physician and nursing notes. Kepro provides a clinical reviewer to attend and participate in fair hearings, either in person or by conference call. The clinical reviewer supports, reviews, and verifies all information submitted in conjunction with current BMS policy/criteria for long-term care.

Kepro Care Management System

We use Atrezzo, our proprietary technology solution to accept and maintain electronic submission of PASRR Level I screenings from providers for all first time and current residents requiring a Resident Review. Our solution focuses on person-centered assessments and assured of compliance with PASRR federal regulations and the Supreme Court Olmstead decision. Atrezzo uses proven algorithms to auto-process PASRR Level I screenings and identify records that meet positive triggers, as well as identify records that require clinical review if the system cannot confirm the screen as negative. providers receive instant notification on all PASRR results along with a printable copy of the PASRR Level I and notification letter reflecting outcomes and next steps if applicable. When results are questionable or require a Categorical Advance Group Determination, Kepro completes Level I clinical reviews within two business days, or five business days if pended for more information. We review the information provided on the Level I screen and determines whether further review under Level II is required and communicate the decision to the submitting provider.

Our best-in-class PASRR solution is based on our expertise in this space, serving Medicaid program beneficiaries and administering quality assurance and improvement across the United States. This allows us to benchmark best practices across programs and geographies. We leverage this depth of knowledge as we transfer our best-in-class PASRR Assessment into our CMS-certified, proprietary Atrezzo platform. This assessment was custom-built into Atrezzo using industry standard software development tools and methodologies to mirror the best practices we have collected and to best accommodate West Virginia's regulations. Our PASRR Assessment provides beneficiaries, providers, and stakeholders ease of use for submission, tracking and trending of PASRR level I screenings, nursing facility admissions, compliance, and Level II evaluations. Level I screeners can find the outcome and print or share the Level I screen.

A1.1.m. Traumatic Brain Injury (TBI) Waiver Services

1. The Agency covers TBIW services for individuals that meet initial and annual medical eligibility requirements for the TBI Waiver Program.
2. As a condition for reimbursement, the Agency requires that the Vendor prior authorize all TBIW services in accordance with current policies.
3. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, Plans of Care, assessments, and other forms or documentation required for determining member eligibility/re-eligibility and prior authorization of TBI Waiver Program services. Authorization(s) must be specific to the member, provider agency, service code, units, start and end date. The units, start and end dates in the authorizations may subsequently be modified/edited as necessary.
4. The Vendor shall have the capability to manage applications and referrals for determining the initial eligibility and annual eligibility determinations of TBIW program members by qualified staff (Certified Brain Injury Specialist) and correspondence to all applicable parties, to include certified mail when requested by the Agency, within fourteen (14) calendar days of referral.
5. All correspondence regarding member eligibility shall be approved by the Agency and any changes requested by the Agency shall be completed within fourteen (14) calendar days.

a. Initial Assessments: The Vendor shall have the capability and established procedures to ensure tracking of all initial applications and determining medical eligibility in accordance with current policies. These procedures include confirmation of financial eligibility within established policy timelines and the release of funded slots.
b. Annual Assessments: The Vendor shall have the capability and established procedures to conduct annual redeterminations of medical eligibility of all members in accordance with current policies. Eligibility redeterminations shall be made no more than ninety (90) calendar days but at least thirty {30) calendar days prior to the member's annual anchor date.
c. Applicant/Member Education: The Vendor shall provide education to all applicants/members regarding program eligibility, choice of service delivery models, choice of providers and services, member rights and responsibilities including safe service delivery environments and the identification and reporting of abuse, neglect, and exploitation.
d. The Vendor shall have the capability and established procedures for maintaining the thirty (30) calendar day minimum timeline for conducting annual re-evaluations when appointments are canceled/rescheduled by the Vendor or member.
e. Managed enrollment: The Vendor shall have the capability and established procedures to determine initial and annual medical eligibility; confirm financial eligibility; and manage the enrollment list (waitlist) in accordance with current policies.
f. Enrollment/ Activation: The Vendor shall have the capacity and established procedures to track the applicant from the time of application, financial eligibility, medical eligibility, and enrollment/activation until the applicant has been determined eligible and fully active in the TBIW program. This will require interfacing with the local DHHR for financial eligibility updates.
g. The Vendor shall have the capability and established procedures to calculate member assessment-based budgets at least annually or more often if a change in need occurs and make the budget amount available to the assigned Case Management Agency, service Agency(s) and fiscal agent for self-directing members (if applicable) in accordance with current policies.
h. Maintain electronic health record: The Vendor shall maintain an electronic health record of all TBIW members and applicants. The Agency, the member's Case Management agency, other agencies authorized to provide TBIW services to the member, and the Fiscal/Employer Agency for self-directing members (if applicable) shall have appropriate access to member data and the ability to input data as needed.
i. The Vendor shall provide follow-up to all TBIW applicants to include contacting the applicant, legal representative and/or family to explain and assist with the application and enrollment processes.
6. The Vendor shall develop and maintain a secure web-based, electronic review request system for prior authorization and eligibility of TBI Waiver services that allows for data input by the submitting provider agencies. The Vendor's system shall have the following capabilities:
a. User roles requiring multifactor identification with functionality to be determined by the Agency to include but not limited to: Case Management Agency Administrator, Case Manager, Service Agency Administrator, Fiscal/Employer Agency Administrator, Fiscal/Employer Agency Resource Consultants, and State Agency Administrator.
b. Automated criteria/rules-based certification system.
c. The ability to process special requests (i.e., Member eligibility extensions) if/when needed.
d. The ability to identify and approve members that qualify for dual services - i.e., Waiver and Personal Care programs.
e. The ability to process member transfers between service delivery models and between traditional provider agencies.
f. The ability to process and export data via electronic data exchange files regarding member eligibility, member referrals, member budgets, member transfers and authorization information to provider agencies and the Fiscal/Employer Agency vendor.
g. The ability to issue notifications regarding member eligibility, referrals, transfers, service authorizations, etc., as appropriate to authorized users.
h. Export authorization information and TBIW attribute/benefit information to the state's claims payor.

i. Produce and/or analyze data for CMS and/or Agency reports at the request of the Agency at no additional cost to the Agency.
j. Manage and report data for various purposes, including but not limited to Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA) report and/or other Legislative reports, as needed.
k. Manage and report monthly to the Agency on CMS quality measures.
l. Produce monthly reports on active enrollees and managed enrollees.
m. Process requests for service authorizations within two (2) business days and in accordance with current policies.
n. Refer requests for self-directed services to the Fiscal/Employer Agent (F/EA) Vendor in accordance with current policies.
o. Calculate member assessment-based budgets that allow the member's case management agency, service agencies, and the Fiscal/Employer vendor for self-directed members (if applicable) to view the status of their authorization requests and input data as needed.
p. Export authorization and member eligibility data to the Online Case Management and integrated Incident Reporting/Management System (IMS).
q. Follow all applicable DHHR policies and court orders.
7. The Vendor shall have the capability to develop educational trainings to include Continuing Education Units (CEUs) for nurses, counselors and Licensed Social Workers and provide information and technical assistance, at no additional cost to the Agency, regarding policies, available services, service delivery models, and the choice between TBIW and institutional care for members, their legal representatives, families, provider agencies, stakeholders and the general community via email, telephone, webinars, etc. To include, but not limited to:
a. Participate in conference calls with providers, statewide trainings, and webinars at the request of the Agency.
b. Provide training and education on subjects requested by the Agency to the provider agencies.
c. Collaborate with other stakeholders in activities at the request of the Agency, i.e., program changes resulting in program policy changes.
d. Communicate program announcements to providers, members, and other stakeholders as necessary to include USPS if requested by the Agency, at no additional cost to the Agency.
e. Make recommendations and develop program forms upon request from the Agency.
f. Conduct general and specified community outreach to grow program enrollment at the request of the Agency.
g. Plan, advertise, and produce provider meetings up to four (4) times per year which will be either face-to-face or by virtual platform upon the request of the Agency to include hospitality and conference room rental if face-to-face. If virtual, the Vendor must use a platform that is accessible for large groups of providers.
h. Assist with planning and facilitate monthly virtual meetings/conference calls with provider agencies to include announcements, updates, and policy clarifications. Maintain written Frequently Asked Questions (FAQs) regarding TBIW policies and procedures and make the FAQs electronically available to stakeholders.
i. Develop and maintain a member handbook and a provider reference guide of all available Case Management and service providers and the services offered in each county. The handbook and reference guide are to be kept up to date and available to members electronically or in printed format upon request at no additional cost to the Agency.
8. In performing TBIW service determinations, the Vendor shall use nationally accredited, researched based criteria in reviewing each prior authorization and eligibility review request. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all TBI Waiver Program services reviewed under the resulting contract.
a. The Vendor shall maintain the capability to update as needed the review criteria for the authorization of TBIW services. The Vendor shall make recommendations regarding policies, procedures, and best practices related to authorization of TBIW services.

b. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria recommendations at the time of presenting the recommended changes.
c. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the term of the contract.
d. The Vendor is responsible for the cost associated with the purchase of any review criteria.
e. Represent the Agency at hearings regarding program eligibility and service authorization determinations.
9. The Vendor shall conduct quality assurance activities with members, families, case management and service agencies, the Fiscal/Employer Agency vendor, stakeholders, and the general community, as necessary and at the request of the Agency. All quality review tools/materials must be approved by the Agency in advance, including whether the reviews will be on-site, virtual or desk reviews. These activities shall include, but not limited to the following:
a. Notify the Agency of the schedule of the quality review cycle at least a quarter in advance.
b. Conduct initial and annual certification reviews of new and existing TBI Waiver providers to include on-site and desk review as requested by the Agency.
c. Conduct quality reviews of all TBI providers at to verify compliance with current policies, appropriate utilization management and documentation of authorized services. This includes, but is not limited to, notifying the provider agencies of reviews based upon timelines established by the Agency, identifying issues that potentially result in disallowances of provider agency claims payments and calculating the disallowance amounts. This review shall include providers with active/enrolled TBI Waiver members at the time of the specified review period. The findings of the quality reviews shall be verbally presented to the agency at the time of the review and provided in writing to the agency at the completion of the review. The Vendor will track the agency's Plan of Correction (when applicable).
d. Conduct a quality review of the self-directed program annually to verify compliance with current policies. The findings of the quality review shall be verbally presented to the Fiscal/Employer vendor at the time of the review and provided in writing to the vendor at the completion of the review. The Vendor will track the vendor's Plan of Correction (when applicable).
e. Conduct follow up reviews to monitor the implementation of approved Plans of Correction. Follow up reviews may be conducted on site or virtually six (6) months following the approval of the Plan of Correction or at a timeline specified by the Agency.
f. Provide the Agency with a monthly comprehensive report of findings of the quality reviews including identification of trends.
g. Manage and facilitate the TBI Quality Improvement Advisory (QIA) Council including quarterly meetings as needed to include travel expenses and overnight stays for members on the QIA Council if they live more than 60 miles away from the location of an in-person meeting. This is to include hospitality and conference room rental. These meetings may be face- to- face or by virtual platform as determined by the Agency. If virtual, the Vendor must use a platform that accommodates large groups. Large groups are defined as up to five hundred (500) participants.
h. The Vendor must have a full-time, in-state Program Manager for TBI program that will attend at least one (1) national conference at request of the Agency.
i. Conduct interviews of members annually using a mutually agreed upon sample of enrolled members. The Agency will determine the interview tool and whether the interviews will be face-to-face or by telephone.
j. Receive, track, triage or investigate complaints submitted by providers, members, or other stakeholders. Complaints will be reported to the Agency each month.
k. Perform daily monitoring of TBIW member incidents reported via the state's Incident Management System (IMS). Investigate critical incidents as needed to protect members' health and welfare. Provide monthly and quarterly reporting of incidents to the Agency.
l. Report and follow up with the DHHR Protective Services Unit when member abuse, neglect or exploitation is suspected.
m. Report suspected Fraud to the DHHR Office of Program Integrity (OPI) and follow-up as required with the Medicaid Fraud Control Unit.

n. Provide the Agency with a monthly comprehensive report on incidents and follow-up activities.
o. Make recommendations regarding enhancements to the IMS and assist with development of specifications and testing of the system as needed.
p. Provide ongoing technical assistance, at no additional cost to the Agency, to provider agencies and stakeholders upon request of the Agency via email, telephone, or other requested medium.
q. Manage and report monthly, during the regular monthly contract meeting, on the Centers for Medicare and Medicaid Services (CMS) quality measures.
r. Maintain current Freedom of Choice/Agency Selection forms.
s. Maintain a current provider agency register that includes services provided by each agency by county with provider agency contact information in the format to be determined by the Agency.
t. Manage and report on all sites owned, leased, or operated by TBIW providers where TBIW members reside and receive services to assure compliance with the CMS Integrated Settings Rule. This includes visiting new sites to ensure compliance prior to the member receiving services.
u. Maintain TBIW provider agency files, information, and reports related to agency certification, quality reviews, complaints, incidents, and other provider data.

We have served as the Operating Agency and Utilization Management Contractor for the Traumatic Brain Injury Waiver (TBIW) program in WV since its inception in November 2011. Since that time, we have worked for the Bureau developing protocols, providing training, assessing for medical eligibility, conducting reviews, facilitating quality councils, and many other tasks over the past 22 years. In 2022, we conducted a total of close to 400 TBIW reviews for West Virginia. Our past performance underscores our commitment to TBI Waiver program success:

- Kepro staff completed 99% of the Assessments of TBI Waiver members and applicants within the timelines as specified for the program in 2020.
- We conducted member outreach activities to increase knowledge of the TBI Waiver and increase enrollment of eligible Medicaid members.
- Member/applicant satisfaction with Kepro TBI Waiver program's assessor and the assessment process was 4.89 out of a possible 5 – Very Satisfied out of 78 Surveys conducted in 2020.

Additionally, we will seek qualified staff to conduct the initial and annual medical eligibility assessments for the TBI waiver program. Staff will be licensed in the State of West Virginia as a Social Worker, LPC, or RN. Staff hired pending his/her CBIS certification will be under the supervision of a licensed and Certified Brain Injury Specialist. Medical eligibility assessments will be reviewed and Level of Care (LOC) will be determined by the supervising staff, until the CBIS credentials are obtained. We are prepared to continue our work with the TBI Waiver program.

Figure 34 TBI Waiver Eligibility Determination and Managed Enrollment List – Applicant outlines the Traumatic Brain Injury Waiver eligibility determination and Medical Necessity Evaluation Request (MNER) process.

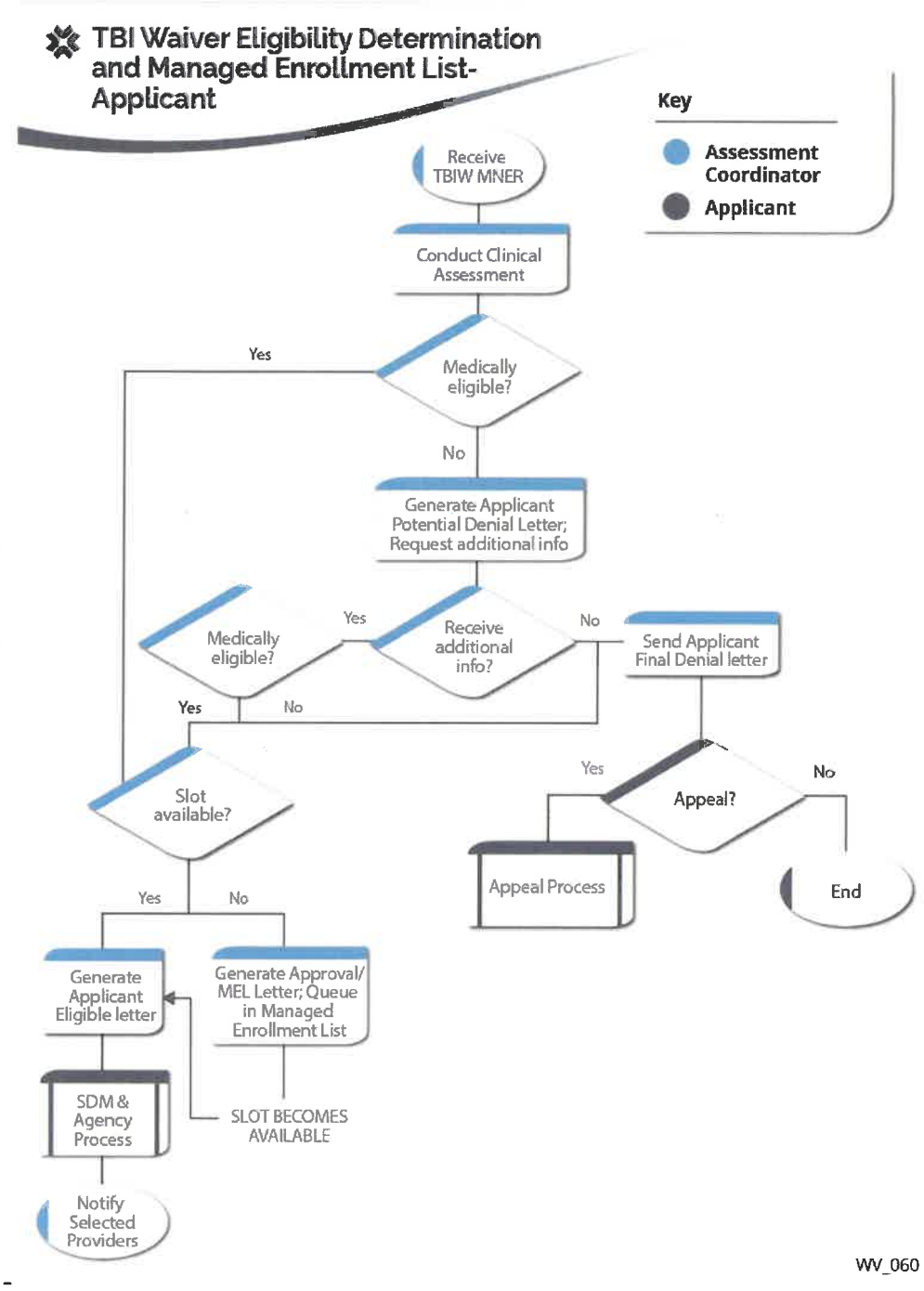


Figure 34. TBI Waiver Eligibility Determination and Managed Enrollment List - Applicant

Kepro's standardized process ensures we continually meet 100% timeliness with TBI Waiver contract requirements.

Exceeding Standards

Kepro's excellence in achieving client-prescribed review timeliness is evident across our West Virginia programs. **We achieved a timeliness rate of 100% in 2022 for our TBI Waiver program.**

The TBI Waiver Eligibility Determination and Managed Enrollment List process for the applicant begins upon receipt of a TBI Waiver request. At receipt, the clinical reviewer determines whether the applicant is medically eligible and, if so, the clinical reviewer then confirms that a slot is available to conduct the assessment using Pre-admission Screening and Rancho Level of Cognitive Functioning. If a slot is not available, the assessment is queued in the Managed Enrolled List (MEL) and the status is updated to "Applicant - MEL" until a slot becomes available. Once a slot is available, the status of the assessment is marked "Applicant Eligible," and the Team Lead sends the appropriate notification, including the chosen service delivery option and agency. Notifications are also sent to Medicaid and the chosen provider; at this time, the Service Delivery Model (SDM) and Agency process begins.

If it is determined that the applicant is not medically eligible, the status changes to "Applicant - Potential Denial." If the applicant submits additional information, the clinical reviewer will assess that information for medical eligibility and follow the process outlined above. If no additional information is submitted to support medical eligibility, the status changes to "Applicant Final Denial" and the clinical reviewer documents the close reason.

Upon status change to Applicant Final Denial, the applicant will be given the option to appeal. If the applicant appeals, the appeal and status is tracked through the Hearing Questionnaire. **Figure 35 TBI Waiver Service Request Process** outlines this process.

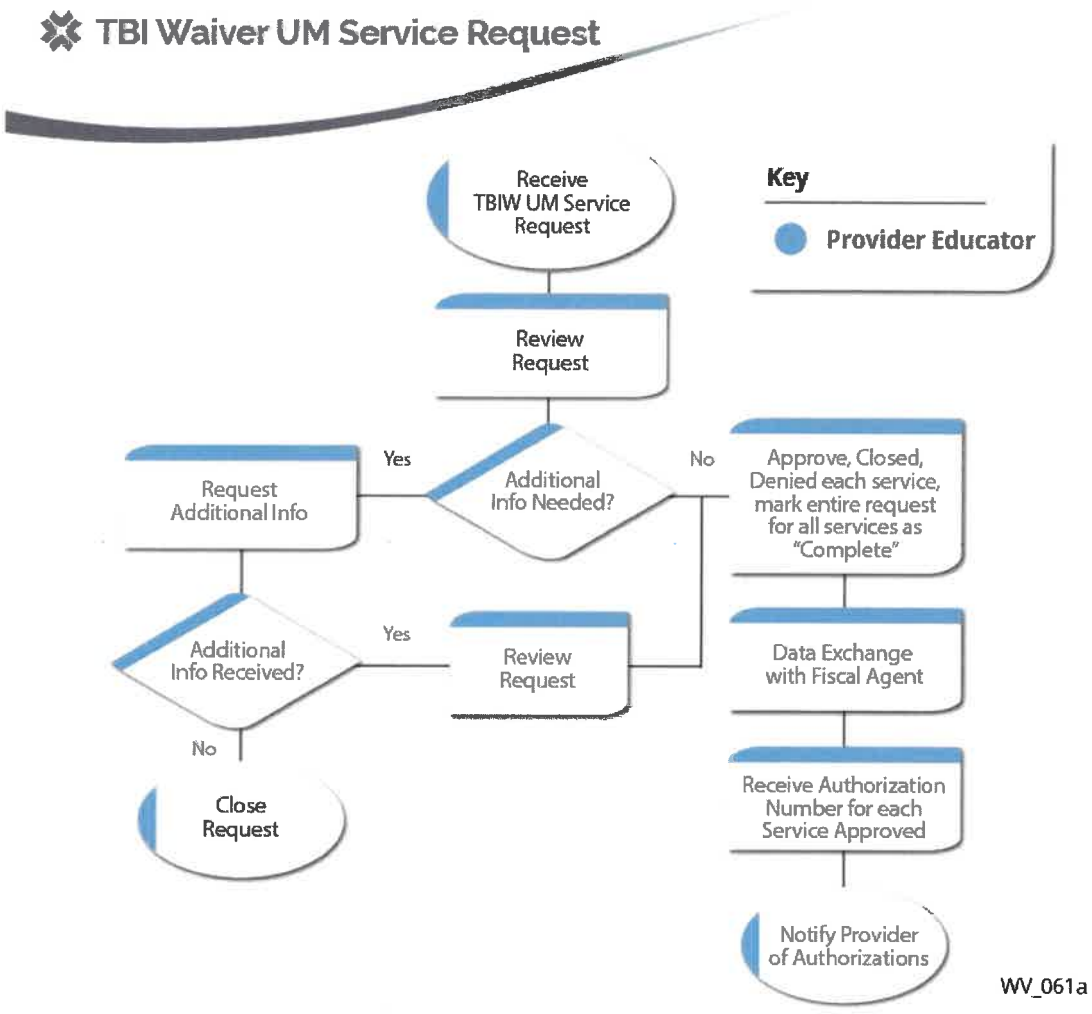


Figure 35. TBI Waiver UM Service Request Process

The TBI Service Request process is streamlined to ensure efficiency and clear authorization decisions.

A TBI Waiver service request can be initiated by an applicant, for a service request, or by a member for a Member - Active Status request. In either of these scenarios, the provider will submit the request and attach a treatment plan supporting the request. Upon receipt of the request and treatment plan, the clinical reviewer evaluates the information and renders a status for each service requested. The clinical reviewer determines whether additional information is needed to support the request; if so, the clinical reviewer enters a note in the system for the provider. If no additional information is needed, to approve, deny, or close the service requested, the clinical reviewer marks the status of each individual service line and once each line within a service request has one of the three statuses, the clinical reviewer marks the request "Complete" and sends the appropriate Notice of Determination. The system validates and helps enforce service limits and overall budget limits of $35,000 annually by imposing rules. If the request passes the rules

algorithm, the system will generate final authorization of all approved services. If the request does not pass the rules algorithm, the request will be sent back to a clinician for clinical review.

Initial and Reevaluation Request for Medical Evaluation

We propose a process of medical eligibility determination that is timely, equitable, person-centered, and includes relevant stakeholders in the determination process. Through this process, we document the member's initial and continuing medical eligibility for participation in the Waiver and provide notification to relevant parties to ensure a thorough understanding of the process as well as the member's Fair Hearing rights and process.

We receive daily referral requests for Waiver program assessment, including requests for either an initial or reevaluation. We process applications on a first-in, first-out basis. We conduct an initial screening of the application to ensure that it is complete, correct and includes all components necessary (such as within age requirements and has applicable diagnosis, etc.). We notify the applicant in the event additional information is required. Once the application is complete, we mail the applicant (with the Bureau's approved letter) and prompt them to obtain financial eligibility through their local DHHR office. At this time, they may also select a Case Management Agency to assist them with this task.

Once verification/approval of financial eligibility is received, we contact the member, establish a date, and time for the medical evaluation, abiding by policy related to contacts, appointments, notices, and other measures. If the assessments cannot be completed, we will discontinue the medical eligibility process and notify the relevant parties to reinitiate the process should they wish to pursue application.

A Certified Brain Injury Specialist (CBIS) conducts the initial and re-evaluation assessments. Initial assessments will be scheduled and completed within 45 days of receipt of financial eligibility approval. Reevaluation assessments will be completed at least 30 days prior to the member's established Anchor Date. These assessments include the Pre-Admission Screening (PAS) and the Rancho Los Amigos Scale pursuant to all Bureau prescribed instructions, guidelines, and program requirements. The CBIS reviews all pertinent physician's orders, assessments, and other documentation available during the assessment.

Exceeding Standards

During Fiscal Year 2022, our TBI Waiver Team completed 96.3% of annual determinations for medical eligibility at least 30 days prior to the member's anchor date, exceeding the 95% deliverable standard.

We make every effort to complete assessments within the timeline. When an assessment cannot be completed within the timeline due to unforeseen circumstances, such as inclement weather or member cancellation, we track and report on the reasons for inability to complete within the designated timeline. Once the assessment is completed, the CBIS submits the evaluations. We then run the data from the assessment through a computerized algorithm based on current program policy and establish a determination of medical eligibility. We notify the member/legal

representative of the outcome of the assessment. We provide a copy of the assessment, and the member/legal representative may provide additional information in the event the determination results in a denial of eligibility. Members are notified of Fair Hearing rights in the event of a denial. Additional information will be considered if received, and a new determination may be made.

If a member is ultimately eligible, we notify all parties. Members who are eligible when no Waiver slot is available will be placed on a managed enrollment list. When there is no managed enrollment list, the provider agency will be prompted to complete and submit a Service Plan.

Authorization

The member's Service Planning team using information from the assessments as well as information about the member's preferences will prepare the member service plan. This service plan will be documented in our information system when complete. We then review the plan to ensure assessed needs have been considered, the member has been involved in the decision-making, and other issues such as medical care, health, and safety have been addressed. We will then review the service plan and provide authorizations to the fiscal system so that the provider can submit claims. We will notify the member and provider when services have been authorized. A budget amount per member will be established based on the total cost of the services deemed necessary by assessment and the Service Plan team. No budget amount may exceed $35,000 per existing policy.

Managed Enrollment

When no slot is available, we will place those applicants determined medically eligible on the TBI Waiver Managed Enrollment List. When a funded slot becomes available, we will prepare correspondence to the eligible applicant/legal representative informing them we will contact them for an assessment and instructing them to obtain financial eligibility at their local DHHR (if it has expired from previously acquiring). Only after the member is determined both medically and financially eligible will Kepro enroll the new program member.

TBI Waiver System

Atrezzo will comply with all security requirements and will incorporate the ability for providers to request authorizations, generation of authorizations and TBI Waiver attribute information to be exported to the claims payor. Atrezzo will serve as a database from which we will produce data for state and federal reporting, including information required for the Hartley Court Monitor. The system will incorporate a Service Delivery Model module through which requests for self-directed services can be referred to the Fiscal/Employer Agent vendor.

Atrezzo also provides secure and accessible access to all users for the submission of requests for authorization. Our portal is 508 compliant and meets security standards required by HIPAA and NIST. Access to our portal requires users' credentials (ID and password) as well as multi factor

authentication and the site is protected with TLS encryption (TLS 1.2 minimum). To ensure Section 508 compliance, our site is re-tested for compliance prior to all updates.

Training and Technical Assistance

During our existing and previous contract, we have been instrumental in developing training for the Bureau related to policy, available services, service delivery models, the choice between TBI Waiver and institutional care, and other relevant topics. We orient training toward multiple audiences, including members, families, agencies, advocacy groups, and others. Training evaluations consistently document high degrees of satisfaction with training our staff conduct.

Did You Know?

2022 Survey Feedback indicated that that 98% participants strongly agreed that our training better prepared them to perform their job.

- We will continue to plan, advertise, and produce statewide training and webinars at the request of the Bureau. We will advertise electronically using an established email distribution list, which includes numerous stakeholders involved in the TBI Waiver program.
- We will host a TBI Waiver Quarterly provider Meeting up to 4 times per year at the request of the Bureau, which will include conference room rental and refreshments for attendees.
- We have already developed an approved training on recognizing and reporting abuse, neglect and exploitation or other critical incidents. We will continue to train on this topic and make the training available to providers (so they can train new staff) at the Bureau's request.
- We will continue to collaborate with the TBI Fund Board and other stakeholder activities to remain current with issues related to the program and the population served in general.
- We will continue to develop and make available the TBI Waiver Program Handbook and a reference guide of available providers/services that we will make available to members during their annual functional assessments.
- Using the established email distribution list, we will continue to communicate program announcements to providers, members, and stakeholders on behalf of the Bureau.
- We will continue to participate in conference calls with providers, trainings, and webinars.
- We will continue to develop program forms and make recommendations to meet the needs of the program best.
- We will continue to conduct general community and specified outreach to grow program enrollment.

Additionally, we will develop educational training for TBIW providers regarding policy, available services, service delivery models, and any other topics requested by the Bureau for Medical Services. We will provide CEUs for RNs, counselors and Licensed Social Workers developed in conjunction with the Bureau for Medical Services. We use RNs to assist in developing topic specific CEUs, which are also in compliance with Board of Nursing and Social Work education requirements.

We provide technical assistance as requested by individual providers or to all TBIW providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide

training and webinars as requested by the Agency and communicate announcement of the training to providers. We will participate in and conduct training for members and other stakeholders as requested by the Agency. We also participate in conference calls at the request of the Agency.

Review Criteria

As directed by current policy, we have administered the Pre-Admission Screening (PAS) and Rancho Los Amigos Scale since 2012 to determine program medical eligibility. Our new staff administering these assessments undergo a comprehensive orientation program where they are trained (classroom style), observe a seasoned staff for a minimum of two assessments, and are observed/assisted by a seasoned staff for a minimum two assessments. Orientation of new staff lasts approximately 2 weeks, but can last up to a month, depending on the new staff's previous experience with the program, comfort level with conducting assessments, and performance.

Did You Know?

In 2022, we conducted four CEU approved training sessions focused on Person Centered Planning and Approach to Service Delivery Training.

We have developed interpretive guidelines for all program eligibility assessments administered and will submit to the Bureau upon request. We continually conduct inter-rater reliability activities with staff and updates interpretive guidelines as necessary. We will present any updates to the Bureau as recommendations for approval. We base all services approved upon nationally accredited, research-based criteria with a clinically sound basis in the Agency-approved manual or automated review of each prior authorization request or eligibility review.

In 2015, we made recommendation for updated policy related to administering eligibility assessments necessary when adding children as a target population for the program. We researched available criteria, found a children's version of the Rancho Los Amigos and made recommendation for appropriate levels to consider for eligibility. We also made recommendation for incorporating age-appropriate milestones when capturing PAS functional abilities. The Bureau evaluated and approved all recommendations prior to implementation. We will continue to research and make recommendation about forms, policy, procedures, and best practice as related to the program.

Quality Assurance Activities

We will continue to conduct quality assurance activities with members, families, agencies, stakeholders, and the general community. Quality assurance and improvement is a core tenant of our healthcare philosophy and business practice. We tackle quality with a holistic approach and constantly seek out opportunities to improve quality within and outside the organization; ultimately with effort to improve the quality of services to members served. With this, we will continue to provide ongoing technical assistance at the request of the Agency. We will report monthly on the Centers for Medicare and Medicaid Services quality measures report. We will monitor our own performance and service quality.

Initial and Continued Certification Reviews

A strong community of well-credentialed and qualified providers is a key component of achieving the goals of the TBI Waiver. Just as important is a rigorous quality assurance and improvement process that identifies provider needs and responds with training and technical assistance programs. Our plan to certify prospective TBI Waiver providers builds on the criteria established in the Bureau's Waiver application as well as our experience with waiver management and provider reviews in West Virginia and other states.

Did You Know?

Our team was **100% compliant** annually reviewing each TBIW provider in Fiscal Year 2022.

The provider certification process begins with an interested provider requesting an application from us. We will send a packet of information to prospective providers that include the Certification Application and Chapter 512 Manual Sections provider Certification and Covered Services.

We must certify all provider agencies. Following the receipt of a completed Certification Application (Initial), we conduct an onsite review if required, to verify that the prospective provider meets certification requirements. This requirement may be waived if the prospective provider is a current LBHC or is enrolled as an ADW, PC, or IDDW provider at the time of application.

We notify BMS' fiscal agent upon satisfactory completion of the onsite review or verification of LBHC, ADW, PC or IDDW status. BMS' fiscal agent will provide the provider applicant with an enrollment packet, which includes the TBIW provider Agreement. BMS fiscal agent sends a letter to the provider and Kepro, informing the certified provider agency it may begin providing and billing for TBIW services. There are three possible determinations that may result from the review process:

- **Full Certification** – We will notify the provider, the Bureau, and the fiscal agent that the provider has been certified to deliver services as of a specific date. The provider will be added to the Agency Selection forms, which we will maintain per county.
- **Provisional Certification** – Provisionally certified providers will be requested to develop a Plan of Correction that addresses deficiencies identified during review. After the plan has been received and reviewed, we will schedule a follow-up review to identify the extent to which providers have implemented the plan of correction. If successful, providers will then be fully certified.
- **Not certified** – For providers that are not certified, we will provide notification in writing with an explanation of the rationale for our certification determination. providers may then reapply after a period of time that we will establish in collaboration with the Bureau.

All providers with an enrolled member will be required to participate in an on-site certification validation and quality review annually. We will continue with notices, as approved by the Bureau, and will begin the on-site validation review with an entrance interview. We will tour the premises to evaluate compliance with ADA and HIPAA compliance complete with digital verification. We will

review documentation (written policies and procedures, competency-based curriculum, personnel files, the quality management plan, the organization chart, and the list of Board of Directors.

Upon completion, we conduct an exit interview to communicate preliminary findings of the review, allow providers to submit any additional documentation, and deliver technical assistance/training as necessary for any deficient areas. Within the Bureau's established timeline, we will finalize and submit completed reports.

On-site Quality Reviews

We began conducting TBI Waiver provider reviews in 2013. We used the reviews as an opportunity to educate all TBI Waiver providers about utilization management, proper documentation of a person-centered plan and services, and incorporation of assessment results into plans. The current on-site provider review tool (developed by us and approved by the Bureau) is easily adapted to capture new quality/performance measures, new services, and new policy.

Exceeding Standards

In Fiscal Year 2022, our TBI Waiver Team completed 100% of initial medical eligibility determinations within 45 calendar days of an approved DHS-2, exceeding the 95% deliverable standard.

We will conduct on-site quality reviews of TBI Waiver providers annually. We will provide the Bureau with the schedule of upcoming reviews a quarter in advance. During this review, we will verify compliance with current state and federal policy guidelines and appropriate utilization management and documentation of authorized services. We will continue with the imperative technical assistance component of the review so that provider can continue to grow their knowledge and understanding of policy and requirements.

We will provide comprehensive draft reports within 10 days of the review to the Bureau and to the provider. These reports will include the Review and Disallowance Reports along with the Plan of Correction. The provider will have up to 30 days to respond to their draft reports. Upon receipt and reconciliation of the provider's response, we will prepare and send all components to the Bureau for final consideration. We will work with the provider until they have an approvable Plan of Correction. We will participate in Review Committee where the Bureau, the Office of Program Integrity, and we will discuss final disallowance amounts. We will prepare the final reports for the Bureau to disseminate to the provider.

We are eager to incorporate a follow-up review of providers who must submit a Plan of Correction after unsatisfactory findings during an on-site review. We believe this is imperative to improving the overall quality of services for our members. Depending on the severity of unsatisfactory findings, we will conduct either a desk or on-site visit of the provider to verify they did implement their Plan of Correction as agreed.

Quality Improvement Advisory Council

On-site provider review findings are an integral way of capturing statewide quality and performance management data as necessary for the CMS reports. We will share cumulative review findings with the Quality Improvement Council. We facilitate meetings of this council quarterly, the purpose of which is to advise the Bureau on program related matters and concerns. We will fund travel expenses for Medicaid members on the council when that member lives greater than 60 miles from the venue and they request reimbursement. To enhance program and disability-related knowledge, we will send a TBI Waiver staff to a national conference at the request of the Bureau.

Participant Experience Survey

We will continue to conduct the Participant Experience Survey with a representative sample of program members annually. We have consistently conducted this survey for TBI Waiver services since 2012 and plan to continue compiling, analyzing, and presenting data from the survey to the Bureau to continually evaluate member experience and improve program quality.

Complaints

We receive, review, track, trend, and/or investigate complaints submitted by providers, members or other stakeholders related to a program member's service(s) through a TBI Waiver provider. We follow a consistent procedure in responding to complaints and reporting to BMS on trends and outcomes. We take each complaint seriously and use it as an opportunity for improvement and technical assistance.

We can receive complaints either verbally or in writing (email or fax). Upon receipt of a formal complaint, we document the complaint and request any necessary information for follow-up. If the issue cannot be resolved over the phone through technical assistance and information and referral, we will investigate the complaint and/or make referrals to appropriate entities.

We inform the complainant of procedures in following a chain of command at the provider agency. Every TBI Waiver provider is required to have a grievance/complaint procedure. It is required that each agency inform program members/legal representatives of this procedure. We will request information about steps taken thus far to resolve the complaint at the Agency level. These steps may include notifying the Case Manager, Waiver Supervisor or accessing the Agency's grievance/complaint procedure. It is not necessary for members to exhaust steps at the Agency level; they may make a direct complaint to us at any time.

- If we suspect that someone is abusing, neglecting, or exploiting the program member, our team will assist the member to make a referral to Adult or Child Protective Services. If the complainant cannot or will not make this referral, we will do so.
- If we suspect a provider agency is not following procedures consistent with certification, we will conduct an on-site or desk review to evaluate compliance.

- If we suspect a provider or agency is billing for and receiving payment for services inappropriately, we will refer to and/or work with the Medicaid Fraud Control Unit (MFCU) through a referral to the Office of Program Integrity (OPI) at BMS to investigate the issue.
- We may receive anonymous complaints. If the complaint contains enough information to follow up, we will do so. If there is no way to follow up based on the information provided, we will log the complaint and indicate insufficient information for action. If complainants request anonymity, we will notify them it may not be possible to follow up on the complaint.
- If we suspect the topic of complaint is systemic, we may request additional information to determine the extent of the complaint.
- When we investigate, we will notify the provider agency of the complaint if doing so will not compromise the integrity of the investigation or put a program member at risk.
- When appropriate, we may utilize the provider agency's internal investigation system to acquire necessary information. In this event, we will request the Agency forward specific information for we to conduct a desk review.
- When appropriate, we may conduct an on-site investigation at the provider agency after consultation with BMS.
- Our team may investigate matters related to TBI Waiver policy manual compliance. For those matters in which the TBI Waiver policy manual overlaps with Adult Protective Services/Child Protective Services or OPI, our team will work with applicable parties or make referrals, as appropriate.

Our team will initially respond either verbally or in writing to formal complaints within two business days. We will respond to complaints in a manner that is the least intrusive approach. Follow-up may require a request for information, interview with staff, the program member/legal representative or other applicable parties and/or an on-site visit.

Incident Management System

At the request of the Bureau, we have participated in development meetings related to the upcoming release of the Incident Management System. Once available, we will assist the Bureau with system testing until it is in production. Our vast experience with developing and testing our own systems will prove invaluable. Since the program's inception, our team has been tracking incidents manually. Once the system is available, we will provide daily monitoring, monthly reporting, and quarterly reporting, as necessary.

Fraud, Waste, Abuse Referral

If we suspect fraud, waste, and/or abuse, we refer our suspicions to the Bureau's Office of Program Integrity (OPI).

Monthly Reporting

We will provide the Agency with monthly comprehensive reporting of findings of the quality reviews including identification of trends during the regular monthly contract meeting, on the Centers for Medicare and Medicaid Services. We prioritize transparency and consistent communication throughout the life of the contract. Our team regularly reports on:

Exceeding Standards

In Fiscal Year 2022, our TBI Waiver final reports on annual provider reviews were 100% accurate, exceeding our 95% deliverable standard.

- **TBIW providers:** Manage and report on all sites owned, leased, or operated by TBIW providers where TBIW members reside and receive services to assure compliance with the CMS Integrated Settings Rule. This includes visiting new sites to ensure compliance prior to the member receiving services.
- **TBIW Monthly Activity Report:** We provide a monthly reporting on the eligibility cases our team has reviewed as well as associated outreach activities.
- **TBIW Enrolled Members:** This monthly report updates the state on the number of actively enrolled members.
- **Meeting Agendas/Minutes:** As part of meeting preparation, our team will prepare and distribute agendas and materials as well as prepare meeting minutes for all Kepro-led or WV DHHR-requested meetings and distribute to the meeting participants.
- **Incident Reports:** On a monthly basis our team will provide reporting on incidents resolved in the previous two-week period.

In addition, we maintain the various documents and forms as required by the state, including:

- Current Freedom of Choice/Agency Selection forms
- Current provider agency register that includes services provided by each agency by county with provider agency contact information in the format to be determined by the Agency.
- TBIW provider agency files, information, and reports related to agency certification, quality reviews, complaints, incidents, and other provider data

A1.1.n. Intellectual and Developmental Disabilities Waiver (IDDW) Services

1. The Agency covers services for individuals that meet initial and annual medical eligibility requirements for the IDD Waiver Program.
As a condition for reimbursement, the Agency requires that the Vendor prior authorize all IDDW services in accordance with current policies.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, Plans of Care, assessments, and other forms or documentation required for determining member eligibility/re-eligibility and prior authorization of IDDW Program services. Authorization(s) must be specific to the member, provider agency, service code, units, start and end date. The units, start and end dates in the authorizations may subsequently be modified/edited as necessary.
3. The Vendor shall have the capability to manage applications and referrals for determining the initial eligibility and annual eligibility determinations of IDDW program members by qualified staff and correspondence

to all applicable parties, to include certified mail when requested by the Agency, within fourteen (14) calendar days of referral. All correspondence regarding member eligibility shall be approved by the Agency and any changes requested by the Agency shall be completed within fourteen (14) calendar days.

a. Initial Assessments: The Vendor shall have the capability and established procedures to ensure tracking of all initial applications and determining medical eligibility in accordance with current policies.

These procedures include confirmation of financial eligibility within established policy timelines and the release of funded slots.

b. Annual Assessments: The Vendor shall have the capability and established procedures to conduct annual redeterminations of medical eligibility of all members in accordance with current policies. Eligibility redeterminations shall be made no more than ninety (90) calendar days but at least thirty (30) calendar days prior to the member's annual anchor date.

c. Applicant/Member Education: The Vendor shall provide education to all applicants/members regarding program eligibility, choice of service delivery models, choice of providers and services, member rights and responsibilities including safe service delivery environments and the identification and reporting of abuse, neglect, and exploitation.

d. The Vendor shall have the capability and established procedures for maintaining the thirty (30) calendar day minimum timeline for conducting annual re-evaluations when appointments are canceled/rescheduled by the Vendor or member.

e. Managed enrollment: The Vendor shall have the capability and established procedures to determine initial and annual medical eligibility; confirm financial eligibility; and manage the enrollment list (waitlist) in accordance with current policies.

f. Enrollment/Activation: The Vendor shall have the capacity and established procedures to track the applicant from the time of application, financial eligibility, medical eligibility, and enrollment/activation until the applicant has been determined eligible and fully active in the IDDW program. This will require interfacing with the local DHHR for financial eligibility updates.

g. The Vendor shall have the capability and established procedures to calculate member assessment-based budgets at least annually or more often if a change in need occurs and make the budget amount available to the assigned Case Management Agency, service Agency(s) and fiscal agent for self-directing members (if applicable) in accordance with current policies.

h. Maintain electronic health record: The Vendor shall maintain an electronic health record of all IDDW members and applicants. The Agency, the member's Case Management agency, other agencies authorized to provide IDDW services to the member, and the Fiscal/Employer vendor for self-directing members (if applicable) shall have appropriate access to member data and the ability to input data as needed.

i. The Vendor shall provide follow-up to all IDDW applicants to include contacting the applicant, legal representative and/or family to explain and assist with the application and enrollment processes.

4. The Vendor shall develop and maintain a secure web-based, electronic review request system for prior authorization and eligibility of IDDW services that allows for data input by the submitting provider agencies. The Vendor's system shall have the following capabilities:

a. User roles requiring multifactor identification with functionality to be determined by the Agency to include but not limited to: Case Management Agency Administrator, Case Manager, Service Agency Administrator, Fiscal/Employer Agency Administrator, Fiscal/Employer Agency Resource Consultants, and State Agency Administrator.

b. Automated criteria/rules-based certification system.

c. The ability to process special requests (i.e., Member eligibility extensions) if/when needed.

d. The ability to identify and approve members that qualify for dual services - i.e., Waiver and Personal Care programs.

e. The ability to process member transfers between service delivery models and between traditional provider agencies.

f. The ability to process and export data via electronic data exchange files regarding member eligibility, member referrals, member budgets, member transfers and authorization information to provider agencies and the Fiscal/Employer Agency vendor.

g. The ability to issue notifications regarding member eligibility, referrals, transfers, service authorizations, etc., as appropriate to authorized users.
h. Export authorization information and IDDW attribute/benefit information to the state's claims payor.
i. Produce and/or analyze data for CMS and/or Agency reports at the request of the Agency at no additional cost to the Agency.
j. Manage and report data for various purposes, including but not limited to Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA) report and/or other Legislative reports, as needed.
k. Manage and report monthly to the Agency on CMS quality measures.
l. Produce monthly reports on active enrollees and managed enrollees.
m. Process requests for service authorizations within two (2) business days and in accordance with current policies.
n. Refer requests for self-directed services to the Fiscal/Employer Agent (F/EA) Vendor in accordance with current policies.
o. Calculate member assessment-based budgets that allow the member's case management agency, service agencies, and the Fiscal/Employer vendor for self-directed members (if applicable) to view the status of their authorization requests and input data as needed.
p. Export authorization and member eligibility data to the Online Case Management and integrated Incident Reporting/Management System (IMS).
q. Follow all applicable DHHR policies and court orders.

5. The Vendor shall have the capability to develop educational trainings to include Continuing Education Units (CEUs) for nurses, counselors and Licensed Social Workers and provide information and technical assistance, at no additional cost to the Agency, regarding policies, available services, service delivery models, and the choice between IDDW and institutional care for members, their legal representatives, families, provider agencies, stakeholders and the general community via email, telephone, webinars, etc. To include, but not limited to:
a. Participate in conference calls with providers, statewide trainings, and webinars at the request of the Agency.
b. Provide training and education on subjects requested by the Agency to the provider agencies.
c. Collaborate with other stakeholders in activities at the request of the Agency, i.e., program changes resulting in program policy changes.
d. Communicate program announcements to providers, members, and other stakeholders as necessary to include USPS if requested by the Agency, at no additional cost to the Agency.
e. Make recommendations and develop program forms upon request from the Agency.
f. Conduct general and specified community outreach to grow program enrollment at the request of the Agency.
g. Plan, advertise, and produce provider meetings up to four (4) times per year which will be either face-to-face or by virtual platform upon the request of the Agency to include hospitality and conference room rental if face-to-face. If virtual, the Vendor must use a platform that is accessible for large groups of providers.
h. Assist with planning and facilitate monthly virtual meetings/conference calls with provider agencies to include announcements, updates, and policy clarifications. Maintain written Frequently Asked Questions (FAQs) regarding IDDW policies and procedures and make the FAQs electronically available to stakeholders.
i. Develop and maintain a member handbook and a provider reference guide of all available Case Management and service providers and the services offered in each county. The handbook and reference guide are to be kept up to date and available to members electronically or in printed format upon request at no additional cost to the Agency.

6. In performing IDDW service determinations, the Vendor shall use nationally accredited, researched based criteria in reviewing each prior authorization and eligibility review request. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all IDDW Program services reviewed under the resulting contract.

a. The Vendor shall maintain the capability to update as needed the review criteria for the authorization of IDDW services. The Vendor shall make recommendations regarding policies, procedures, and best practices related to authorization of IDDW services.
b. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria recommendations at the time of presenting the recommended changes.
c. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the term of the contract.
d. The Vendor is responsible for the cost associated with the purchase of any review criteria.
e. Represent the Agency at hearings regarding program eligibility and service authorization determinations.
7. The Vendor shall conduct quality assurance activities with members, families, case management and service agencies, the Fiscal/Employer Agency vendor, stakeholders, and the general community, as necessary and at the request of the Agency. All quality review tools/materials must be approved by the Agency in advance, including whether the reviews will be on-site, virtual or desk reviews. These activities shall include, but not limited to the following:
a. Notify the Agency of the schedule of the quality review cycle at least a quarter in advance.
b. Conduct initial and annual certification reviews of new and existing IDDW providers to include on-site and desk review as requested by the Agency.
c. Conduct quality reviews of all IDDW providers at to verify compliance with current policies, appropriate utilization management and documentation of authorized services. This includes, but is not limited to, notifying the provider agencies of reviews based upon timelines established by the Agency, identifying issues that potentially result in disallowances of provider agency claims payments and calculating the disallowance amounts. This review shall include providers with active/enrolled IDDW members at the time of the specified review period. The findings of the quality reviews shall be verbally presented to the agency at the time of the review and provided in writing to the agency at the completion of the review. The Vendor will track the agency's Plan of Correction (when applicable).
d. Conduct a quality review of the self-directed program annually to verify compliance with current policies. The findings of the quality review shall be verbally presented to the Fiscal/Employer vendor at the time of the review and provided in writing to the vendor at the completion of the review. The Vendor will track the vendor's Plan of Correction (when applicable).
e. Conduct follow up reviews to monitor the implementation of approved Plans of Correction. Follow up reviews may be conducted on site or virtually six (6) months following the approval of the Plan of Correction or at a timeline specified by the Agency.
f. Provide the Agency with a monthly comprehensive report of findings of the quality reviews including identification of trends.
g. Manage and facilitate the IDDW Quality Improvement Advisory (QIA) Council including quarterly meetings as needed to include travel expenses and overnight stays for members on the QIA Council if they live more than 60 miles away from the location of an in-person meeting. This is to include hospitality and conference room rental. These meetings may be face- to- face or by virtual platform as determined by the Agency. If virtual, the Vendor must use a platform that accommodates large groups. Large groups are defined as up to five hundred (500) participants.
h. The Vendor must have a full-time, in-state Program Manager for the IDDW program that will attend at least one (1) national conference at request of the Agency.
i. Conduct interviews of members annually using a mutually agreed upon sample of enrolled members. The Agency will determine the interview tool and whether the interviews will be face-to-face or by telephone.
j. Receive, track, triage or investigate complaints submitted by providers, members, or other stakeholders. Complaints will be reported to the Agency each month.
k. Perform daily monitoring of IDDW member incidents reported via the state's Incident Management System (IMS). Investigate critical incidents as needed to protect members' health and welfare. Provide monthly and quarterly reporting of incidents to the Agency.

l. Report and follow up with the DHHR Protective Services Unit when member abuse, neglect or exploitation is suspected.
m. Report suspected Fraud to the DHHR Office of Program Integrity (OPI) and follow-up as required with the Medicaid Fraud Control Unit.
n. Provide the Agency with a monthly comprehensive report on incidents and follow-up activities.
o. Make recommendations regarding enhancements to the IMS and assist with development of specifications and testing of the system as needed.
p. Provide ongoing technical assistance, at no additional cost to the Agency, to provider agencies and stakeholders upon request of the Agency via email, telephone, or other requested medium.
q. Manage and report monthly, during the regular monthly contract meeting, on the Centers for Medicare and Medicaid Services (CMS) quality measures.
r. Maintain current Freedom of Choice/Agency Selection forms.
s. Maintain a current provider agency register that includes services provided by each agency by county with provider agency contact information in the format to be determined by the Agency.
t. Manage and report on all sites owned, leased, or operated by IDDW providers where IDDW members reside and receive services to assure compliance with the CMS Integrated Settings Rule. This includes visiting new sites to ensure compliance prior to the member receiving services.
u. Maintain IDDW provider agency files, information, and reports related to agency certification, quality reviews, complaints, incidents, and other provider data.

In the 12 years that we have served as WV DHHR's Operating Agency and Utilization Management contract for the Intellectual and Developmental Disabilities (IDD) Waiver program, our team has proven our successes and commitment to West Virginia members. Since stepping in as UM contractor in 2010, and in working on various IDD Waiver program elements in the several years prior, we have established itself as a reliable organization with a deep knowledge of our stakeholders and how best to serve them. In 2022 alone, we conducted a total of nearly 42,000 IDD Waiver reviews for West Virginia.

Since program initiation, we have worked diligently to conduct member annual functional assessments, as well as provider reviews. Satisfaction rates continue to be high for both, as evidenced by the data below:

- ✓ In 2018, the satisfaction rate for the 7,764 returned surveys was 100%.
- ✓ In 2019, the satisfaction rate for the 4,324 returned surveys was 100%.
- ✓ In 2020, the satisfaction rate for the 1,234 returned surveys was 100%. Rate of return declined significantly due to the global pandemic and resulting need to conduct services remotely.
- ✓ In 2021, the satisfaction rate for the 936 returned surveys was 100%. Rate of return further declined due to the global pandemic and resulting need to conduct services remotely.
- ✓ In 2022, the satisfaction rate for the 975 returned surveys was 100%.

Our successful program management of IDD Waiver services has included numerous achievements that have benefited both the State and West Virginia members and highlighted our adaptability to changing needs:

Eliminating Managed Enrollment List – Kepro was instrumental in accomplishing West Virginia's goal of clearing the managed enrollment list for IDD Waiver Services in January 2020. Our team was able to streamline program operations and simultaneously ensure existing member needs were addressed when our personnel released 1,068 slots to waiting members and overall decrease the average wait time to receive a slot. We provided considerable resources and effort, including close coordination with program stakeholders, to carry out this strategy.

Did You Know?

Since Kepro's intervention, the managed enrollment list has significantly diminished and we have reduced average wait times to approximately 6 months to 1 year, a dramatic decrease from the program's previous average wait times of almost 5 years.

Prior to releasing the more than 1,000 slots, the average wait time for individuals on the managed enrollment list was 4.5 years before receiving IDD services. To remedy this situation, our approach was measured: our team coordinated closely with program stakeholders to release approximately 250 slots to individuals over the course of four months. As program volumes typically released a maximum of 150 slots in a one-month period, releasing 250 slots for four consecutive months posed a significant departure from program standards. Awarding slots over the course of months also helped minimize the strain on our provider network and ensured that sufficient resources were available to members.

We saw an opportunity to improve member experience and identified the appropriate solution; we engaged West Virginia program stakeholders to roll out slots in a measured and sustainable manner that would ensure members received necessary services, while providers had the capacity to meet program demands.

Patient Safety Initiative for ISS/GH Program – Per question 12 of Amendment 2, we understand that Intensively Supported Settings and Group Homes (ISS/GH) Health and Welfare Check Assessments will be part of the new contract's scope of work. As described in this section and as the incumbent vendor currently providing these services, we fully understand this scope and the staff and processes needed to deliver these services. In September 2021 we collaborated with West Virginia to implement a Safety Initiative for members in ISS/GH. We work with the State's incident management system to audit program reports and ensure provider compliance with ISS/GH reporting requirements. Our audit measures include review of personnel files to ensure all staff who work in these settings are qualified to do so, completion of the provider-Controlled HCBS on-site and service plan assessments, health and welfare, and service environment review for more than 1,200 members living in an ISS or GH. Our compliance audits also included a review of provider adherence to program protocols, which entails on-site visits to member homes as well as having a registered nurse review and monitor medication lists. In implementing this program Kepro partnered with West Virginia to design the metrics and indicators monitored within the incident management system, that will most effectively point to shortfalls in patient safety measures.

The nursing staff, who primarily conduct the reviews, have been through extensive, specialized training in order to conduct these reviews and have been integral in developing materials and the process. Additionally, we have two foremost experts on the IDD Waiver program leading this initiative.

Once deficits have been discussed with the provider, we develop a draft Plan of Compliance (POC) based on findings. This Plan of Care is forwarded to the provider and is their opportunity to put together an acceptable plan for addressing the deficits. We review these POCs until they can be approved.

Our team has also incorporated provider education as part of the Patient Safety Initiative. We provide education throughout each review that we conduct. Recent education initiatives have centered on HCBS Integrated Settings requirements, which are new to both members and providers. We provide a general overview of the requirements to members, providers, and staff alike to ensure that all stakeholders are knowledgeable of the roles they play in the process.

IDD/Waiver Expertise

Kepro's work with IDD Waiver services plays a significant role serving West Virginians. Kepro has accomplished the following:

- Released 1,068 slots in accordance with Governor's order
- 67,206 authorized service lines in 2022
- 26,379 documentation requests in 2022
- 13,021 service modifications requested in 2022
- 6,109 assessments in 2022

We also provide general education to staff outside of HCBS reviews. For example, we train staff on reviews that verify whether medications have been administered properly. If we observe that an agency is deficient in this area, we require the overseeing nurse to be present at the exit so that the individual remains abreast of the requirements. Any other areas in which we have identified a deficiency in provider knowledge are handled as such: once we identify the concern Kepro develops a training program and ensures all relevant stakeholders receive appropriate and thorough instruction. Our team also makes our staff available to assist with any questions regarding requirements and remedying deficiencies.

COVID-19 Response – Kepro responded swiftly and efficiently to adjust IDD Waiver services following the onset of COVID-19. All face-to-face aspects of the program, including in-home evaluations and in-person treatment settings, were halted for the safety of members and staff alike. To ensure that members experienced limited disruptions to services, we assisted WV DHHR in enhancing communication across all stakeholders. We held weekly phone conferences with providers to convey Agency communications regarding eased regulations for home visit requirements and face-to-face requirements and any other in-person aspect of the Waiver program. We facilitated up to the moment changes to such regulations, which ensured that providers were informed and could continue to serve members under pandemic guidelines. Our enhanced communication continues to the present day, as the Agency relies on our team to facilitate changes in the regulation landscape, as the COVID-19 pandemic winds down.

Our communication with providers regarding American Rescue Plan Funds, and the retainer payments available to providers. West Virginia provided funds to assist providers in retaining staff amid the pandemic. Since retainer payments became available in, 2020 and again in 2022, we have aided providers in education, and assisted West Virginia in allotting in retainer funds to retain much needed healthcare personnel for the IDD Waiver program.

Our IDD Waiver communications are distributed to close to 600 individuals, including approximately 100 providers in addition to other stakeholders such as Case Managers, residential service providers, advocacy organizations, and DHHS leadership. Kepro leverages relationships within the provider community along with data analysis to identify key trainings to suggest to WV DHHR.

We have worked hand in hand with the state and providers to ensure we carry out the program requirements no matter the healthcare landscape. During the COVID-19 crisis, Kepro facilitated communication between providers and BMS through weekly provider calls. Beginning in March of 2020, we held bi-weekly calls with providers and continued this through December 2021 to ensure they remained abreast of changing state policies and procedures, as the state implemented COVID-19 specific measures. While we have reverted to initial monthly scheduled calls, providers benefited tremendously from the additional communication.

Implementation Assistance for American Rescue Plan Act (ARPA) funds

Kepro assisted BMS with distributing memos and announcements related to temporary rate increases for ARPA funds. We also maintain this information on our IDDW Policy Rates document that was updated and distributed as changes occurred. We assisted BMS with applying two rounds of retainer payments - the first round took place in 2020 and the second round in 2022. Residential codes for members residing in ISS/GH settings received increases in their residential service usage comparable to day services that were not available due to the mandatory closures of day facilities, as well as those that chose not to return to day services due to the risk of infection.

IDD Waiver Registration Coordinators also worked with the contractor and providers to interpret and authorize two rounds of available retainer payments.

Long-Term Partnership

With over 10 years of direct experience as the UM contractor for the WV IDD Waiver program, and a total of 17 years of experience with numerous facets of IDD program management, our team has developed the program and member knowledge needed to understand what will best serve stakeholders. In our time serving West Virginia IDD Waiver program, some of our accomplishments include:

- HCBS satisfaction surveys conducted across ISS/GH members and Specialized Foster Care providers to ensure satisfactory performance.

- Conducted 95 educational seminars in various formats – face-to-face, webinar, email, and telephone – in 2022 covering a variety of topics approved by the State.
- Assessed more than 6,000 program members in 2022 for the purpose of individualized budgets and/or medical eligibility.
- Served as the primary resource for provider Education and Technical assistance. We conducted over 100 provider education sessions, including face-to-face, email, and webinar trainings covering topics such as Care Management Information and Registered Nurse trainings. Our provider Educators also provided ongoing education to agencies through email and additional meetings to assist in developing programs and ensure their continued compliance with program regulations.
- Represented the Agency in Exceptions Hearings.
- Participated in or developed policies and forms to support new policies and procedures including implementation of Conflict Free Case Management and Draft Review Manual Updates.
- Engaged in Quality Improvement Advisory Councils amid COVID-19 restrictions and constraints.
- Participated in and facilitated Quarterly provider Meetings.
- Completed member-controlled setting assessments in compliance with CMS' Integrated Settings Rule.
- Ongoing completion of provider-controlled settings assessments for Specialized Family Care Homes and Intensively Supportive Settings.

Our extended time servicing WV DHHR's IDD Waiver program has involved dozens of staff and countless initiatives to improve member, provider, as well as State experience. As a result of this commitment to excellence, we have developed and streamlined our IDD Waiver processes to suit each of our stakeholders.

Initial Application Processing

We will continue to manage and track initial applications for the IDD Waiver program. Within 48 hours of receipt of an initial application, we will key the request into the Atrezzo Care Management system and contact the applicant/legal representative to request they choose an Independent Psychologist (IP) to complete their Individual Psychological Evaluation (IPE) that will be used to determine initial medical eligibility. Upon receipt of their chosen IP, we will refer the member's case to the IP through the system. The IP will then document their attempt to contact the member for scheduling the IPE and document the appointment date and time within the system. This comprehensive system allows for seamless transition between Kepro, the Medical Eligibility Contract Agent (MECA) and IP functions. The workflow can be found in **Figure 36 IDD Waiver Application Workflow.**

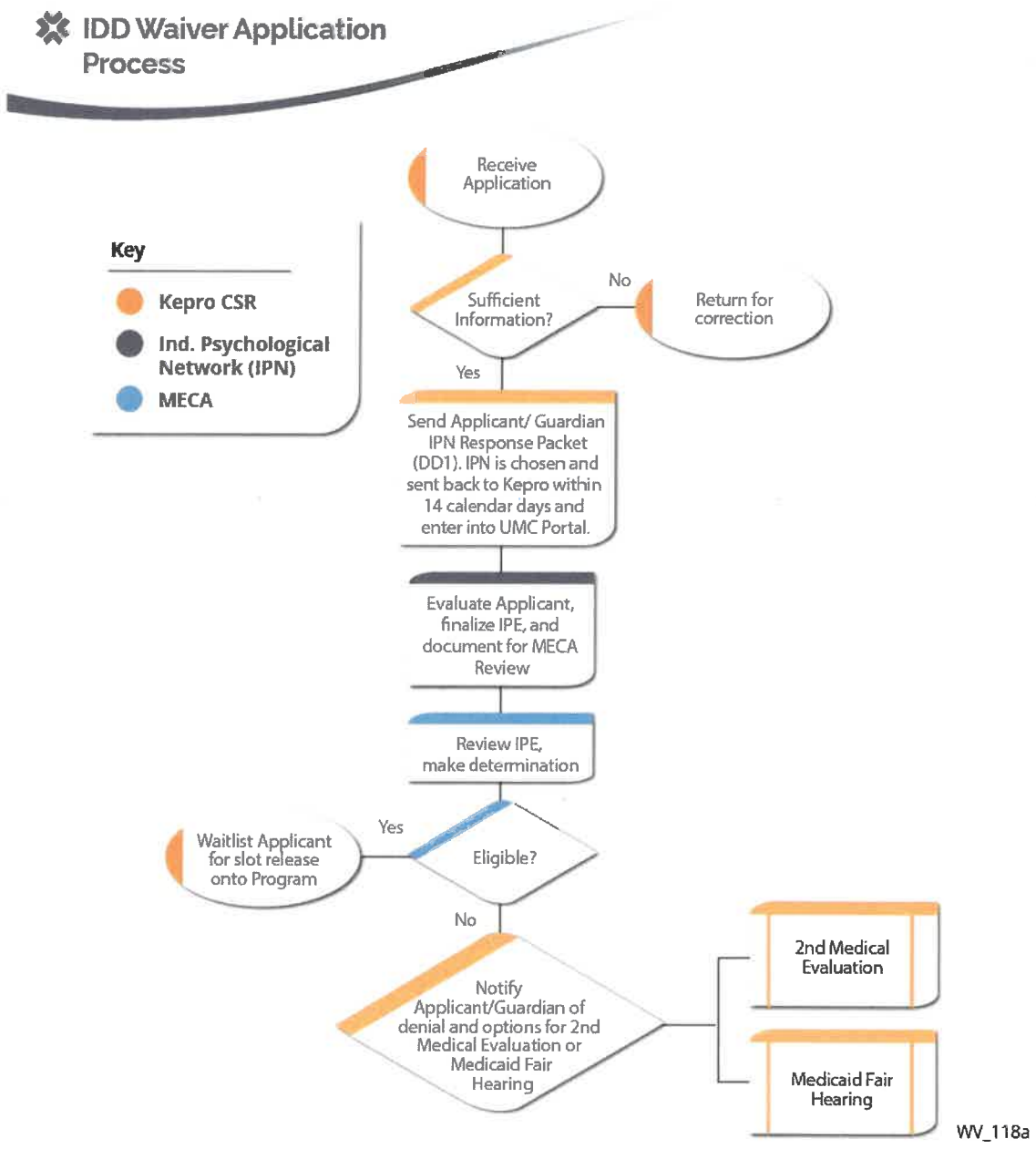


Figure 36. IDD Waiver Application Workflow

This process flow has ensured thousands of requests are handled quickly and efficiently.

Once the IPE is complete, the IP will upload the assessment into the system for review by the MECA who will determine whether the applicant is medically eligible for IDD Waiver services. The MECA then enters their decision within Atrezzo, which prompts us to send the appropriate Notice of Decision Letter (either applicant-eligible or applicant-denied), which we mail to the applicant/legal representative.

In the event medical eligibility is not initially determined by the MECA, the applicant has the option to request a second medical evaluation or Medicaid Fair Hearing. We assist the applicant in exercising the second medical evaluation option, following the same initial process, with exception of selecting a different IP. **Figure 37 IDD Waiver Second Medical Evaluation** demonstrates the second medical evaluation process.

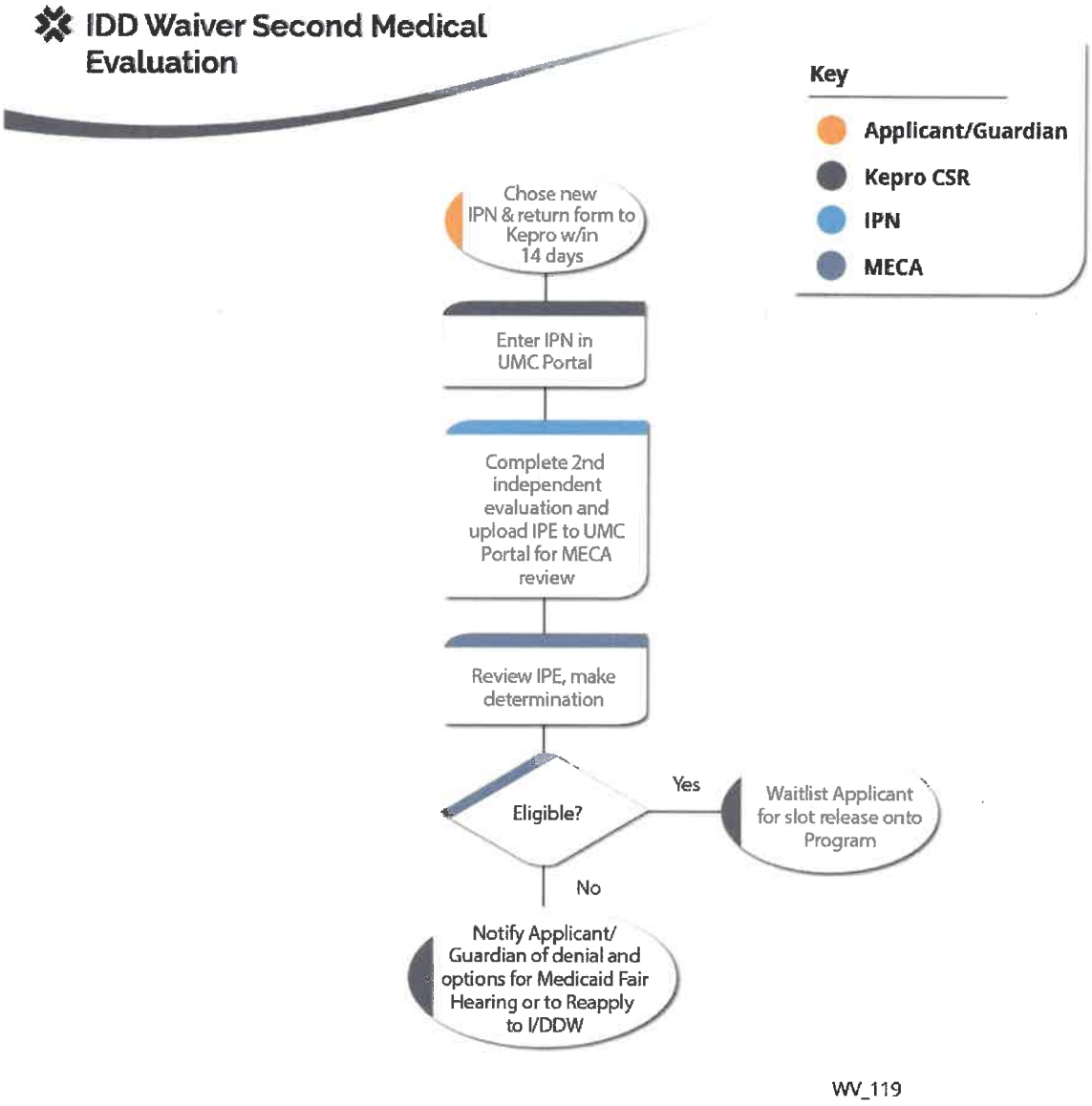


Figure 37. IDD Waiver Second Medical Evaluation
This process ensures that IDD Waiver members receive thorough and complete evaluations.

Managed Enrollment

Those applicants determined to be medically eligible will be placed on the IDD Waiver Managed Enrollment List which is currently maintained by Kepro. New applicants are entered at the end of the managed enrollment list, ensuring earlier applicants receive the most current slot availability. When a funded slot becomes available, we will prepare correspondence to the eligible applicant/legal representative informing them we will contact them for a functional assessment and instructing them to obtain financial eligibility at their local DHHR office. Only after the member is determined both medically and financially eligible will Kepro activate the applicant onto the program. We are prepared to continue communicate with the local WV DHHR offices and/or claims payor system for financial eligibility updates to ensure this requirement is met. **Figure 38 IDD Waiver Managed Enrollment List to Active Status** illustrates the process for moving from the managed enrollment list to active status.

Exceeding Standards

In Fiscal Year 2022, our IDD Waiver program was **100% compliant** with maintaining and delivering an accurate managed enrollment list based on Federal and State policy guidelines.

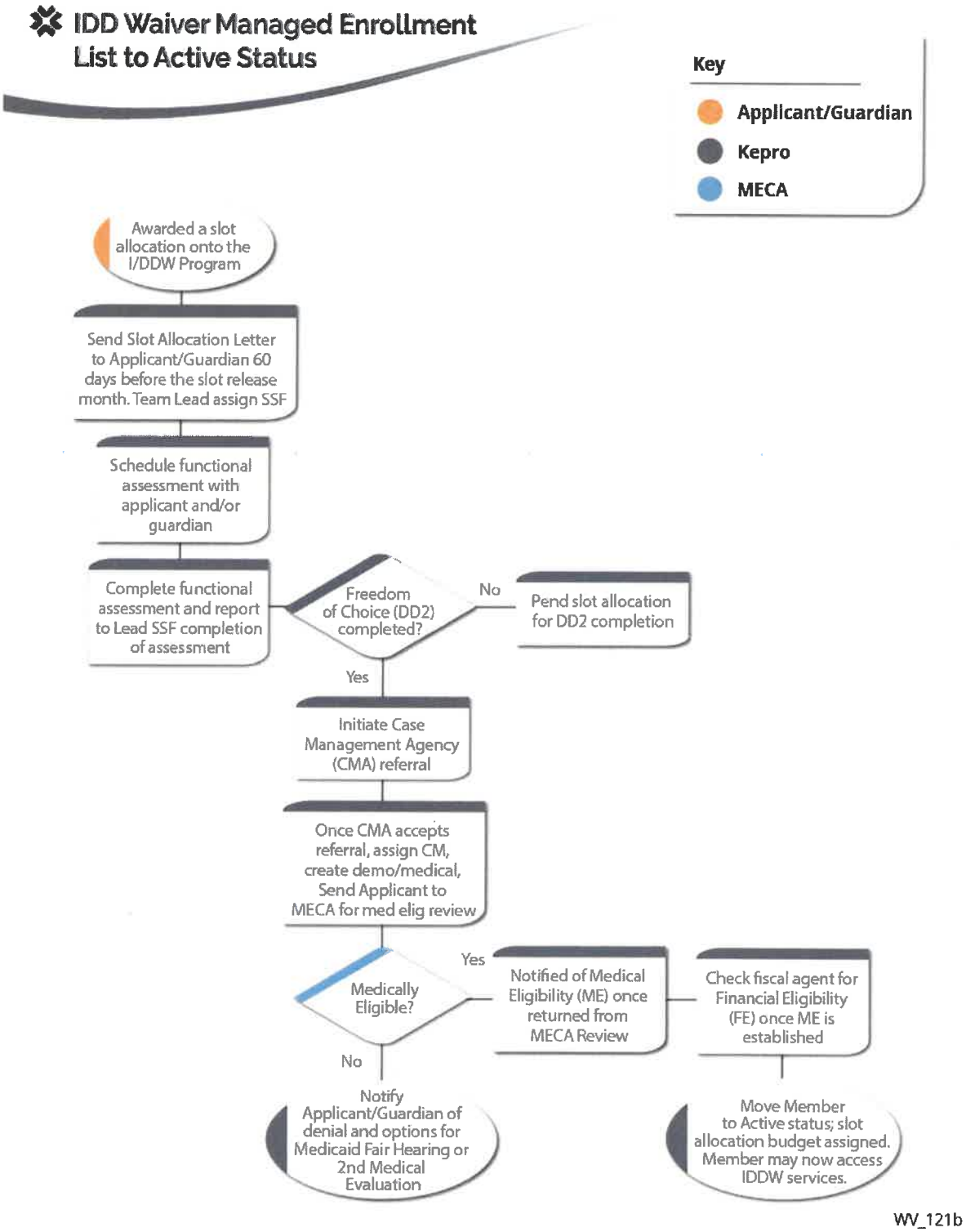


Figure 38. IDD Waiver Managed Enrollment List to Active Status

For timely and orderly slot allocation, Kepro's processes are established and streamlined to WV DHHR standards.

Identification of Slots for Release

We will track discharged Program Members to assist BMS with the identification of slots available for release. If an individual is discharged from the program but did not access services during the fiscal year, their slot would be available to the next person on the managed enrollment list. The information about the slots available is provided within Kepro's monthly reports, in which we will make a recommendation to BMS of the number of available slots and recommend the date of release. In making recommendations to BMS, Kepro considers timeliness as we strive to allow sufficient time for the new member to have their initial assessment with the Service Support Facilitator and to establish financial eligibility through their WV local DHHR office by enforcing a minimum of 30 days following notice of the slot release. Upon receiving approval from BMS, we will mail the Slot Allocation Letter to the individual and/or legal representative prior to the date of release.

Initial Assessment

Our experience conducting initial assessments is extensive, with our team having completed 2,673 assessments since 2015. A Service Support Facilitator with Kepro will be assigned to complete the Initial Assessment either at the local WV DHHR office or in the home of the individual receiving the slot. If the SSF is unable to establish contact with the Individual/Legal Representative due to outdated or incorrect contact information, the SSF Lead will make every attempt to work with BMS to secure updated contact information prior to slot release. If no additional information is available and contact cannot be established, we will send a certified letter to the Individual/Legal Representative to the address on file requesting they contact KEPRO within two weeks from the date of the letter to schedule the initial assessment. If the assessment is not completed by the Date of Slot Release, the slot will not be released, and the status of the Individual will remain as 'Applicant-Eligible' in the system until the assessment is completed. If the Individual/Legal Representative does not respond to Kepro within two weeks from the date the certified letter was sent, the Lead Service Support Facilitator will make a request to BMS that the case be closed and removed from the MEL. If closure is granted, the SSF Lead will close the application in the system moving the individual's status from 'Applicant – Eligible' to 'Applicant-Closed.' In special circumstances, BMS may request the application remain in 'Applicant – Eligible' or 'Open' status until assessment completion.

Exceeding Standards

Kepro's excellence in achieving client-prescribed review timeliness is evident across our West Virginia programs. We achieved a timeliness rate of 99.98% in 2022 for our IDDW program.

The Initial Assessment will include a component of education, in that a Service Support Facilitator (SSF) will educate potential program members/legal representatives and review the program's approved Handbook during each assessment and answer questions and/or refer the member to an applicable resource contact. The SSF will also review and assist in the completion of the Freedom of Choice form, in which the individual/guardian will select the service delivery model (traditional

or self-directed), as well as their choice of Case Management providers. The SSFs will education and ensure Conflict Free Case Management is followed. The SSFs will use standardized instruments, which may include Structured Interview, Extraordinary Care Assessment (ECA) (The SSF will complete the ECA only if the Individual is residing in a Natural Family or Specialized Family Care Setting), Inventory for Client and Agency Planning (ICAP) and the appropriate version of the Adaptive Behavior Assessment System for purposes of data necessary for the MECA to determine medical eligibility and for Kepro to develop an individualized budget.

Annual Functional Assessment

We will track attempted/successful contacts and appointments in Atrezzo. Experienced staff (Service Support Facilitators) will conduct the Annual Functional Assessment at least 30 calendar days and no longer than 90 calendar days prior to the member's Anchor Date. Data from the assessment will be input into the system, an individualized budget will be established, and MECA can use the data/assessments to determine continued medical eligibility for IDD Waiver services.

Exceeding Standards

During Fiscal Year 2022, our IDDW team completed 98.9% of annual determinations for medical eligibility at least 45 days prior to the member's anchor date, exceeding the deliverable standard of 95%.

The Annual Functional Assessment will incorporate a component of education, in that a Service Support Facilitator will educate potential program members/legal representatives and their chosen respondents about choices for the service delivery model (traditional or self-directed). Information will also address their choice of Case Management providers and implementation of Conflict Free Case Management, an option for Waiver services or for those provided in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). We will review the program's approved Handbook during each assessment and answer questions and/or refer the member to an applicable resource contact. We will use the standardized and other instruments, which may include Structured Interview, Early Childhood Assessment (ECA), Inventory for Client and Agency Planning (ICAP) and the appropriate version of the Adaptive Behavior Assessment System for purposes of data necessary for the MECA to determine medical eligibility and for Kepro to develop an individualized budget.

We will make every effort to complete assessments within timeline. When we cannot complete an assessment within the timeline due to unforeseen circumstances, such as inclement weather or member cancellation, we will track and report on the reasons for inability to complete within designated timeline.

Individualized Waiver Budgets

BMS' budgetary model has evolved through our contract years, yet the primary intention of a fair and equitable means of determining funds available for individualized Waiver services per member remains constant. Our knowledge of the budget process evolution, emphasis on person centered

planning, and successful implementation of the current model supports our continuation to serve this population.

Service Authorizations

We use our Atrezzo system, to review and prior authorize services delivered to IDD Waiver members. providers submit all data and requests electronically. The interdisciplinary team (IDT) chooses services and supports at the Individual Program Plan (IPP) meeting. The Case Manager submits prior authorization requests and chosen providers to us. Requests are then reviewed by our Registration Coordinator to ensure the team's recommended services are within the individualized Waiver budget and rules outlined in the IDD Waiver policy manual. If the request does not exceed the individualized Waiver budget or service limits, and the IDT addressed all health and safety needs, we can authorize the requested services, and we will electronically refer services to all chosen providers and/or the fiscal/employer agent for acceptance or rejection. If the service plan does not meet these conditions, the Registration Coordinator will request additional information and/or corrections from the Case Manager. Once the Case Manager addresses the requested actions, the Registration Coordinator will authorize the service plan. **Figure 39. Intellectual / Developmental Disability Waiver (IDDW) First Level Negotiation/Request** outlines the IDDW Service Authorization and Negotiation Process.

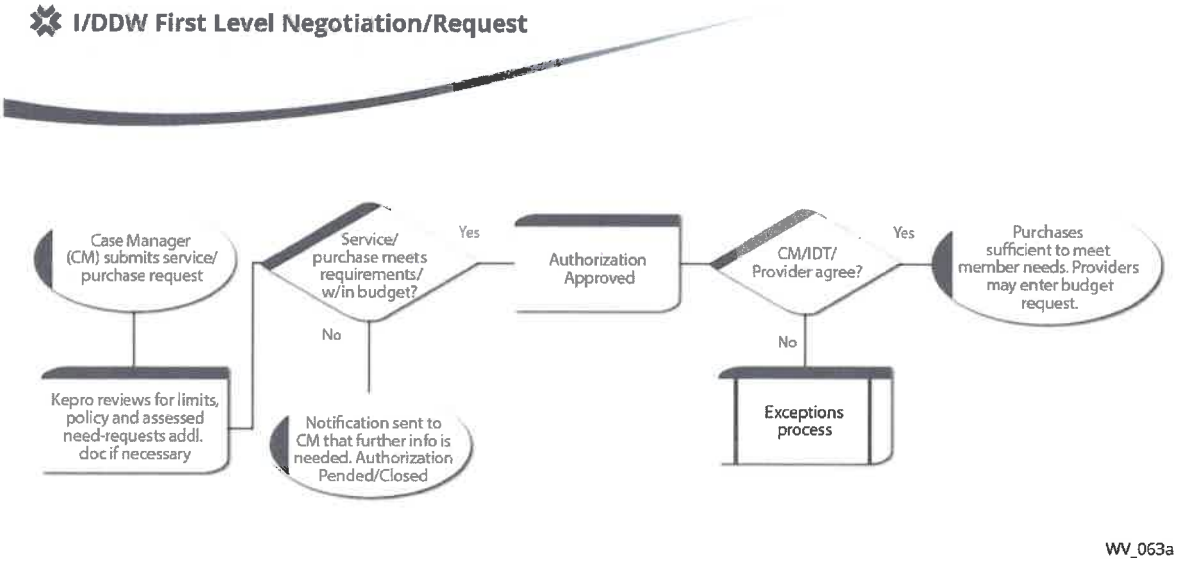


Figure 39. Intellectual/Developmental Disability Waiver (IDDW) First Level Negotiation/Request
Kepro's processes are connected to enable a streamlined and integrated process flow.

The IDDW Service Authorization and Negotiation Process consists of three levels. The process begins at the First Level/Negotiation Request. The Case Manager (CM) submits the service or purchase request. Kepro reviews the request for limits, policy, and assessed need. We may request additional documentation, if necessary, to complete the review. If documentation submitted does not justify the clinical need for the requested service or units, the request will not be approved,

and the authorization will be closed. We will not recommend which services should be reduced as this is a team decision. We will identify whether service mix is above the service limit, living arrangement limit, and/or the budget limit.

If after reviewing it is determined that the service or purchase request meets all requirements and that the purchases are within the budget amount, the service is approved. If the CM, Interdisciplinary Team (IDT), and provider agree with the approval, the purchases are sufficient to meet member need and the Service Authorization and Negotiation process is complete. The system sends a notification to the Case Manger that we have approved all requested services. The agencies will then be able to accept or reject those authorizations. If they accept, the authorization the process is complete until the IDT's next meeting. After the initial authorization approval, the IDT can make modifications throughout the service year to the previously approved authorizations as needed if they are within the budget, service limits, and meet documentation requirements.

Exceptions, Prehearing Conference, and Medicaid Fair Hearing

If Kepro is unable to authorize all services requested by the IDT, the member may request an Exception or Medicaid Fair Hearing. We will manage and track those cases where the member requests further review. **Figure 40 IDD Exceptions Process** outlines the exceptions process.

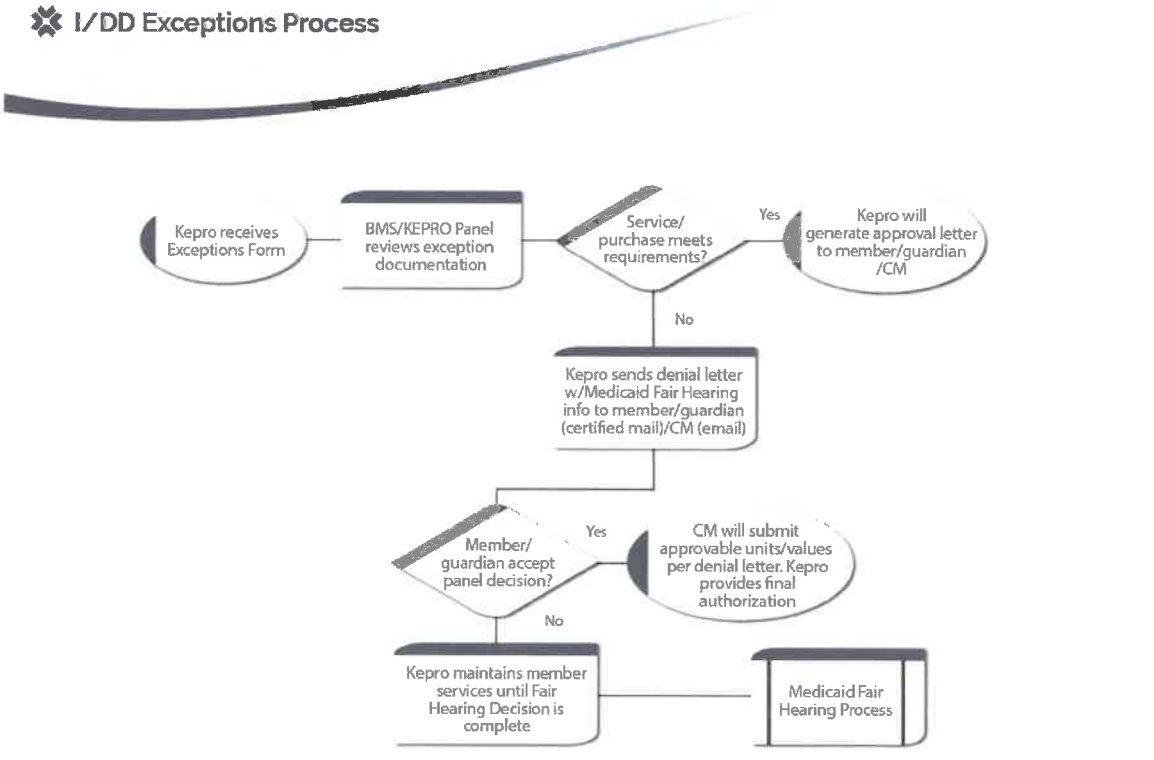


Figure 40. IDD Exceptions Process
Kepro provides a clear and consistent process for reviews.

The IDDW Exceptions Process begins when we are notified in writing of the IDT's intent to pursue an exception via the Exceptions Form. The BMS/Kepro Panel will review the exception documentation to determine the appropriateness of the request. If through review, it is determined that the request should be approved, the process is complete. The provider can enter the budget request. The number of approved units are listed on the Exception Approval and are calculated by the exception panel and incorporate policy regarding service limit caps concerning units. Approved units are also listed in Notices of Denial.

If through exception review it is determined that the documentation does not justify the clinical need for the requested service or units, the request will be denied, and the original Kepro authorization decision is upheld. Kepro sends a Notice of Denial (NOD) including Medicaid Fair Hearing information to the member or legal representation via certified mail within three business days of the final decision. In addition, we send notification to the SC Agency via email. The NOD will indicate the number of service(s) BMS has deemed clinically appropriate based on the information provided. The member or legal representative will have 13 days to request service continuation and 90 days to request a hearing. The Case Manager, IDT, and provider will review the NOD and explain the options to the member or legal representative. During this discussion, the Medicaid Fair Hearing process is explained to the member. The Case Manager, IDT, and provider guides the member in making a determination about proceeding to Medicaid Fair Hearing options. The Case Manager, IDT, and provider connects the member or legal representative to advocacy organizations, if necessary.

If the member or legal representative agrees with the denial, the Case Manager will submit approvable units or values indicated in the NOD. We provide final authorization.

If the member or legal representative does not agree with the denial, they have an option to submit a Hearing Request form. If We receive the Hearing request form within 13 days following the member's receipt of the NOD, we will modify the comparable units that were approved the previous year. If the hearing request form is received within 90 days of member receipt of the NOD, the Case Manager will resubmit the approvable units or values per the NOD. The member or legal representative is required to sign and return the Fair Hearing Request form to BMS. This begins the Medicaid Fair Hearing Process.

Did You Know?

Kepro conducted an average of approximately 940 exception cases over the last 3 years for WV DHHR.

Following an adverse determination, we notify the member that they have the option to access a prehearing conference as an interim step before going to Medicaid Fair Hearing. This process allows members to discuss their positions with the Bureau and allows the Bureau to express its position as well as relevant policy that supports the denial. We will continue to coordinate prehearing conferences. **Figure 41 IDDW Medicaid Fair Hearing Process** outlines the Medicaid Fair Hearing Process.

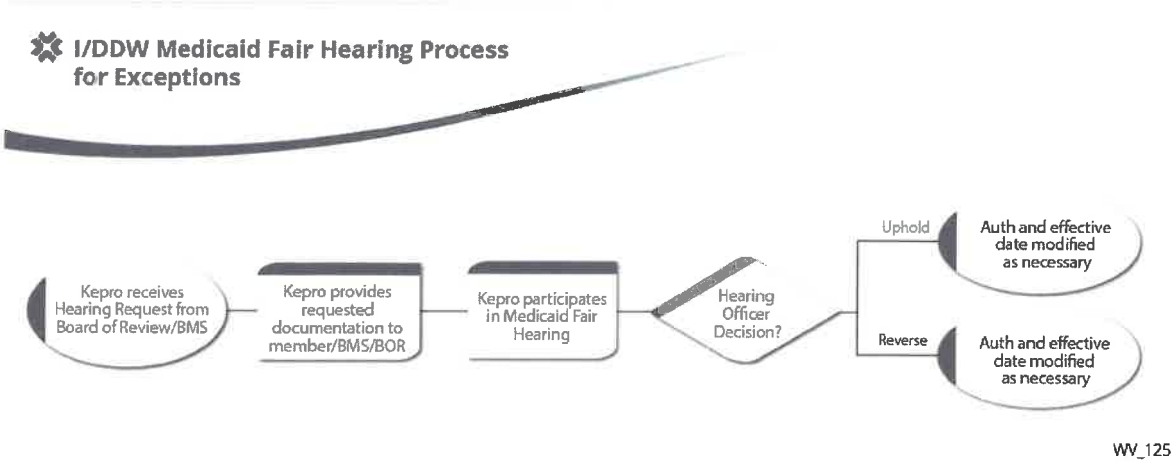


Figure 41. IDDW Medicaid Fair Hearing Process

Kepro's standardized process enables us to successfully represent the Agency at hearings.

The Medicaid Fair Hearing process begins when the member or legal representative returns the Fair Hearing Request form. If the form is returned within 13 days of following receipt of the NOD the comparable services from last year within caps are approved. If the form is returned within 90 days of receipt of the NOD the approvable units are determined from the NOD. Based on the Hearing Officer decision, the authorization and effective date are modified, as necessary.

Atrezzo Care Management System

We propose our Atrezzo system as the IDD Waiver program technology solution. This system allows multiple user types to interface with member records as their user role permits; displays each member's individualized budget; and provides a framework and a process for the prior authorization request of waiver services. It also provides a process to submit/receive authorization requests for services; assists with management of assessment completion through tracking of appointment contacts and outcomes; and provides a framework for oversight of the eligibility process. This comprehensive system tracks slot allocation and distribution through waitlist management; manages transfer of agency and/or service delivery model if the member wishes to self-direct their services; refers requests for self-directed services to the Fiscal/Employer Agent vendor and provides a central location for document storage by allowing multiple users to attach documents onto a single member's record.

We successfully managed program application and enrollment through this system allowing for better tracking for release of program slots throughout the year instead of just at a new fiscal year. The system prompts providers submitting a request for authorization to verify and update the member's demographic and medical information prior to submitting a request. The system includes validation rules to prevent submission of requests with missing information. In the event a program member's needs change, the system will accommodate modification (or special) requests for authorization review.

The system automatically transfers authorization and attribute information to the claims payor each night; though information is available in "real time." We specifically designed the system to capture data necessary for the Centers for Medicare and Medicaid Services (CMS) quality measures. We will manage and produce the monthly Discovery and Remediation and other reports at the request of the Bureau.

All authorizations exported will be specific to the member, provider agency, service code, units, start and end date. We will export authorizations and member data to the online CM/IMS system if requested. We will export data and authorizations to the Fiscal/Employer Agent (F/EA) vendor if self-directed services are added to this program. The system processes and tracks agency referrals, discharges, letters/notices, PAS assessments and allows for document upload by various user types. Data necessary for routine and ad hoc reports is maintained within the system and is accessible for reporting and analysis. BMS has made the system mandatory for all agencies and other applicable contractors.

Our system also provides secure and accessible access to all users for the submission of requests for authorization. Our portal is 508 compliant and meets security standards required by HIPAA and NIST. Access to our portal requires users' credentials (ID and password) as well as multi factor authentication and the site is protected with TLS encryption (TLS 1.2 minimum). To ensure 508 compliance, our site is re-tested for 508 compliance prior to all updates.

Review Criteria

As directed by current policy, we have been administering the Inventory for Client and Agency Planning since 2005 and the Adaptive Behavior Assessment System since 2011. These assessments, in conjunction with the Structured Interview and the Extraordinary Care Assessment (both developed by our team) comprise the Annual Functional Assessment.

New Kepro staff administering these assessments undergo a comprehensive orientation program where they receive training on policies and procedures, observe a seasoned staff member for a minimum of one week (usually 10-15 assessments), and are observed/assisted by a seasoned staff member for a minimum of one week (usually 10-15 assessments). Orientation of new staff lasts approximately one month, but can last up to two months, depending on the new staff's previous experience with the program, comfort level with conducting assessments and performance.

Kepro developed interpretive guidelines for all assessments administered and will submit to the Bureau upon request. We continually conduct inter-rater reliability activities with staff and update interpretive guidelines, as necessary. Staff will present any updates to the Bureau as recommendations for approval.

During the Annual Functional Assessment, Kepro will also continue to provide the education component including choice of providers, choice of service delivery model, choice of Waiver or institutionalization. We will also present any changes or updates to the script or forms related to these tasks to the Bureau for recommended changes.

We will conduct this education and assessment face-to-face, or virtually according to BMS' directives. The findings will be the basis to determine the member's level of functioning in the following areas as currently required for program eligibility: self-care, receptive or expressive language, learning, mobility, self-determination, and capacity for independent living.

We will use nationally accredited, research-based criteria with a clinically sound basis in order to recommend policy related to authorizing services. We will make recommendations regarding policy, procedures, and best practice to the Bureau annually or more frequently.

Maintain Agency Selection Forms

We maintain the Freedom of Choice form, along with other relevant documents, pertaining to the daily operations of the IDD Waiver program. The documents are integrated into a member file or attached to our electronic system.

Quality Assurance Activities

We will continue to conduct quality assurance activities with members, families, agencies, stakeholders and the general community. Quality assurance and improvement is a core tenet of our philosophy and business practice. We tackle quality with a holistic approach and constantly seek out opportunities to improve quality within and outside the organization.

Our quality assurance activities for the IDD program include a Kepro commitment to hold annual on-site reviews for members in ISS/GH settings. Beginning in August 2021, Kepro began conducting annual on-site reviews for more than 1,000 members in these settings to compliance with program requirements as well as health and safety standards.

A Plan of Compliance will be issued for those who are not compliant and Kepro staff will work with the Agency to remedy areas requiring improvement until the Plan of Compliance can be approved. To ensure that the state remains apprised of all quality improvement initiatives, we will report findings monthly to BMS.

As part of the remediation, written materials for appropriate provision of services will be developed and disseminated among the involved providers. Additionally, we will increase staff to ensure quality of services in the areas of Positive Behavior Support and to ensure statewide coverage of all agencies for review and all follow up activities.

In addition, this measure will include Home and Community Based Service questionnaires sent to members to ensure satisfaction with Kepro performance. For agencies that receive less than satisfactory reviews, all involved personnel including direct care staff will receive targeted training tailored to improving areas identified during the review process.

With this, we will continue to provide ongoing technical assistance at the request of the Agency. We will report monthly on the Centers for Medicare and Medicaid Services quality measures report, as well as monitor the quality of our own services.

Education, Training and Technical Assistance

During our existing and previous contracts, Kepro was instrumental in developing training for the Bureau related to policy, available services, service delivery models, choices between Waiver and institutional care, and other relevant topics. We orient our training toward multiple audiences, such as members, families, agencies, advocacy groups, and local WV DHHR staff. ·We provided training and assistance related to implementation of Conflict Free Case Management (CFCM) — in November 2022, we conducted an overview of CFCM with the Conflict-of-Interest Exceptions Process and Q& A session for more than 300 agency professionals. Our training evaluations consistently report satisfaction with the training conducted by our staff.

Our education and training plan covers a wide range of training topics including, but not limited to:

- Planning, publicizing, and producing statewide training and webinars on a schedule to be developed with the Agency. For efficiency, we use an established email distribution list, which includes many stakeholders involved in the IDD Waiver program., to advertise electronically.
- Hosting the IDD Waiver provider meeting up to four times per year (quarterly), including conference room rental and refreshments for attendees.
- Offering our previously developed and approved training to providers (and to help train their new staff) on recognizing and reporting abuse, neglect and exploitation or other critical incidents.
- Collaborating with the Developmental Disabilities Council, West Virginia Association of Positive Behavior Support (WVAPBS) Network and other stakeholders to update or expand our training to address current issues related to the program and disabilities in general.
- Developing, maintaining, publishing, and distributing the approved Member Handbook and reference guide of available providers/services (available to members during their annual functional assessments).
- Communicating announcements to providers, members, and stakeholders on behalf of the Bureau, using the established email distribution list.
- Participating in the Annual Families Conference (at the invitation of the Agency).
- Participating in Policy Clarification and other calls and webinars.
- Developing program forms and recommendations to best meet the needs of the program.

Data Collection and Reporting

We have participated in policy decision meetings, monthly contract management meetings and provided data for the Bureau in relation to the Centers for Medicare and Medicaid Services (CMS) required quality reporting. We will continue to send all required program reports within designated timeframes.

Note the following accomplishments in Training and Technical Assistance for the year 2022:

- 33 face-to-face training sessions were conducted
- 33 provider on-site technical assistance sessions were conducted
- 62 online and/or conference call trainings were conducted
- 74 provider reviews were completed
- 13 provider policy clarification calls were conducted

Exceeding Standards

We were 100% compliant annually reviewing each IDD Waiver provider in Fiscal Year 2022.

Note the following data related to the COVID-19 response:

In March 2020, Kepro began conducting calls every-other-week with providers and other stakeholders to address the impact of and concessions for COVID-19. In January 2022, monthly calls resumed.

Provider Reviews

We began conducting IDD Waiver provider reviews in 2007. We used the initial review process to educate all IDD Waiver providers about utilization management, proper documentation of a person-centered plan and services, and incorporating assessment results into those plans. We continue to improve the review process and review tool at the discretion of the Bureau. The current on-site provider review tool (developed by Kepro and approved by the Bureau) is easy to adapt to capture new quality/performance measures, new services, and new policy.

Upon this review, we will verify compliance with current state and federal policy guidelines, appropriate utilization management, and documentation of authorized services. We will notify the Bureau of the review schedule a quarter in advance. We will continue with the imperative technical assistance component of the review so that providers can continue to grow their knowledge and understanding of policy and requirements.

We will provide comprehensive draft reports within 10 business days of the review exit to the Bureau and to the provider. These reports will include the Review and Disallowance Reports along with the Plan of Correction. The provider will have up to 30 days to respond to their draft reports. Upon receipt and reconciliation of the provider's response, we will prepare and send all components to the Bureau for final consideration. We will participate in Review Committees where the Bureau, the Office of Program Integrity, and we will discuss final disallowance amounts. We will prepare the final reports for the Bureau to disseminate to the provider.

We are eager to incorporate a follow-up review of providers who must submit a Plan of Correction because of unsatisfactory findings during an on-site review. We believe this process is imperative to improving the overall quality of services for our members. Depending on the severity of unsatisfactory findings, we will conduct either a desk or on-site visit of the provider to verify they did in fact implement their Plan of Correction.

Quality Improvement Advisory Council

On-site provider review findings are an integral way of capturing statewide quality and performance management data as necessary for the CMS reports. Cumulative review findings will be shared with the Quality Improvement Advisory Council. We will facilitate meetings of this council quarterly whose purpose is to advise the Bureau on program related matters and concerns. we will fund travel expenses for Medicaid members on the council when that member lives greater than 60 miles from the venue and they wish to receive reimbursement. To enhance program and disability-related knowledge continuously, we will send IDD Program Manager or staff to at least one national conference at the request of the Bureau.

Participant Experience Survey

We have implemented the Consumer Assessment of Healthcare providers and Systems (CAHPS) Home-and Community-Based Services Survey to monitor participant experience since 2021. Once participants are finalized from a random selection of the program population, Kepro mails a letter to the individual and, if applicable, legal representative explaining the survey to determine whether they would like to participate; follow-up calls are made up to two weeks following initial release of the letter to finalize member participation. Surveys are completed via telephone interviews with members and their legal representatives by the Consumer Family Educators. We will provide data regarding CAHPS surveys to BMS and to other parties as requested.

Satisfaction with Kepro performance in providing IDD Waiver program services is further encapsulated by our member satisfaction surveys. In the past two years, we have conducted nearly 2,000 surveys and received an average satisfaction score of 4.88 out of a possible 5.

Table 14 IDD Member Satisfaction Survey Results outlines our successful ratings across all survey categories.

Years	Answers my questions	Polite and friendly	Written materials provided were useful	Captured abilities / support needs	Assmt at a time/ location convenient for me	Adequate Time for Accurate Assmt	I have a better understanding of the Budgeting Assessment process	# of Surveys
2021	4.98	4.98	4.85	4.80	4.88	4.93	4.80	777
2022	4.96	4.97	4.86	4.75	4.89	4.88	4.79	1,141

Table 14. IDD Member Satisfaction Survey Results
Kepro maintains a nearly 4.9 average satisfaction rating out of 5 across members surveyed.

Complaints

We will receive, review, track/trend, and/or investigate complaints submitted by providers, members or other stakeholders related to a program member's services through an IDD Waiver provider. We follow a consistent procedure in responding to complaints and reporting to BMS on trends and outcomes. We take each complaint seriously and view them as a potential opportunity for improvement and technical assistance.

We can receive complaints either verbally or in writing (email or fax). Upon receipt of a formal complaint, we will document the complaint and request any necessary information for follow-up. If the issue cannot be resolved over the phone through technical assistance and information and referral, we will investigate the complaint and/or make referrals to appropriate entities.

We will inform the complainant of procedures in following a chain of command at the provider agency. Every IDD Waiver provider is required to have a grievance/complaint procedure. It is required that each agency inform program members/legal representatives of this procedure. We will request information about steps taken thus far to resolve the complaint at the Agency level. These steps may include notifying the Case Manager, Waiver Supervisor or accessing the Agency's grievance/complaint procedure. It is not required that the complainant initially follows a chain of command at the Agency-he or she may make direct complaint to us. If we suspect:

- Abuse, neglect, or exploitation of a program member, we will assist the complainant in making a referral to Adult or Child Protective Services. If the complainant cannot or will not make this referral, we will do so.
- A provider agency is not following procedures consistent with the Office of Health Facilities Licensure Accreditation and Certification (OHFLAC). We will refer the issue to and/or work to assist OHFLAC with their investigation. OHFLAC's policy requires unannounced investigations, and the provider will not receive notification of an investigation by OHFLAC.
- A provider or agency is billing for and receiving reimbursement for services inappropriately, we will refer to, and/or work to investigate with, the Medicaid Fraud Control Unit (MFCU). This process will begin with a referral to the Office of Program Integrity (OPI) at BMS.

We may receive anonymous complaints. If the complaint contains enough information to follow-up, Kepro will do so. If there is no way to follow-up based on the information provided, Kepro will log the complaint and indicate that there was not enough information to follow-up. If complainants request to remain anonymous, we will notify them that we may not be able to follow up on the complaint.

- If we suspect the issue of complaint is systemic, we may request additional information to determine the extent of the complaint.
- When we investigate a complaint, we will notify the provider agency of the complaint if doing so will not compromise integrity of the investigation or put a program member at risk.

- When appropriate, we may utilize the provider agency's internal investigation system to acquire necessary information. In this event, we will request the Agency forward specific information for Kepro to conduct a desk review.
- When appropriate, we may conduct an on-site investigation at the provider agency after consultation with BMS.
- We may investigate matters related to IDD Waiver policy manual compliance. When the IDD Waiver policy manual overlaps with Adult Protective Services/Child Protective Services, OHFLAC or OPI, we will work with applicable parties or make referrals, as appropriate.

We will initially respond either verbally or in writing to formal complaints within two business days. An anonymous complaint cannot be considered a formal complaint. Complaints will be handled in a manner that is the least restrictive necessary. Follow-up may require a request for information, interview with staff, the program member/legal representative or other applicable parties and/or an on-site visit.

Incident Management System

At the request of the Bureau, we continue to participate in meetings pertaining to the State's current incident management system. Our vast experience with developing and testing our own systems will prove invaluable. We will continue to perform daily monitoring and provide monthly and quarterly reports on data input to the Incident Management System. Our experience with the existing IMS includes the following:

- Provide guidance to agency staff on how to register/de-activate users to maintain current accounts and avoid sensitive information breaches
- Create new listings or agencies that have been approved to provide member services
- Provide technical assistance to users on how to navigate and utilize system functions to uphold policy requirements
- Manually send out follow-up reminder notification emails to users when incidents are nearing no-compliance for the 14-day timeline and tracks that information on a continuous spreadsheet
- Tracks, verifies, and communicates system outages
- Unlocks incidents to enable users to make approved edits to incident entries
- Performs daily monitoring of non-simple incidents to ensure incidents are being classified correctly and appropriate follow-up is occurring
- Attends WellSky meetings to provide clarification on system functions, reporting needs, test features and provide feedback
- Identifies, verifies, and deletes any erroneous entries to avoid over-reporting as well as ensure accurate data measures
- Utilizes system data reports to compile incident information for discover and remediation
- Researches individual incident cases, identified as priority/high risk, to ensure reporting accuracy and appropriate follow-up action has been completed

- Identify system breaks and report to DHHR IMS Project Manager
- Identify system limitations and manipulate system functions to create workarounds
- Identify follow-ups completed
- Re-open cases that have exceeded reporting timeline
- Ongoing assessment of system functionality and identification of problem areas with reporting to the State.
- Email and phone communication to educate providers on what is needed to complete cases, provide clarification on incidents, etc.
- First line contact for providers when unable to complete entry, communicate system functional "workarounds."
- Data tracking regarding incident volume, resolution rate per provider
- Data comparison to CMS requirements
- Development of training improvement plans for providers

Fraud, Waste, Abuse Referral

If we suspect fraud, waste, and/or abuse, we will refer our suspicions to the Bureau's Office of Program Integrity (OPI).

A1.1.0. Children with Serious Emotional Disorder (CSED) Waiver Services

1. The Agency covers SED services for members who meet eligibility guidelines for the SED Waiver Program. Members will receive annual assessments to determine re-eligibility guidelines. As a condition for reimbursement, the Agency requires that all SED services receive prior authorization in accordance with current policies.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, plans of care, assessments, plans of care and all other forms of documentation through postal mail, fax and/or electronic submission required for prior authorization and eligibility review of SED Waiver Program services.
3. The Vendor understands that the Agency is committed to streamline families' access to appropriate wraparound services in our communities. The centralized access point to home and community-based services to meet the needs of children who otherwise might be at risk of out of home placement as well as assist those returning to the community from placement will be the initial application to the CSEDW program.
4. The Vendor shall have the capability to manage application and referrals for determining the initial eligibility of the SED Waiver program members, and shall correspond to all applicable parties, immediately using the fastest forms of communication available.

a. Initial Assessments: The Vendor shall have the capability and established procedures to ensure tracking for initial applications in accordance with current policies and reporting on each member's progress through the Assessment Pathway weekly. Upon receipt of a referral for CSEDW services, the Vendor shall immediately refer the child to the Bureau for Behavioral Health's Children's Mental Health Wraparound so that the child can begin receiving services from the Pathway within 72 hours of referral by Vendor. The Vendor will immediately confirm the child is an Agency beneficiary and if not, the Vendor will refer the child to the local DHHR office for eligibility and enrollment when applicable. The Vendor will immediately assess the child to determine if the applicant has a Child and Adolescent Functional Assessment Score (CAFAS) or a Preschool and Early Childhood Functional Assessment Score (PECFAS) over 90 and if so, the Vendor will immediately:

i. Facilitate completion of the CSEDW Waiver Application.

ii. Facilitate a choice with the family of an Independent Evaluator who can complete the evaluation within fourteen (14) calendar days.
iii. Schedule the appointment and authorize the evaluation services.
b. If the referred child does not have a CAFAS/PECFAS score higher than 90, the Vendor will immediately inform the BBH Children's Mental Health Wraparound that the child does not qualify for CSEDW services. If the referral application also included a release of information from the Bureau of Social Services, then the Vendor will inform the BSS worker what the status is within the CSEDW application process to include when the scheduled appointment is with the IEN, if the child did score over 90 on the CAFAS/PECFAS, etc.
c. If the child is determined eligible for the CSEDW program as determined by the Medical Eligibility Contracted Agent, the Vendor shall facilitate with the family the completion of the Freedom of Choice form choosing Home and Community-Based Services over Institutional Services and also the choice of a Wraparound Facilitator Agency and a Direct Services Agency according to current policies.
d. Annual reviews: The Vendor shall have the capability and established procedures to conduct annual functional assessments and assist with redeterminations of medical eligibility of all members to determine individualized waiver budgets and program in accordance with current policies.
e. The Vendor shall have the capability and established procedures for maintaining the thirty (30)-day timeline for re-evaluations when appointments are canceled by the Vendor or member in accordance with current policies and court orders at least thirty (30) calendar days prior to the member's annual anchor date.
f. Managed enrollment: The Vendor shall have the capability and established procedures to verify both medical and financial eligibility and manage the managed enrollment list (wait list), if applicable in accordance with current policies.
g. The Vendor shall have the capability to maintain electronic health records of all SED members available to the Agency as applicable to Administrative Service Organization functions.
5. The Vendor shall develop and maintain a secure web-based, electronic review request system for prior authorization and eligibility review of SED Waiver services that allows for data input by the submitting providers. The Vendor's system shall have the capability for:
a. Automated criteria/rules-based certification system.
b. The ability to process special requests (WV-BMS-SED-12 Program eligibility extensions) if/when needed.
c. Export authorization information and SED Waiver attribute information to the claim's payor.
d. Produce and/or analyze data for CMS and/or Agency reports at the request of the Agency.
e. Manage and Report Monthly to the Agency on CMS quality measures report.
f. Process requests for service authorizations in accordance with current policies.
g. Refer requests for self-directed services to the (F/EA) Vendor in accordance with current policies.
h. Calculate member assessment-based budgets.
i. Follow all applicable DHHR policies and court orders.
j. Develop and send ad-hoc requests as determined by the Agency in a timely manner.
6. The Vendor shall have the capability to develop educational trainings (including power points) and provide technical assistance, at no additional cost to the Agency, about policies, available services, service delivery models, and the choice between SED Waiver and institutional care for members, families, Agencies, stakeholders and the general community via email, telephone, webinars etc. Vendor shall, at a minimum:
a. Plan, advertise and produce statewide trainings and webinars at the request of the Agency to include trainings on the Assessment Pathway.
b. Plan, advertise and produce Face-to Face provider meetings up to four (4) times per year upon request of the Agency, to include hospitality and conference room rental, at no additional cost to the Agency.
c. Provide training and education on identifying and reporting suspected abuse, neglect, exploitation, or other critical incidents to the appropriate Agencies, at no additional cost to the Agency.
d. Collaborate with the Developmental Disabilities (DD) Council, West Virginia Association of Positive Behavior Support (WVAPBS) Network and other workgroup/stakeholder activities at the request of the Agency, at no additional cost to the Agency.

e. Develop and maintain a member handbook and a reference guide of all available providers and services provided by county to be distributed yearly to members.
f. Communicate program announcements to providers, members, and other stakeholders as necessary and when requested, at no additional cost to the Agency.
g. Participate in the annual Families Conference at the request of the Agency, at no additional cost to the Agency.
h. Participate in conference calls, statewide trainings, and webinars at the request of the Agency, at no additional cost to the Agency.
i. Make recommendations and develop program forms upon request from the Agency, at no additional cost to the Agency.
7. In performing SED Waiver Program service determinations, the Vendor shall use nationally accredited, research/evidenced-based, criteria in reviewing each prior authorization and eligibility review request. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all SED Waiver Program services reviewed under the resulting contract.
a. The Vendor shall maintain the capability to update the review criteria SED Waiver Program services reviewed under the resulting contract. The Vendor shall make recommendations about policies, procedures, and best practices to the Agency annually, regarding what, if any, changes should be made to the criteria that will be used for the following calendar year. The Vendor will maintain Agency selection forms and modify the forms at the request of the Agency.
b. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria recommendations at the time of presenting the recommended changes.
c. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the resulting contract.
d. The Vendor is responsible for any cost associated with the purchase of any review criteria.
8. Upon the Agency's request, the Vendor shall conduct quality assurance activities with members, families, Agencies, stakeholders, and the general community, as necessary or at the request of the Agency. These activities shall include, but not be limited to, the following:
a. Conduct initial and continued certification reviews of new and existing SED Waiver providers to include on-site, and desk review as requested by the Agency.
b. Conduct on-site quality reviews of all SED providers annually to verify compliance with current policies and appropriate utilization management and documentation of authorized services This includes but is not limited to; notifying the Agency of scheduled review cycle a quarter in advance, and calculating disallowance amounts per provider reviewed.
c. Conduct follow up visits to monitor approved plans of correction ant the request of the Agency.
d. Manage and facilitate the SED Quality Improvement Advisory {QIA) Council including quarterly face-to-face meetings as needed to include travel expenses and overnight stays for members on the QIA Council if they live more than 60 miles away.
e. The Vendor is to have a Program Manager for SEDW program that attends a national conference at request of the Agency
f. Conduct face-to-face Participant Experience Survey interviews using a representative sample of enrolled members.
g. Receive, track and triage or investigate complaints submitted by providers, members, or other stakeholders. Manage and report on incidents as required by current policies.
h. Perform daily monitoring and provide monthly and quarterly reporting and assistance with the state's Incident Management System.
i. Analyze and conduct individualized statistical budget model.
j. Provide ongoing technical assistance via email, telephone, upon request at no additional cost to the Agency.

k. The Vendor must have a backup contact/individual for when the Program Manager of SEDW is unavailable.
9. The Vendor shall have the capacity and established procedures to assure that initial eligibility assessments are conducted in a setting and circumstances consistent with professional standards and assures that environmental factor (e.g., work surfaces, lighting, etc.) do not interfere with the applicant/member's performance. If the applicant/member's performance is compromised, it should be noted in the subsequent evaluation report with a statement indicating whether or not the assessing psychologist believes that validity of the assessment was compromised.
10. The Vendor shall have the capacity and established procedures to develop a process and procedural manual for the eligibility and/or evaluation process for the SED Waiver program within thirty (30) calendar days of contract award. The manual and any updates must be approved by the Agency fourteen (14) calendar days prior to implementation.
11. The Vendor shall have the capacity and established procedures to develop a process for completing initial assessments and determinations of medial eligibility of approximately 400 applicants utilizing evaluations (Medical, Psychiatric, Psychological, etc.) within ninety (90) calendar days of a complete initial application and will notify the Agency in writing of all determinations.
12. The Vendor shall have the capacity and established procedures to complete annual re-determination of medical eligibility.
13. The Vendor shall have the capacity and established procedures to ensure accurate reporting of quarterly data pertaining to evaluations, completed, timelines, eligibility decisions and hearings.
14. The Vendor shall have the capacity and established procedures to provide administrative operational functions necessary to support the medical eligibility process for the SED Waiver program.
15. The Vendor shall describe their plan to demonstrate a guarantee of ongoing quality assurance and improvement within the eligibility process for SED Waiver Program.
16. The Centralized Wraparound Hub includes the following:
a. Initial Eligibility Assessments to determine which wraparound program may be appropriate.
b. The Vendor will conduct the following ASO Functions:
i. Receive/Maintain referrals.
ii. Completes CAFAS/PECFAS.
iii. Initial Eligibility assessments.
iv. Manage referrals to the appropriate entities per active WV Wraparound policies and procedures.
v. Manage documentation per active Agency policies and procedures.
vi. Family and provider notifications.
vii. Software program for tracking/reporting.

We have been providing Children with Serious Emotional Disorder (CSED) Waiver Services to West Virginia for the past four years. As the incumbent and original provider of these services for the WV DHHR program, we have worked with West Virginia to build the program and, over the course, implement changes to streamline the processes with all stakeholders in mind. In 2022, we conducted 1,100 prior authorization reviews, as well as 2,721-member eligibility assessments.

For example, our volume and workflow changed significantly over the course of 2022. In January of 2022, we received 60 CSED non-duplicated applications; this number steadily increased to 178 by December of 2022. This increase shows that over the course of 2022, we processed close to three times the volume as the year progressed, with minimal disruption, lag in processing times or issues cited by members or providers. Adaptability to the changing healthcare landscape is critical to serving the West Virginia population effectively.

Kepro's excellent performance is further underscored by our consistency in meeting contract deliverables and successfully accomplishing all required metrics. The below key metrics summarize this commitment to success and effective program management:

- ✓ 95% of families were contacted within 3 days of referral in 2022.
- ✓ From the start of the Waiver we have served 2,565 families/applicants since January 2021.
- ✓ 100% of the Independent Evaluations were scheduled within 14 days unless the family desired a specific clinician.
- ✓ 100% of notifications of medical eligibility were completed within five days.

Our experience over the past four years has enabled us to refine our practices regarding West Virginia processes. We are proud of the partnership that we've built and the performance standards that we've been able to meet over this time. **Figure 42 Combined CSED, Wraparound, and QRTP Process** highlights our combined process for Children with Serious Emotional Disorder, Wraparound, and Qualified Residential Treatment Program.

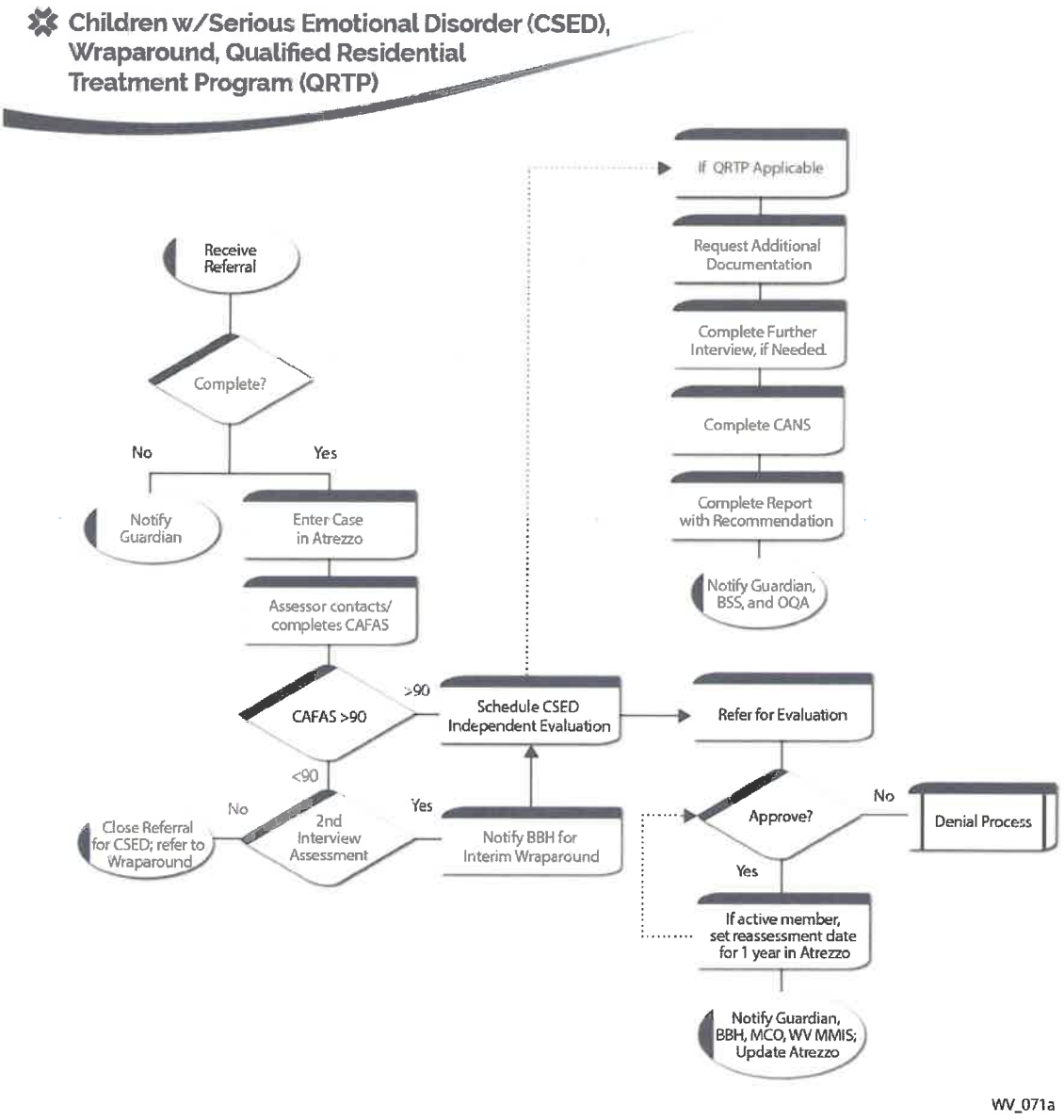


Figure 42. Combined CSED), Wraparound, and QRTP Process

This process integrates all required assessments to ensure the member's continued health and safety.

This process combines the areas of Children with Serious Emotional Disorder (CSED), Wraparound, and the Qualified Residential Treatment Program (QRTP) process, and it is performed by Kepro's Service Support Facilitator. The process begins when the Service Support Facilitator receives a referral:

- If the referral is not complete, the Guardian is notified.
- If the referral is complete, the case is entered in Atrezzo.
- The Support Facilitator contacts the Guardian and completes the CAFAS assessment.

  - If the CAFAS score is less than 90 and a second interview assessment is not conducted, the referral is then closed for CSED, and the case is referred to the Wraparound process.
  - If the CAFAS score is less than 90 and a second assessment is completed which resulted in a score of 90 or above, the Support Facilitator notifies BBH for Interim Wraparound. Then the CSED is scheduled, it is determined if QRTP is applicable, and the case is referred for evaluation.
  - If the CAFAS score is greater than 90, the CSED Independent Evaluation is scheduled, it is determined whether a QRTP is applicable, and the case is referred for evaluation.
- If the CSED Independent Evaluation can be approved and the member is active, the Support Facilitator will set the reassessment date for one year in Atrezzo and then notify the Guardian, BBH, MCO, WV MMIS, and update Atrezzo.
- If the CSED Independent Evaluation cannot be approved, the Denial process (**Figure 43 CSED Denial Process**) begins.

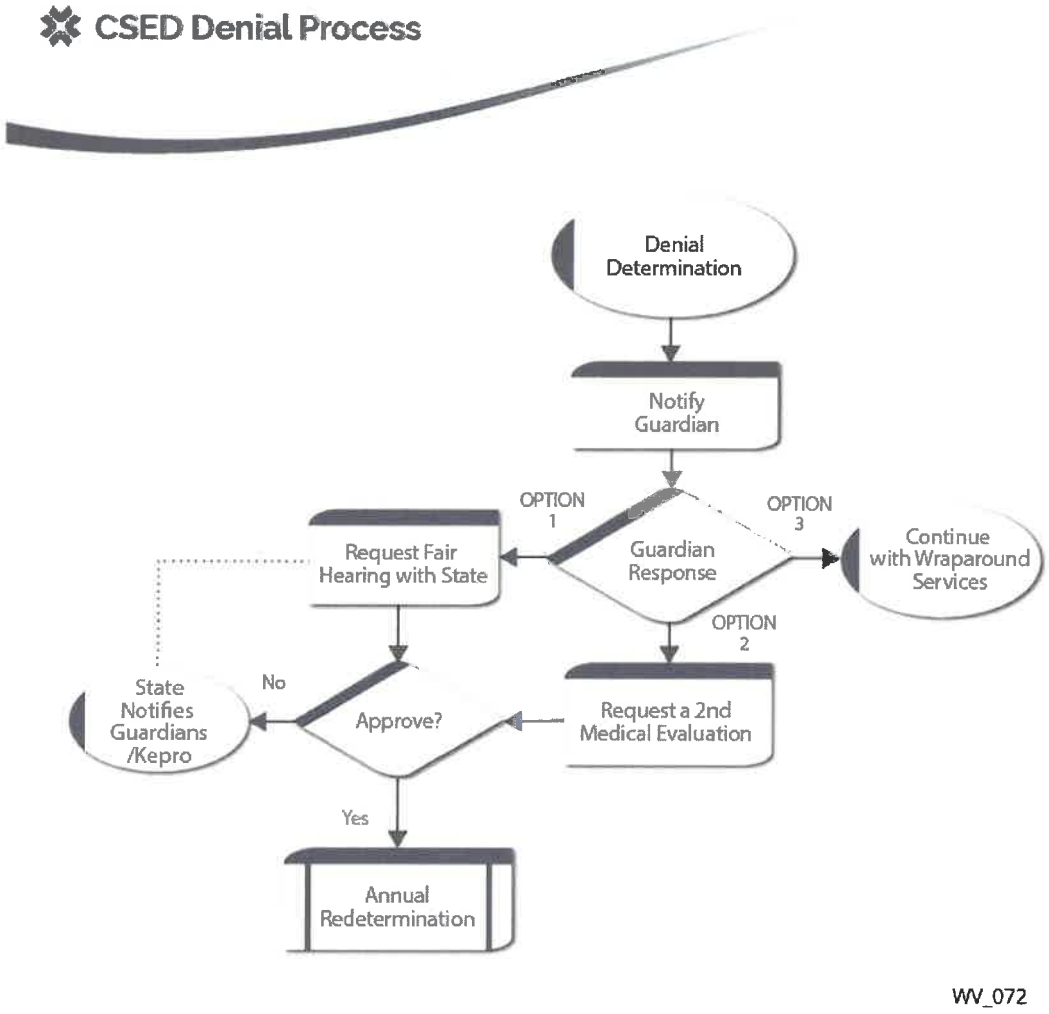


Figure 43. CSED Denial Process

Kepro's process is standardized for efficiency and ease of execution.

During the CSED Denial process, the guardian is notified of three options.

- The first option is for the Guardian to request a second medical evaluation of the case. If the case is approved, the Annual Redetermination process begins. If not approved, the State notifies the Guardian and Kepro. The Guardian may request a fair hearing if denied at this level.
- The second option for the Guardian is a fair hearing with the State. If the case is approved through fair hearing, the Annual Redetermination process begins. If the case is not approved during the fair hearing, the State notifies the Guardians and Kepro.
- The third option is for the Guardian to continue with Wraparound Services.

We propose a timely, equitable, person-centered process of initial and annual medical eligibility determination that includes relevant stakeholders in the determination process. Through this process, we document the member's initial and continuing medical eligibility for participation in

the Waiver as determined by PCA. We also provide notification to relevant parties to promote a thorough understanding of the process as well as the member's Fair Hearing rights and process.

We will receive daily referral requests for waiver program assessment. Applications will be considered on a first-in, first-out basis. We will conduct an initial screening of the application to ensure that it is complete, correct and includes all components necessary. Then we will complete the CAFAS. If the score is over 90, we will schedule the applicant with an Independent Evaluator. We will notify the applicant in the event additional information is required. If the application is eligible, we will mail the applicant (with the Bureau's approved letter) and if they are not already Medicaid eligible, we will prompt them to obtain financial eligibility through their local DHHR.

The SSF will contact the member to establish a date and time for the independent evaluation, abiding by policy related to contacts, appointments, notices, and other measures. If the assessments cannot be completed, we will discontinue the medical eligibility process and notify the relevant parties to reinitiate the process should they wish to pursue application. Once the application is approved, we will verify financial eligibility.

We will conduct the initial and re-evaluation assessments with the instrument CAFAS and/or CANS. Scores are captured in Atrezzo. We will make every effort to complete assessments within timeline. When an assessment cannot be completed within timeline due to unforeseen circumstances, such as inclement weather or member cancellation, we will track and report on the reasons for inability to complete within designated timeline.

We will notify the member/legal representative the outcome of the assessment. We will provide a copy of the assessment, and the member/legal representative may provide additional information in the event the determination results in a denial of eligibility. Members will be notified of Fair Hearing rights in the event of a denial. If a member is ultimately eligible, we will notify all parties. Members who are eligible when no Waiver slot is available will be placed on a managed enrollment list. When there is no managed enrollment list, we will notify the Aetna Better Health WV, MCO of the approval and they will take over the Waiver Member's care. the provider agency will be prompted to complete and submit a Service Plan, considering the assessments.

Managed Enrollment

When no slot is available, those applicants determined medically eligible will be placed on the CSED Waiver Managed Enrollment List. When a funded slot becomes available, we will prepare correspondence to the eligible applicant/legal representative informing them they will be contacted for an assessment and instructing them to obtain financial eligibility at their local DHHR (if it has expired from previously acquiring). Only after the member is determined both medically and financially eligible will Kepro enroll the new program member.

Atrezzo Care Management System

We currently process these assessments in Atrezzo. When we first initiated this assessment with the state, we anticipated approximately 300-400 assessments annually. In just the first year, we received over 1,000 assessments. The children that are assessed are West Virginia-based but vary in their family and living situations, guardianships, systems involvement, and clinical acuity. Those involved with the process include DHHR guardians and probation officers.

Education, Training and Technical Assistance

We have successfully developed training for the Bureau and stakeholders related to policy, available services, service delivery models, the choice between CSED Waiver and institutional care, and other relevant topics. We orient our training toward multiple audiences, such as members, families, agencies, advocacy groups, and local WV DHHR staff. Our training evaluations consistently report satisfaction with the training conducted by our staff. Training evaluations will be monitored to ensure satisfaction with the training conducted by Kepro staff.

Our education and training plan covers a wide range of training topics including, but not limited to:

- Hosting a CSED Waiver provider meeting up to four times per year (quarterly), including conference room rental and hospitality for attendees.
- Refining/offering our existing, approved training to providers (and to help train their new staff) on recognizing and reporting abuse, neglect and exploitation or other critical incidents.
- Communicating announcements to providers, members, and stakeholders on behalf of the Bureau, using the established email distribution list.
- Participating in conference calls with providers, trainings, and webinars.
- Developing program forms and recommendations to best meet the needs of the program.
- Conducting general community and specified outreach to grow program enrollment.

Review Criteria

As directed by current policy, we will utilize nationally accredited research-based criteria with a clinically sound basis. Kepro staff administering assessments will undergo a comprehensive orientation program where they are trained in state processes and procedures. Orientation of new staff will last approximately two weeks, but can last up to a month, depending on the new staff's previous experience and comfort level with conducting assessments and performance.

We will develop interpretive guidelines for all program eligibility assessments administered and will submit to the Bureau upon request. We will regularly conduct inter-rater reliability activities with staff and updates interpretive guidelines, as necessary. Any updates will be presented to the Bureau as recommendations for approval.

Quality Assurance Activities

We will continue to conduct quality assurance activities with members, families, agencies, stakeholders, and the general community. Quality assurance and improvement is a core tenet of our philosophy and business practice. We apply a holistic approach and constantly seek out opportunities to improve quality within and outside the organization to improve the quality of services to members. With this, we will provide ongoing technical assistance at the request of the Agency. We will report monthly on the Centers for Medicare and Medicaid Services quality measures report. We will monitor our own performance and the quality of our services.

Initial and Continued Reviews

Annual provider reviews are established based on BMS policy and procedures, and any requirements set for in the CMS approved waiver application. We will conduct on-site quality reviews of CSED Waiver providers annually. We will provide the Bureau with the schedule of upcoming reviews a quarter in advance. During this review, we will verify compliance with current state and federal policy guidelines and appropriate utilization management and documentation of authorized services. We will continue with the imperative technical assistance component of the review so that provider can continue to grow their knowledge and understanding of policy and requirements.

Upon exit, we will conduct an exit interview to communicate preliminary findings of the review. At that time, the provider may submit any additional documentation and provide technical assistance/training as necessary for any deficient areas. Within the Bureau's established timeline, we will finalize and submit completed reports.

We will provide comprehensive draft reports within 10 days of the review to the Bureau and to the provider. These reports will include the Review and Disallowance Reports along with the Plan of Correction. The provider will have up to 30 days to respond to their draft reports. Upon receipt and reconciliation of the provider's response, we will prepare and send all components to the Bureau for final consideration. We will work with the provider until they have an approvable Plan of Correction. We will participate in Review Committee where the Bureau, the Office of Program Integrity, and we will discuss final disallowance amounts. We will prepare the final reports for the Bureau to disseminate to the provider. We will complete a follow-up review of providers who must submit a Plan of Correction because of unsatisfactory findings during an on-site review. Depending on the severity of unsatisfactory findings, Staff will conduct either a desk or on-site visit of the provider to verify they did implement their Plan of Correction.

We will facilitate quarterly Quality Improvement Advisory Council meetings to advise the Bureau on program related matters and concerns. We will fund travel expenses for Medicaid members on the council when that member lives greater than 60 miles from the venue and they wish to be reimbursed. We can also send a CSED Waiver staff to a national conference.

A1.1.p. Personal Care Services

1. The Agency covers Personal Care (PC) services for individuals that meet eligibility requirements for the PC Program. As a condition for reimbursement, the Agency requires that the Vendor prior authorize all PC services in accordance with current policies.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, assessments, and other forms or documentation required for determining member eligibility/re-eligibility and prior authorization of PC services. All authorization(s) must be specific to the member, provider agency, service code, units, start and end date. The units, start and end dates in the authorizations may subsequently be modified/edited, as necessary.
3. The Vendor shall develop and maintain a secure web-based, electronic review request system for prior authorization and eligibility review of Personal Care services that allows for data input by the submitting providers. The Vendor's system shall have the capability for:

a. User roles requiring multifactor identification with functionality to be determined by the Agency to include but not limited to: Case Management Agency Administrator, Case Manager, Service Agency Administrator, Fiscal/Employer Agency Administrator, Fiscal/Employer Agency Resource Consultants, and State Agency Administrator.
b. Automated criteria/rules-based certification system
c. The ability to process special requests (i.e., Member eligibility extensions) if/when needed.
d. The ability to identify and approve members that qualify for dual services - i.e., Waiver and Personal Care programs.
e. The ability to process member transfers between service delivery models and between traditional provider agencies.
f. The ability to process and export data via electronic data exchange files regarding member eligibility, member referrals, member budgets, member transfers and authorization information to provider agencies and the Fiscal/Employer Agency vendor (should the Agency allow for self-direction of PC services).
g. The ability to issue notifications regarding member eligibility, referrals, transfers, service authorizations, etc., as appropriate to authorized users.
h. Produce and/or analyze data for CMS and/or Agency reports at the request of the Agency at no additional cost to the Agency.
i. Manage and report monthly to the Agency on CMS quality measures.
j. Refer requests for self-directed services to the Fiscal/Employer Agent (F/EA) vendor in accordance with current policies (should the Agency allow for self-direction of PC services).
k. Calculate member assessment-based budgets that allow the member's case management agency, service agencies, and the Fiscal/Employer vendor for self-directed members (if applicable) to view the status of their authorization requests and input data as needed.
l. Follow all applicable DHHR policies.

4. The Vendor shall make recommendations and develop program forms upon request by the Agency, including draft forms or modified forms already in use. Upon approval by the Agency, the forms will be changed within fourteen (14) calendar days.
5. In performing Personal Care Program service determinations, the Vendor shall use nationally accredited, researched based, criteria in reviewing each prior authorization and eligibility review request. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all Personal Care Program services reviewed under the resulting contract.

a. The Vendor shall maintain the capability to update the review criteria for all Personal Care Program services reviewed under the resulting contract. The Vendor shall make recommendations about policies, procedures, and best practices to the Agency annually, regarding what, if any, changes should be made to the criteria that will be used for the following calendar year.
b. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria recommendations at the time of presenting the recommended changes.

c. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the resulting contract.
d. The Vendor is responsible for any cost associated with the purchase of any review criteria.
e. The Vendor is responsible for notifying members when it has been determined the member qualifies for Level II services.
6. The Vendor shall provide data analysis and reporting. These activities shall include, but are not limited to, the following:
a. Export authorization information to the service provider and to the claim's payor.
b. Export authorization and member eligibility data to the Online Case Management and integrated Incident Reporting/Management System (IMS).
c. Produce and analyze data, as requested by the Agency, in a timeframe to be mutually agreed upon by both parties.
7. The Vendor shall have the capacity and established procedures to have a Registered Nurse to conduct initial assessments of all applicants to determine medical eligibility and service levels within seven (7) calendar days of receiving the referral unless the member is being discharged from a medical facility and then this must be completed within two (2) business days of receipt of referral.
8. The Vendor shall have the capacity and established procedures to have a Registered Nurse to conduct re-evaluation assessments of all members to determine medical eligibility and service levels at least thirty (30) calendar days prior to the member's anchor date.
9. The Vendor shall have the capacity and established procedures to educate Member/Family/Agency/Stakeholder about policies and available services to include on-going training and technical assistance, at no additional cost to the Agency.
a. Participate in Quarterly conference calls/meetings with providers.
b. Participate and/or conduct Statewide trainings and webinars upon request from the Agency at no additional cost.
10. The Vendor shall have the capacity and established procedures to process special requests (member eligibility extensions) upon request.
11. The Vendor shall have the capacity and established procedures to consult with the Agency and make recommendations about policies and procedures and draft policy recommendations upon request by the Agency.
12. The Vendor shall have the capacity and established procedures to draft responses to the Agency on quality measures.
13. The Vendor shall have the capability to manage applications and referrals for determining the eligibility of the Personal Care program members, and correspondence to all applicable parties, to include certified mail at no additional cost when requested by the Agency:
a. Initial Evaluations: The Vendor shall have the capability and established procedures to ensure determinations for initial eligibility in accordance with current policies.
b. Annual Re-evaluations: The Vendor shall have the capability and established procedures to ensure re-evaluations of annual functional assessments of all members in accordance with current policies.

We began exercising a Personal Care (PC) option from the RFP in 2018. Since the program's initiation, we have worked diligently with the State to write policies outlining the policies and procedures needed to streamline and adapt the PC program to better care for members. Our work has helped to provide both convenience to members and cost savings for the State. In 2022, we conducted a total of over 5,500 PC reviews for West Virginia. We have delivered this service successfully, exceeding 95% timeliness since program initiation.

In addition, our past performance has never fallen below the 95% contract requirement, and our staff have never required remediation. In more than 12,000 Satisfaction Surveys conducted covering both the Personal Care Services program and Registered Nurse Assessors over the past

five years, Kepro consistently maintained an average of 4.98 out of 5. In 2022, we scored 5 across all categories with more than 2,000 members surveyed. **Table 15 Personal Care Services Satisfaction Survey Results** details Kepro's survey results since the program's beginning in 2018.

Year	RN Arrived on Time	RN Explained Assmt Purpose	RN Answered My Questions	RN Polite & Friendly	RN Explained Materials	Explained My Abilities & Needs	Adequate Time for Accurate Assmt	# of Surveys
2018	4.97	4.97	4.97	4.98	4.97	4.97	4.97	1,837
2019	4.98	4.98	4.97	4.98	4.97	4.97	4.98	3,874
2020	4.96	4.97	4.98	4.98	4.98	4.98	4.98	2,360
2021	4.99	4.99	4.99	4.99	4.99	4.99	4.99	2,068
2022	**5.00**	**5.00**	**5.00**	**5.00**	**5.00**	**5.00**	**5.00**	2,317

Table 15. Personal Care Services Satisfaction Survey Results
We have maintained an overall average of 4.98 out of 5 in satisfaction results over the past five years.

We obtained these high ratings by establishing and maintaining standardized processes that meet the Agency's timeliness and documentation requirements.

Initial and Reevaluation Request for Medical Evaluation

Kepro receives daily requests for both initial and reevaluation assessments. We utilize the web portal for the WV Personal Care Program. We will receive re-evaluation requests for processing through the system as well as initial requests, physician's orders, and other documentation regardless of the mode of receipt. A registered nurse will conduct both initial and re-evaluation Pre-Admission Screening (PAS) assessments pursuant to all Bureau prescribed instructions, guidelines, and program requirements. We will continue to follow all DHHR guidelines.

We will make every effort to complete initial and annual assessments within required timelines. When we cannot complete an assessment within timeline due to unforeseen circumstances, such as inclement weather or member cancellation, we will track and report on the reasons for inability to complete within designated timeline. Once the assessment is completed, the nurse will submit the evaluation electronically through the web portal. We will then run the data from the assessment through a computerized algorithm based on current program policy and establish a determination of medical eligibility and service level for medically eligible individuals. **Figure 44 Initial Eligibility Process for Personal Care Services** highlights our initial eligibility process.

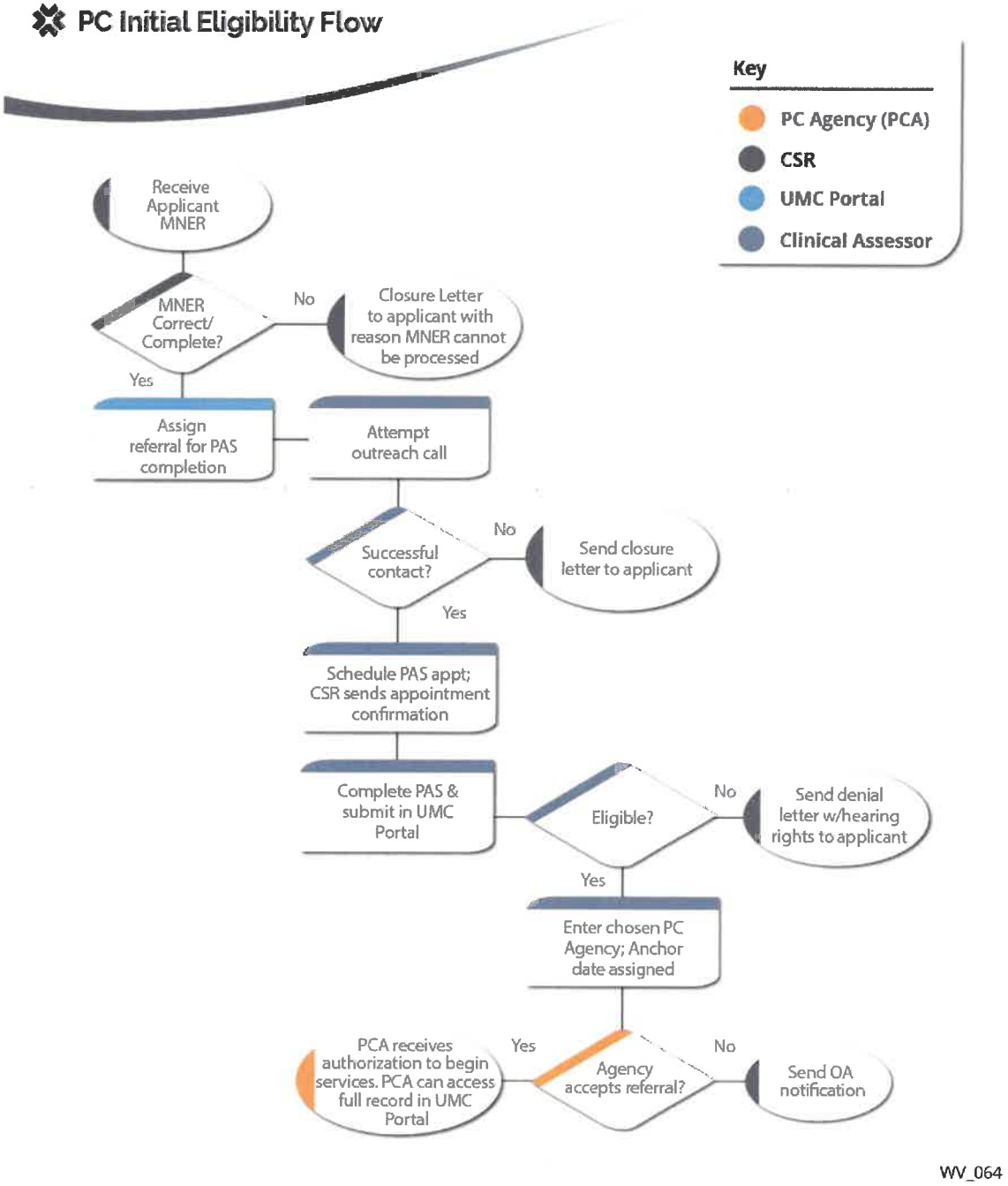


Figure 44. Initial Eligibility Process for Personal Care Services
Kepro consistently completes MNERs within two business days.

The Initial Eligibility Process for PC services begins when the physician, provider, or applicant submits a MNER via email, fax, or mail. The receiving Customer Service Representative (CSR) verifies the initial PC-MNER to determine if it is complete and correct, and then goes on to verify Medicaid eligibility through a review of the claims payor system. If the request is incomplete or

incorrect, a closure letter is sent to the applicant with the reason the MNER cannot be processed. If all required information contained in the MNER is complete and correct, the referral is forwarded to a Clinical Assessor for Pre-admission Screening (PAS) completion and the applicant is contacted to schedule an appointment. As part of our ongoing work with WV DHHR, Kepro consistently meets our service level agreement to process the MNER, including those marked for Dual Services, within two business days.

Once the PAS appointment is scheduled, confirmation is mailed to the applicant. If the nurse is unable to reach the applicant after three failed attempts, a closure letter is sent explaining we were unable to contact the individual to set up an appointment. The initial Pre-admission Screening must be completed within 30 calendar days of receipt of MNER with current BMS guidelines.

Once the PAS is complete and the applicant chooses a PCA, the PAS Assessment data is submitted and evaluated by an algorithm to determine eligibility and the appropriate service level. When eligibility is verified, the RN enters the chosen PCA and Anchor Date into the system. A notification is sent to the chose PCA to alert them of approval or denial. If the applicant is ineligible the RN s-ends a denial letter, which outlines hearing rights, to the applicant.

The selected PCA must accept or reject the referral within the web portal. When the referral is accepted, the PCA has access to the record and can make initial contact with the individual. In situations where the Agency does not accept referral, we send the Operating Agency a notification the referral was rejected. The Operating Agency is responsible to assist the applicant in additional agency selections. **Figure 45 PC Reevaluation of Medical Eligibility Process** highlights our process.

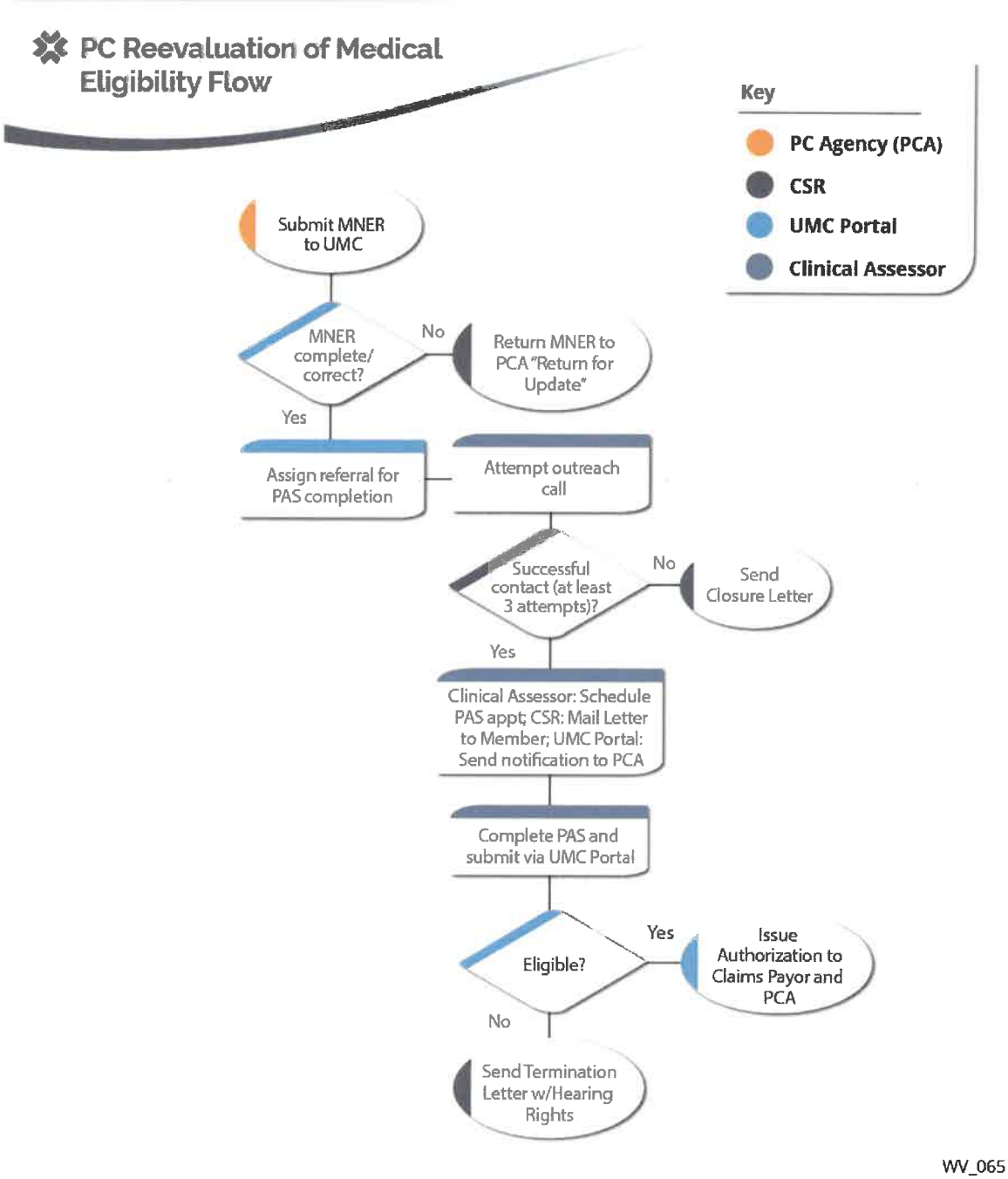


Figure 45. PC Reevaluation of Medical Eligibility Process
The annual PAS must be completed prior to the Anchor date.

The PC Reevaluation of Medical Eligibility Process begins when the Personal Care Agency (PCA) submits the MNER to the web portal. The PCA has between 90 and 45 days prior to the member's

Anchor Date to attach a complete, correct, and signed PC-MNER form to the member's record within the web portal. We will complete the annual assessment 30 days prior to the anchor if the MNER is submitted within timelines. The CSR will review the attachment to verify the member's continuing Medicaid eligibility with access to the claims payor system. The CSR reviews the MNER, including Dual Services MNERs, within two business days to determine if the required information is complete and correct. If the information submitted with the MNER is not complete or correct, we return the MNER to the PCA via the system with the status "Return for Update." When a correct and complete PC-MNER is received, dual services eligibility is confirmed, and the member's Medicaid eligibility is verified, the PC-MNER is submitted for PAS review, and the Clinical Assessor will contact the member to schedule a PAS appointment. Once the PAS is completed and the PAS Assessment data is submitted, it will run through the algorithm for eligibility and service level determination. Annual PAS appointments are required to be completed prior to the listed Anchor date when the MNER is submitted on time. If at this point, the member is deemed ineligible, we send a termination letter with hearing rights enclosed. If the applicant or service is eligible, the reviewer issues authorization to the claims payor and PCA via the system.

Personal Care System

This secure web-based electronic system tracks applicant/member status, contacts, appointments, selections of service delivery models, agencies, and many other data elements. The Atrezzo Care Management system automatically determines medical eligibility based on the Pre-Admission Screening results and calculates service level for eligible applicants/members through an algorithm developed based on policy. The system provides automated authorizations and allows for the submission and processing of special requests to extend existing authorizations as well as exports authorization information to the claims payor. The system alerts the Personal Care Agency of both service levels including Level I and Level II. All authorizations exported will be specific to the member, provider agency, service code, units, start and end date. We will export authorizations and member data to the online CM/IMS system if requested. We will export data and authorizations to the Fiscal/Employer Agent (F/EA) vendor if self-directed services are added to the WV Personal Care Program. The system processes and tracks agency referrals, discharges, letters/notices, PAS assessments and allows for document upload by various user types. Data necessary for routine and ad hoc reports is maintained within the system and is accessible for reporting and analysis. BMS has made the system mandatory for all agencies and other applicable contractors.

Kepro's system also provides secure and accessible access to all users for the submission of requests for authorization. Our portal is Section 508 compliant and meets security standards required by HIPAA and NIST. Access to our portal requires users' credentials (ID and password) as well as multi factor authentication. The site is protected with TLS encryption (TLS 1.2 minimum). To ensure Section 508 compliance, our site is re-tested for compliance prior to all updates.

Data and Reporting

We have been exercising the Personal Care optional work since 2018. We have participated in policy decision meetings, monthly contract management meetings and provided data for the Bureau in relation to the Centers for Medicare and Medicaid Services (CMS) required quality reporting. We will continue to send all required program reports within designated timeframes.

Hearings

If an applicant or member experiences an adverse action (is denied Personal Care medical eligibility, a service level is reduced for a member, or if a requested service level is denied) we will follow the Agency's Medicaid Fair Hearing and Personal Care Program policy procedures. A written notice of the adverse action will be prepared and mailed to the member and/or legal representative. This notice will include the applicable policy resulting in the adverse action, what elements for approval were not met and the right to appeal for state fair hearing. BoSS currently coordinates hearings and accesses Atrezzo for historical documents to prepare the hearing packet. BoSS schedules and coordinates hearings with the State Hearing Officer, member, legal representative, and others. We will make available an RN to participate and/or represent the department in member prehearing conferences and/or hearings either telephonically or in-person as required by the Agency.

Quality Assurance, Evaluation Timelines

Through our Quality Assurance program, we will ensure determinations for initial eligibility and service level occur within approved parameters of receiving the referral in accordance with current federal and state policy guidelines. Re-evaluations will be completed at least 30 days prior to the member's established Anchor Date (dependent on providers submitting the re-evaluation request within timeline). All emergent requests will be completed within two business days per policy. All PC/Dual request will be processed within two business days. We will complete routine inter-rater reliability and quality assurance/improvement activities. We will make recommendations about policy, procedure, and best practices to the Agency annually about what, if any, changes should be made to the criteria. All materials and data related to criteria recommendations will be provided to the Bureau for consideration. We will submit any recommended modifications or interpretation of the criteria to the Bureau for consideration and approval prior to implementation.

Training and Technical Assistance

We will provide technical assistance to providers and stakeholders regarding policies and program services. Our staff will participate in required provider trainings either face to face or virtually upon request. We will attend all Personal Care Program Quarterly meetings either virtually or face to face. We will communicate program announcements to providers, members, and other stakeholders when requested. We will develop forms and make recommendations when as requested.

Fraud, Waste, Abuse Referral

If we suspect fraud, waste, and/or abuse, we will refer our suspicions to the Bureau's Office of Program Integrity (OPI).

A1.1.q. Aged and Disabled Waiver (ADW) Services

1. The Agency covers ADW services for individuals that meet initial and annual medical eligibility requirements for the ADW Program. As a condition for reimbursement, the Agency requires that the Vendor prior authorize all ADW services in accordance with current policies.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, Plans of Care, assessments, and other forms or documentation required for determining member eligibility/re-eligibility and prior authorization of ADW Program services. All authorization(s) must be specific to the member, provider agency, service code, units, start and end date. The units, start and end dates in the authorizations may subsequently be modified/edited as necessary.
3. The Vendor shall have the capability to manage applications and referrals for determining the initial eligibility and annual eligibility determinations of ADW program members by qualified staff and correspondence to all applicable parties, to include certified mail when requested by the Agency, within fourteen (14) calendar days of referral.

All correspondence regarding member eligibility shall be approved by the Agency and any changes requested by the Agency shall be completed within fourteen (14) calendar days.

a. Initial Assessments: The Vendor shall have the capability and established procedures to ensure tracking of all initial applications and determining medical eligibility in accordance with current policies. These procedures include confirmation of financial eligibility within established policy timelines and the release of funded slots.
b. Annual Assessments: The Vendor shall have the capability and established procedures to conduct annual redeterminations of medical eligibility of all members in accordance with current policies. Eligibility redeterminations shall be made no more than ninety (90) calendar days but at least thirty (30) calendar days prior to the member's annual anchor date.
c. Applicant/Member Education: The Vendor shall provide education to all applicants/members regarding program eligibility, choice of service delivery models, choice of providers and services, member rights and responsibilities including safe service delivery environments and the identification and reporting of abuse, neglect, and exploitation.
d. The Vendor shall have the capability and established procedures for maintaining the thirty (30) calendar day minimum timeline for conducting annual re-evaluations when appointments are canceled/rescheduled by the Vendor or member.
e. Managed enrollment: The Vendor shall have the capability and established procedures to determine initial and annual medical eligibility; confirm financial eligibility; and manage the enrollment list (waitlist) in accordance with current policies.
f. Enrollment/ Activation: The Vendor shall have the capacity and established procedures to track the applicant from the time of application, financial eligibility, medical eligibility, and enrollment/activation until the applicant has been determined eligible and fully active in the ADW program. This will require interfacing with the local DHHR for financial eligibility updates.
g. The Vendor shall have the capability and established procedures to determine the member's Service Level at least annually or more often if a change in need occurs and make the Service Level available to the assigned Case Management Agency, service Agency(s) and fiscal agent for self-directing members (if applicable) in accordance with current policies.
h. Maintain electronic health record: The Vendor shall maintain an electronic health record of all ADW members and applicants. The Agency, the member's Case Management agency, other agencies authorized to provide ADW services to the member, and the Fiscal/Employer Agency for self-directing members (if applicable) shall have appropriate access to member data and the ability to input data as needed.

i. The Vendor shall provide follow-up to all ADW applicants to include contacting the applicant, legal representative and/or family to explain and assist with the application and enrollment processes.

4. The Vendor shall develop and maintain a secure web-based, electronic review request system for prior authorization and eligibility of ADW services that allows for data input by the submitting provider agencies. The Vendor's system shall have the following capabilities:

a. User roles requiring multifactor identification with functionality to be determined by the Agency to include but not limited to: Case Management Agency Administrator, Case Manager, Service Agency Administrator, Fiscal/Employer Agency Administrator, Fiscal/Employer Agency Resource Consultants, Bureau of Senior Services (BoSS) Administrator, and State Agency Administrator.

b. Automated criteria/rules-based certification system.

c. The ability to process special requests (i.e., Member eligibility extensions) if/when needed.

d. The ability to identify and approve members that qualify for dual services - i.e., Waiver and Personal Care programs.

e. The ability to process member transfers between service delivery models and between traditional provider agencies.

f. The ability to process and export data via electronic data files regarding member eligibility, member referrals, member Service Levels, member transfers and authorization information to provider agencies and the Fiscal/Employer Agency vendor.

g. The ability to issue notifications regarding member eligibility, referrals, transfers, service authorizations, etc., as appropriate to authorized users.

h. Export authorization information and ADW attribute/benefit information to the state's claims payor.

i. Produce and/or analyze data for CMS and/or Agency reports at the request of the Agency at no additional cost to the Agency.

j. Manage and report data for various purposes, including but not limited to Legislative Oversight Commission on Health and Human Resources Accountability (LOCHHRA) report and/or other Legislative reports, as needed.

k. Manage and report monthly to the Agency on CMS quality measures that are within the Vendor's scope of work.

l. Produce monthly reports on active enrollees and managed enrollees.

m. Process requests for service authorizations within two (2) business days and in accordance with current policies.

n. Refer requests for self-directed services to the Fiscal/Employer Agent (F/EA) Vendor in accordance with current policies.

o. Determine member assessment-based Service Levels that allow the member's case management agency, service agencies, and the Fiscal/Employer vendor for self-directed members (if applicable) to view the status of their authorization requests and input data as needed.

p. Export authorization and member eligibility data to the Online Case Management and integrated Incident Reporting/Management System (IMS).

q. Follow all applicable DHHR policies and court orders.

5. The Vendor shall have the capability to develop educational trainings to include Continuing Education Units (CEUs) for nurses, counselors and Licensed Social Workers and provide information and technical assistance, at no additional cost to the Agency, regarding policies, available services, service delivery models, and the choice between ADW and institutional care for members, their legal representatives, families, provider agencies, stakeholders and the general community via email, telephone, webinars, etc. To include, but not limited to:

a. Participate in conference calls with providers, statewide trainings, and webinars at the request of the Agency.

b. Provide training and education on subjects requested by the Agency to the provider agencies.

c. Collaborate with other stakeholders in activities at the request of the Agency, i.e., program changes resulting in program policy changes.

d. Communicate program announcements to providers, members, and other stakeholders as necessary to include USPS if requested by the Agency, at no additional cost to the Agency.

e. Make recommendations and develop program forms upon request from the Agency.
f. Conduct general and specified community outreach to grow program enrollment at the request of the Agency.
6. In performing ADW service determinations, the Vendor shall use nationally accredited, researched based criteria in reviewing each prior authorization and eligibility review request. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all ADW Program services reviewed under the resulting contract.
a. The Vendor shall maintain the capability to update as needed the review criteria for the authorization of ADW services. The Vendor shall make recommendations regarding policies, procedures, and best practices related to authorization of ADW services.
b. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria recommendations at the time of presenting the recommended changes.
c. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the term of the contract.
d. The Vendor is responsible for the cost associated with the purchase of any review criteria.
e. Represent the Agency at hearings regarding program eligibility and service authorization determinations.
f. The Vendor must have a full-time, in-state Program Manager for the ADW program that will attend at least one (1) national conference at request of the Agency.
g. Manage and report on all sites owned, leased, or operated by ADW providers where ADW members reside and receive services to assure compliance with the CMS Integrated Settings Rule. This includes visiting new sites to ensure compliance prior to the member receiving

Our West Virginia team has successfully provided Aged and Disabled Waiver (ADW) Services since 2009. In 2022, we conducted over 8,000 ADW reviews for West Virginia. Over the past six years, we have conducted nearly 24,000 surveys for member and applicant satisfaction Assessment Process and RN Assessors. In that time, we scored an overall average of 4.96 out of 5 on customer satisfaction surveys, indicating a significant level of member satisfaction. **Table 16. Aged and Disabled Waiver Satisfaction Survey Results** outlines our scores across surveyed categories.

Year	RN Arrived on Time	RN Explained Assmt Purpose	RN Answered My Questions	RN Polite and Friendly	RN Explained Materials	Explained My Abilities & Needs	Adequate Time for Accurate Assmt	Number of Surveys
2016	4.93	5.00	4.99	4.97	4.94	4.94	4.94	1,158
2017	4.97	5.00	4.96	5.00	4.96	4.96	4.96	3,784
2018	4.97	4.97	4.97	4.98	4.97	4.97	4.97	4,064
2019	4.98	4.96	4.97	4.97	4.97	4.97	4.97	3,809
2020	4.97	4.98	4.98	4.98	4.98	4.98	4.98	3,193
2021	4.94	4.94	4.94	4.95	4.94	4.94	4.94	4,203
2022	4.99	4.97	4.97	4.97	4.97	4.97	4.97	3,679

Table 16. Aged and Disabled Waiver Satisfaction Survey Results
Kepro leverages best practices continually improved to provide excellent services to West Virginians.

Initial and Reevaluation Request for Medical Evaluation

Kepro receives daily request for both initial and reevaluation assessments. Kepro continues to use the web portal that was implemented in 2014. We will continue to receive re-evaluation requests for evaluation through this system and initial requests, and physician's orders regardless of the mode of receipt. A registered nurse will conduct both initial and re-evaluation Pre-Admission Screening (PAS) assessments pursuant to all Bureau prescribed instructions, guidelines, and program requirements. We follow all DHHR guidelines and court orders.

We will make every effort to complete initial and annual assessments within required timelines. When we cannot complete an assessment within timeline due to unforeseen circumstances, such as inclement weather or member cancellation, we track and report on the reasons for inability to complete within designated timeline. Once the assessment is completed, the nurse will submit the evaluation electronically. We will then run the data from the assessment through a computerized algorithm based on current program policy and establish a determination of medical eligibility and service level for medically eligible individuals. We will export authorization and member eligibility data to the online Care Management system for ADW and all other Waiver programs.

We provide program education to all applicants and members regarding program eligibility, choice of service delivery models, choice of providers, members rights and responsibilities on informed consent, freedom of choice, safety, conflict-free case management and reporting abuse and neglect. Our staff provides follow up and assistance to all applicants and members during the enrollment and application process. We will continue to utilize satisfaction surveys with both members and applicants. We will complete CMS integrated settings surveys for provider-controlled settings. **Figure 46** outlines the **Aged and Disabled Waiver (ADW) Services Initial Eligibility Process**.

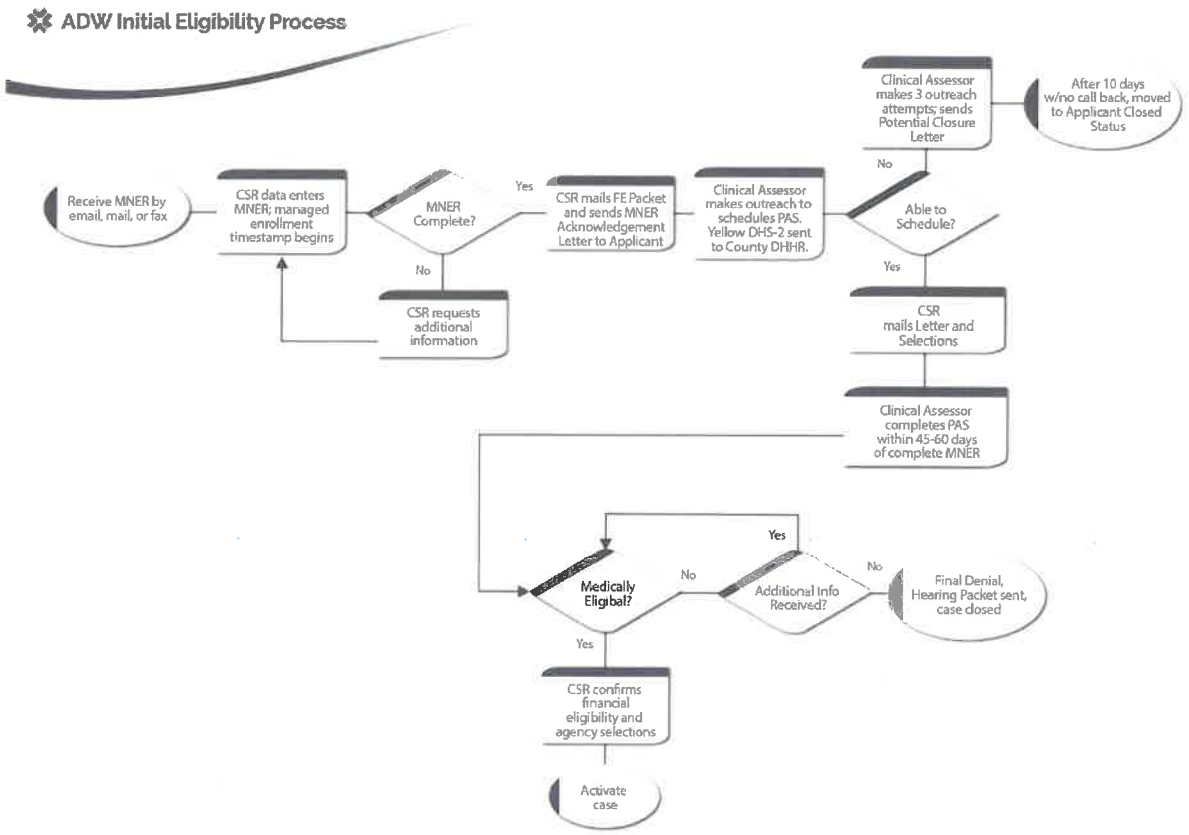


Figure 46. Aged and Disabled Waiver (ADW) Services Initial Eligibility Process
We have established an adaptable system that is efficient in handling tens of thousands of members.

We will receive the MNER by email, mail, or fax. Once the CSR enters the MNER the managed enrollment timestamp begins. If it is determined that the MNER is not complete, the CSR requests additional information. If the MNER is complete, the CSR mails the Financial Eligibility Packet and sends the MNER Acknowledgement Letter to the applicant. The Clinical Assessor will then conduct outreach to schedule the PAS. The CSR will also send the Yellow DHS-2 to the County DHHR. If not able to reach the applicant after three outreach attempts, the CSR will send the Potential Closure Letter to the applicant. If the applicant does not respond within 10 days, the referral is moved to Applicant Closed Status.

When the Clinical Assessor contacts the applicant, they will schedule the appointment at a convenient time for the individual. The Clinical Assessor then mails the letter and selections to the applicant. The Clinical Assessor will then complete the initial and re-evaluation PAS within required timelines and, if it is determined that the applicant is not medically eligible, the provider is able to submit additional information supporting medical eligibility. If additional information is

not received, the Clinical Assessor will close the case with a final denial and send the Hearing Packet to the applicant.

If it is determined that the applicant is medically eligible a letter is sent to notify applicant. Once final financial eligibility is received the financial eligibility date is entered and anchor date given.

Figure 47 outlines the **ADW Services Annual Eligibility Process.**

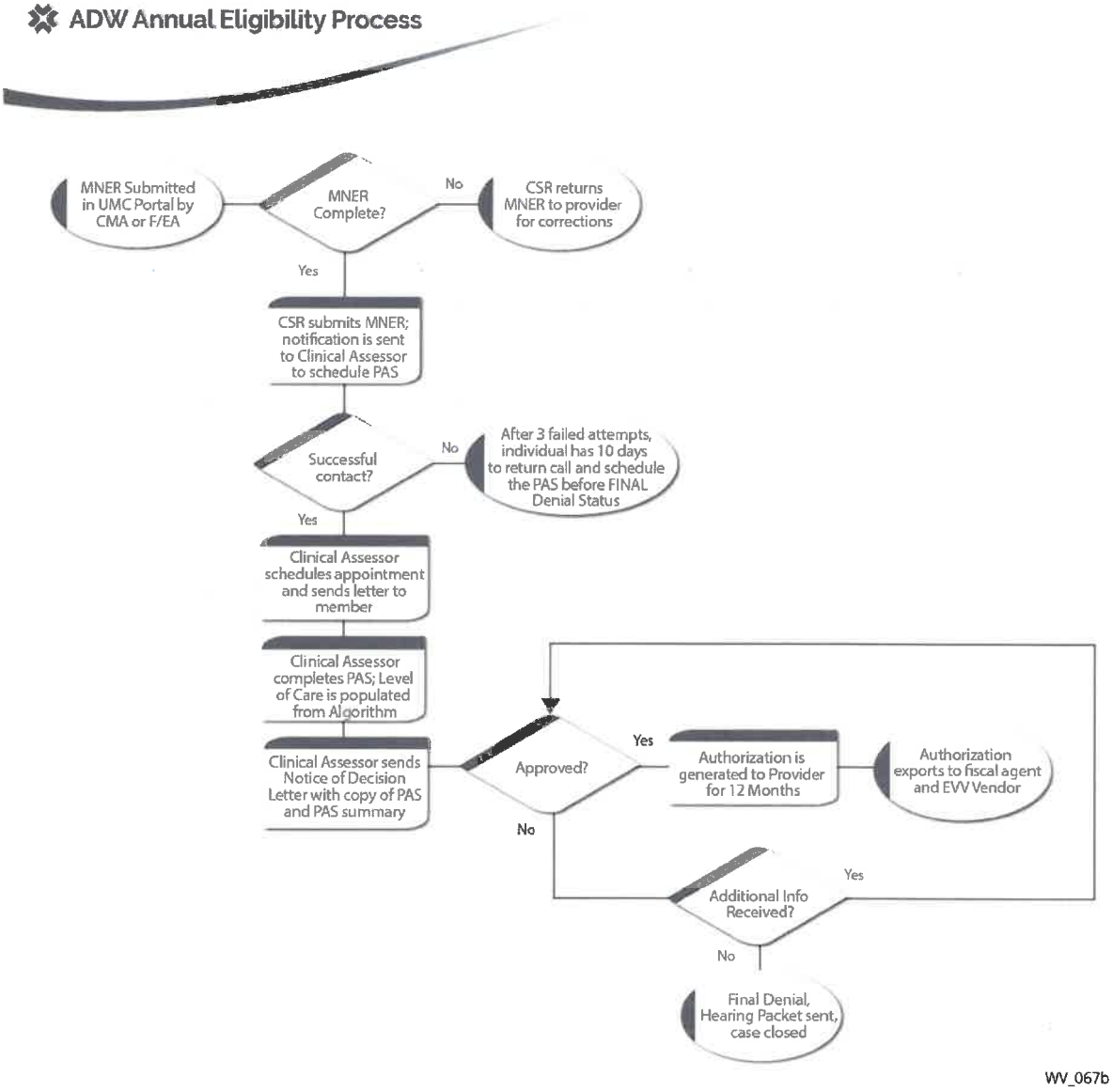


Figure 47. ADW Annual Eligibility Process

Kepro built an annual eligibility review process that accommodates WV DHHR needs.

The ADW Annual eligibility process begins with the submission of the MNER. The CSR will review the MNER to ensure that it is complete. If it is not complete, it is returned to the provider. If

Exceeding Standards

Our ADW program was 100% compliant in maintaining and delivering an accurate managed enrollment list based on federal and state policy guidelines during Fiscal Year 2022.

complete, the CSR submits the MNER, and a notification is sent to the Clinical Assessor to schedule the PAS. If the Clinical Assessor is unable to make contact after three attempts, the request is placed in Potential Closure, and the individual will then have 10 days to schedule the PAS before the case goes into final denial status. Upon contact with the individual, the appointment is scheduled and sent to the member. Next, the PAS is completed by the Clinical Assessor and the Level of Care (LOC) is populated by the algorithm. An Annual Notice of Decision (NOD) letter is mailed to the Member with a copy of the PAS, including the PAS Summary. If approved, authorization is generated to the provider for 12 months, and the process ends with an authorization export to Gainwell and HHA. If it is not approved, the Clinical Assessor will determine if additional information is needed. If additional information is needed, upon receipt, the Clinical Assessor will once again check for Level of Care (LOC) approval to complete the process. If additional information is not applicable at this point, the Member will move to a final denial status. We have provided management and oversight of medical eligibility and service level determination in support of the Bureau's Aged and Disabled Waiver program since 2009. Since that time, we have participated in policy decision meetings, monthly contract management meetings and provided data for the Bureau in relation to the Centers for Medicare and Medicaid Services (CMS) required quality reporting. In addition, to ensure Kepro incorporates all West Virginia reporting requirements we will export both authorization and member eligibility data to the online Care Management system.

Data and Reporting

We have provided management and oversight of medical eligibility and service level determination in support of the Bureau's Aged and Disabled Waiver program since 2009. Since that time, we have participated in policy decision meetings, monthly contract management meetings and provided data for the Bureau in relation to the Centers for Medicare and Medicaid Services (CMS) required quality reporting. We will continue to send all require program reports within designated timeframes.

Managed Enrollment

Medically and financially eligible applicants will be placed on the Managed Enrollment List (if applicable) which we currently maintain – and will continue to do so. Once a funded slot is available, we will "release" the slot, and electronically refer the case to the Agency/agencies or Fiscal/Employer Agent vendor. Approved re-evaluation assessments will automatically generate authorizations for services. For purposes of streamlining and efficiencies, communication with the agencies and/or vendors will be through the Aged and Disabled system whenever possible.

Hearings

If an applicant or member experiences an adverse action (is denied Aged and Disabled Waiver medical eligibility, a service level is reduced for a member, or if a requested service level is denied) we will follow the department's Medicaid Fair Hearing and Aged and Disabled Waiver program policy procedures. A written notice of the adverse action will be prepared and mailed to the member and/or legal representative. This notice will include the applicable policy resulting in the adverse action, what elements for approval were not met and the right to appeal for state fair hearing. BoSS currently coordinates hearings and accesses Atrezzo for historical documents to prepare the hearing packet. BoSS schedules and coordinates hearings with the State Hearing Officer, member, legal representative, and others. We will make available an RN to participate and/or represent the department in member prehearing conferences and/or hearings either telephonically or in-person as required by the Agency.

Aged and Disabled Waiver System

We implemented the Atrezzo Care Management system for the Aged and Disabled Waiver in July 2014. This secure web-based electronic system tracks applicant/member statuses, contacts, appointments, selections of service delivery models, agencies, and many other data elements. The system automatically determines medical eligibility based on the Pre-Admission Screening results and calculates service level for eligible applicants/members through an algorithm developed based on policy. The system provides automated authorizations and allows for the submission and processing of special requests to extend existing authorizations as well as exports attribute and authorization information to the claims payor. All authorizations exported will be specific to the member, provider agency, service code, units, start and end date. We will export authorizations and member data to the online CM/IMS system if requested. The system processes and tracks agency referrals, discharges, letters/notices, PAS assessments and allows for document upload by various user types. Data necessary for routine and ad hoc reports is maintained within the system and is accessible for reporting and analysis. BMS has made the system mandatory for all agencies and other applicable contractors.

Kepro's system also provides secure and accessible access to all users for the submission of requests for authorization. Our portal is 508 compliant and meets security standards required by HIPAA and NIST. Access to our portal requires users' credentials (ID and password) as well as multi factor authentication and the site is protected with TLS encryption (TLS 1.2 minimum). To ensure 508 compliance, our site is re-tested for 508 compliance prior to all updates.

Quality Assurance, Evaluation Timelines

Through our Quality Assurance program, we will ensure determinations for initial eligibility and service level occur within approved parameters of receiving the referral in accordance with current federal and state policy guidelines and court orders. Re-evaluations will be completed at least 30 days prior to the member's established Anchor Date (dependent on providers submitting the re-

evaluation request within timeline). We will complete routine inter-rater reliability and quality assurance/improvement activities. We will make recommendations about policy, procedure, and best practices to the Agency annually about what, if any, changes should be made to the criteria. All materials and data related to criteria recommendations will be provided to the Bureau for consideration. We will submit any recommended modifications or interpretation of the criteria to the Bureau for consideration and approval prior to implementation.

Aged and Disabled Waiver Training and Technical Assistance

We will develop education trainings to include CEU's for nurses, counselors, and licensed social workers. We will provide technical assistance to providers and stakeholders regarding policies, available services, service delivery models, and the choice between ADW and institutional care when requested by the Agency. Our staff will participate in any required provider trainings either face to face or virtually when requested by the Agency. We will communicate program announcements to providers, members, and other stakeholders when requested. Our team will conduct general and specified community outreach when requested by the Agency. We will develop forms and make recommendations when requested by the Agency. We will have a full time, in-state Program Manager to attend the National Conference at the request of the Agency.

Fraud, Waste, Abuse Referral

If we suspect fraud, waste, and/or abuse, we will refer our suspicions to the Bureau's Office of Program Integrity (OPI).

A1.1.r. Take Me Home (TMH) Services

1. TMH participants may receive all Agency services for which they qualify.
2. The Vendor will be required to flag, track and report on the status of all eligible TMH participants (as determined by TMH staff) accessing the Aged & Disabled Waiver, Traumatic Brain Injury Waiver, and the State Plan Personal Care Program for those who are dually eligible for Waiver and Personal Care services. This will include:
   a. Tracking the status of MFP participants who apply for Waiver and State Plan services (if applicable).
   b. Notifying designated Take Me Home staff of medical eligibility determinations (including potential denials & denials) and Service Model and provider selections.
   c. Notifying designated TMH staff of Fair Hearing requests and Hearing determinations.
   d. Notifying ADW and TBIW providers when an eligible TMH participant has selected their Agency.
   e. Notifying designated TMH staff if a current TMH participant loses ADW, TBIW or State Plan Personal Care medical eligibility (If applicable).
   f. Preparing monthly reports on the status of TMH participants accessing Waiver and State Plan Personal Care services (if applicable)
3. Upon the Agency's request, the Vendor shall conduct quality assurance activities with members, families, Agencies, stakeholders, and the general community as necessary or at the request of the Agency. These activities shall include, but not limited to, the following:
   a. Conduct quality reviews of the services TMH participants receive as members of the ADW and TBI programs.
   b. Prepare summary report of quality review findings specific to TMH participants accessing ADW and TBI Waiver services.
   c. The Vendor shall participate in conference calls at the request of the Agency.

Kepro began our involvement and collaboration with the Take Me Home-WV (TMH) program with its approval in 2011. This "Money Follows the Person" demonstration program successfully supports the transition of eligible members from long-term care facilities to their own homes and communities. We have prepared and disseminated correspondence to program stakeholders (such as Traumatic Brain Injury Waiver providers) on behalf of the TMH program. We participated in TMH Advisory Council and quarterly meetings and conference calls. We will continue these efforts and will incorporate TMH services into existing systems and procedures.

Upon notice from TMH staff that an Aged and Disabled Waiver (ADW), Traumatic Brain Injury Waiver (TBIW) or Personal Care (PC) applicant is eligible for TMH services, Kepro will flag the application as related to a TMH member. As related to ADW, TMH members are already "flagged" in the ADW system along with a start date and end date for TMH approval. For optimal coordination of TMH Services and existing programs, we can add this feature to the Personal Care and Traumatic Brain Injury systems. Along with flagging the case, we will incorporate a TMH user role into the system. This will allow for instant notification to designated/approved TMH staff of medical eligibility determinations including potential denials and denials, chosen service model, provider selections, Fair Hearing requests and determinations and will allow TMH staff to update the status of TMH participation.

We will prepare monthly status reports on the status of TMH members accessing Waiver and State Plan Personal Care services – as based on the member's eligibility status. The TMH monthly report shall include:

- Medical eligibility status for initials and reevaluation assessments
- Fair Hearing status (if applicable)
- Current service delivery model selection
- Current selection of provider.

We will work with TMH staff to determine the elements and documentation requirements necessary for best practice related to provision of TMH Services. We will conduct on-site and/or desk reviews of these services and prepare a summary report of review findings when requested. Kepro proposes that a documentation/desk review is conducted initially with providers of TMH Services for a representative sample of members. If review findings are not satisfactory as determined by the Bureau's threshold, we will provide on-site follow-up review and education/technical assistance.

A1.1.s. Lab/Genetics Services

1. The Vendor shall develop, implement, and maintain a UM program, which includes prior authorization for any laboratory/molecular diagnostic tests and/or pathology services:
a. BRCA testing
b. Oncotype DX
c. Genetic testing
d. Molecular diagnostic and Pathology tests

e. Drug Screening
f. Any other identified laboratory service or over utilized and/or high- cost lab services
2. The Agency reserves the right to modify the list, through either addition or deletion of laboratory procedures subject to prior authorization over the term of the contract.
3. Vendor shall develop, implement, and maintain a Molecular Diagnostic Services Program and propose coverage determinations and/or prior authorizations in addition to the following:
a. Accept claim and/or any documentation from lab or ordering physician needed to complete determination and/or prior authorization process.
b. Develop a method to determine test specific correct coding and pricing (when no price is available in the Medicare Clinical Laboratory Fee Schedule) that Vendor can submit to Fiscal Agent for adjudication.
c. Coordinate with and submit information needed to Fiscal Agent to ensure adjudication.
d. Generate appropriate policies to support decisions.
e. Update master file with new policies for quarterly release.
f. When making determinations and pricing decisions take into consideration the WV State Plan, any applicable federal regulations and policy comparisons of other State Agencies. The Agency shall have prior approval of the proposed plan and policy.
g. Scope of Molecular Diagnostic Services may include, but is not limited to:
h. Tier 1- 81200-81383 CPT code range
i. Tier 2- 81400-81479 CPT code range
j. Micro dissection- 88380-88381
k. HCPCS: Molecular pathology procedure; physician interpretation and report- G0452
l. Not otherwise classified (NOC)- 81479, 84999, 85999, 86849, 87999, 88199,88299,88399,89398.
4. The Agency reserves the right to modify the list, through either addition or deletion, over the term of the contract.

In the last several years, we have seen an increased demand for the development and implementation of a more robust UM system to authorize high-cost laboratory services, particularly laboratory/molecular diagnostic tests and/or pathology services to aid in the treatment of diagnosed conditions. In 2022, under our current contract with WV DHHR, we conducted close to 1,600 Lab/Genetics services reviews. the prior authorization of lab/genetics services is conducted using InterQual®, local medical policies, and BMS Manual Chapter 529. Prior authorization of lab/genetics services will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

Through thorough review and research, we developed, and will continue to develop, criteria for Genetic/Molecular Diagnostic services in conjunction with and for BMS in these review areas as new codes are implemented by BMS. Over the last several years CPT and/or HCPCS coding systems expanded to incorporate numerous genetic testing and drug screening codes. Our team assists the Bureau by:

- Researching codes and making coverage recommendations (genetic testing added in 2015)
- Researching and recommending criteria (e.g., Cystic Fibrosis criteria
- Developing criteria when criteria is not available (Drug Screening/G Codes)
- provider education, webinars, and training (Drug Screening/G codes and BRAC)

The increased number and types of laboratory services covered by the Bureau for Medical Services that require prior authorization include:

- Cystic Fibrosis, Toxicology laboratories; Vectra (Rheumatoid Arthritis Disease Activity)
- Drug metabolism (pharmacogenics) sequence analysis
- Targeted genomic sequence analysis panel
- Targeted genomic sequence analysis panel solid organ or hematolymphoid neoplasm
- Infectious agent antigen
- Infectious agent DNA or RNA
- infectious agent detection by DNA or RNA
- Cytogenic analysis for chromosomal abnormalities
- Cytogenomic analysis for constitutional chromosomal abnormalities
- Exome
- Inherited bone marrow failure syndromes
- Oncology Breast, MRNA
- Oncology (uveal melanoma)
- Thiopurine (TPMT)

We will continue to assist the Agency when InterQual® criteria are not available by providing recommendations to BMS based on research of clinically sound and research-based criteria endorsed by our Medical Director and physicians in the specialty of the criteria under review. These criteria can also be edited to create local medical policies (LMPs) that conform to BMS specific policies. Local medical policies are developed for existing criteria sets, as policy is updated or clinical practices changes. Recommendations are sent to BMS for approval, and once approved, are implemented. Providers are updated regarding criteria changes and if the criteria are not proprietary, they are available to providers unless otherwise specified by BMS. Proprietary criteria, such as InterQual, may not be disclosed to providers; however, InterQual has developed SmartSheets in many review areas that can be made available to providers upon request.

We will update the review criteria annually, and alert BMS to any recommended changes in the criteria, considering the WV State Plan, any applicable federal regulations and policy comparisons to other state agencies. Any recommended changes in criteria will be included in the annual report provided to the Agency. Since InterQual criteria is utilized in several review areas it is not within the purview of Kepro or BMS to make major modifications to the proprietary criteria set- however, recommendations will be made to the Agency for any additions or edits that may need to be approved to conform to BMS policies. For all other policies, recommended changes will be presented to the Agency for consideration. The Bureau may reject current or recommended criteria and specify different criteria to be used. We will provide the Agency with access to a complete set of materials associated with the criteria annually. Kepro assumes responsibility for the cost of InterQual review materials and any other criteria set adopted that is not public domain. Further, we developed a Molecular Diagnostic Services Program to:

- Make coverage recommendations related to new testing codes as well as codes that move from investigational/experimental to standard medical practice
- Assist BMS with coding and pricing for services where pricing is not available in the Medicare Clinical Laboratory Fee Schedule, considering the WV State Plan, any applicable federal regulations and policy comparisons to other state agencies
- Request agency approval of the criteria for: 1) Tier 1 81200-81383 CPT code range; 2) Tier 2- 81400-81479 CPT code range; 3) Micro-dissection 88380-88381; 4) HCPCS- G0452; 5) Not Otherwise Classified Codes (NOC)- 81479, 84999, 85999, 86849, 87999, 88199, 88299, 88399, 89398, and; 6) other laboratory/codes as requested by the Agency

Stakeholder Engagement and Education

We will develop educational trainings for laboratory/genetic testing stakeholders on topics requested by the BMS. Technical assistance is provided as requested by individual providers or to all Laboratory/Genetics service providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will provide the following services to the BMS to ensure appropriate utilization management of laboratory/genetic testing services:

- Participate in conference calls at the request of the Agency.
- Develop a reference manual for providers.
- Maintain updated imaging/radiology information, instructions, updates, code lists, bulletins, links to other information and sites, and announcements of new information on the website.
- Hold initial orientations to the system with key stakeholders, as requested by the Agency.
- Provide support to the Agency related to stakeholder inquires, including but not limited to members, providers, facilities, legislators, and/or other government offices or officials.
- Provide a toll-free line for providers and members for inquiries regarding service coverage, prior authorization status or to answer questions regarding issues or problems with a prior authorization request.
- Make recommendations or develop forms upon request of the Agency.
- Represent the Agency regarding UM and/or Agency policies, guidelines and/or other criteria at meetings, conferences, or educational seminars, as needed.

We will also coordinate with Gainwell, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. We will also monitor over- and under- utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

A1.1.t. Out-of-Network (OON) Services

1. The Vendor shall develop, implement, and maintain a UM program, which includes prior authorization for any Out of Network services according to the Agency policies: Out of Network services are only approved when it

meets medical necessity for the member to be treated by an out-of-network, non-enrolled provider, because there is no In-Network provider available or appropriate that can meet the member's need. Any non-emergent service that is done Out of Network (OON) requires prior authorization obtained by an In-Network attending/ordering/referring provider as per the Agency's policies. Any OON provider wanting to provide services for Agency members must enroll with the Agency.

2. Vendor shall have the ability to fulfill the OON process, to include but not limited to the following:

a. Confirm attending/ordering/referring provider is in-network and member's eligibility. If the member is enrolled in an MCO the attending/ordering/referring provider is notified and directed to the MCO. If the member is ineligible for Medicaid or WVCHIP benefits and/or has Third Party Liability (TPL) the request is closed, and the provider and member are notified of the reason.

b. Determine enrollment status of provider and/or facility being referred to. If in-network the usual prior authorization process is implemented.

c. Determine if service requested is a covered service.

d. Determine if service requested requires an OON prior authorization per the Agency's policies.

e. Determine if service can be appropriately provided In-network. Notify attending/ordering/referring provider of In-Network provider's that are available.

f. Determine if medical necessity is met for the OON service. If medical necessity is not met a denial letter is sent to the member and all providers stating the reason for denial, and the member's notification of appeal rights, and if applicable, the procedures, for the attending/ordering/referring provider's ability to request a peer-to- peer review and/or reconsideration. If medical necessity is met, enrollment tracking begins, the Fiscal Agent is notified of approval by Vendor and the Fiscal Agent sends enrollment letter. Vendor holds the prior authorization (unless urgent) until enrollment of the provider is completed and directs the OON provider to the Fiscal Agent for enrollment. (Fiscal Agent provider Enrollment Policy and Procedure E- 104). Fiscal Agent/Vendor coordinates enrollment and prior authorization efforts. Fiscal Agent communicates via tracking the enrollment of the OON provider to the Vendor within a specified timeframe.

Kepro fully understands that services must be provided by in-network providers whenever practicable. Since 2011, we have conducted out-of-network provider reviews to ensure that when out-of-network providers are needed, the circumstances are valid and medically necessary as defined in this section and by BMS policy. For example, in instances when services may not be available from in-network providers or special circumstances exist. In 2022, we reviewed 30 cases for West Virginia to ensure out-of-network provider usage was in full compliance with Medicaid regulations. **Figure 48** outlines our **Out-of-Network Provider Review Process**.

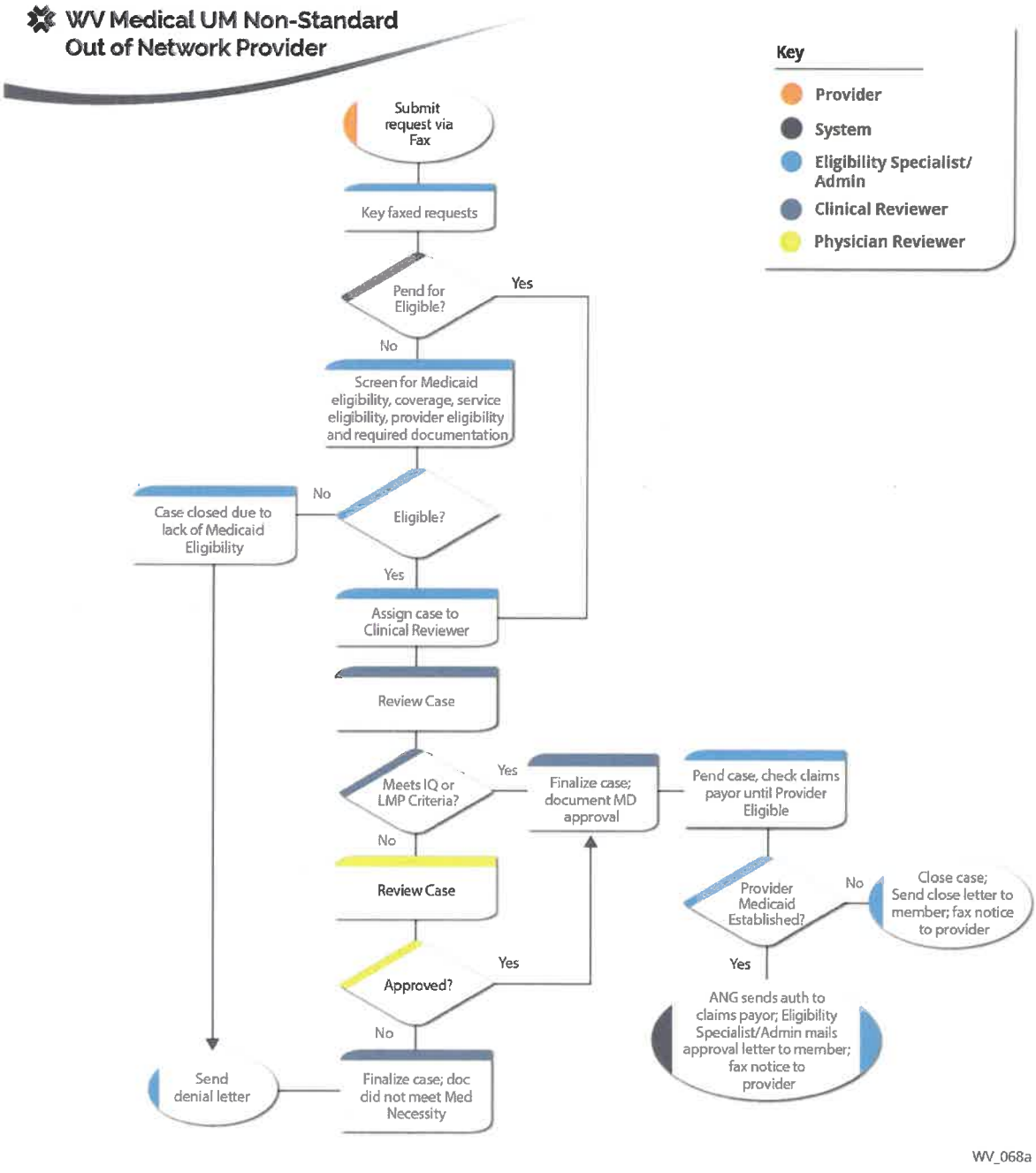


Figure 48. Out-of-Network Provider Review Process

A well-established process for out-of-network provider review is critical to ensuring medically necessary.

The out-of-network provider review process begins when a provider listed in a prior authorization request for medical/behavioral health is not enrolled in the network. We will review in-network options for a viable provider and will contact the Options for in-network providers for that service are explored and the WV Medicaid enrolled referring physician and requested out-of-network

provider are contacted. If we determine an in-network provider is available to provide the service, the initial request is closed, and the referring physician and member are made aware of available in-network providers who are enrolled to provide the service. If no in-network provider is identified, and the review determines that the out-of-network provider is appropriate and medically necessary, an authorization is granted. However, the information cannot be exported to the MMIS system until the out-of-network provider is enrolled.

Next, call tracking is initiated with Gainwell enrollment, the provider is referred for enrollment via letter and telephonic notification, and the request is placed in a status "Hold for provider Enrollment." Once the provider is enrolled, the authorization is exported to Gainwell. If the provider fails to enroll, the referring physician and member are notified. In the event the provider is denied enrollment, the referring physician and the member are informed, and the authorization may either be assigned to another designated out-of-network provider or closed. If a different out-of-network provider is selected, the process begins again until the authorization can be assigned.

We will prior authorize necessary services provided by out-of-network providers. providers will be informed of the enrollment process and any prior authorizations will be time limited. Referrals to out-of-network must come from a West Virginia Medicaid practitioner and the request must be supported with sufficient documentation to determine that the prior authorization is medically necessary and that the service cannot be obtained through an in-network provider.

We currently provide out-of-network services for BMS on a case-by-case basis, and we understand the value of consistent monitoring of these providers for both the management of the fiscal requirements of the Medicaid Program and the best interests of the Medicaid members. Kepro understands the BMS requirement that out-of-network prior authorization periods and enrollment time must coincide. We are familiar with program requirements including the requirement that services, which can be provided by an in-state or border provider, should not be authorized out-of-network, unless deemed as a medical emergency. Additionally, a WV Medicaid enrolled practitioner must request the services. We are also aware the specified providers have been designated as in-network providers when services they provide are not available in-state or from border providers.

Currently, border facilities are not considered out-of-network and are enrolled as border or in-state providers. The out-of-network process does not apply to any out-of-state provider designated as in-network. We have worked diligently with the BMS to develop and document a more streamlined approach to handling out-of-network services, which includes:

- Improving the Bureau's ability to control addition of providers
- Ensuring that each request is treated consistently
- Ensuring that members can access out-of-network services in a timely fashion
- Ensuring that out-of-network providers can be paid in a timely manner for authorized services rendered to WV Medicaid members

Stakeholder Engagement and Education

We will develop educational trainings and webinars for stakeholders on referring and providing out-of-network services as requested by the BMS. Technical assistance is provided as requested by individual providers or to all providers when changes in out-of-network policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will provide the following services to the BMS to ensure appropriate utilization management of imaging services:

- Participation in conference calls at the request of the Agency.
- Development of a reference manual for providers.
- Maintenance of updated imaging/radiology information, instructions, updates, code lists, bulletins, links to other information and sites, and announcements of new information on the website.
- Providing initial orientations to the system with key stakeholders, as requested by the Agency.
- Supporting the Agency related to stakeholder inquires, including but not limited to members, providers, facilities, legislators, and/or other government offices or officials.
- Providing a toll-free line for providers and members for inquiries regarding service coverage, prior authorization status or to answer questions regarding issues or problems with a prior authorization request.
- Recommending or developing forms upon request of the Agency.
- Representing the Agency regarding UM and/or Agency policies, guidelines and/or other criteria at meetings, conferences, or educational seminars, as needed.

We will also coordinate with Gainwell, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. Additionally, we will monitor over- and under- utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

A1.1.u. Cardiac Rehabilitation

1. Cardiac rehabilitation is a comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore members with heart disease to active and productive lives. The central component of cardiac rehabilitation is a prescribed regimen of physical exercises intended to improve functional work capacity and to improve the member's well-being. Members who use tobacco must be referred to the tobacco cessation program. The cardiac program consists of a series of supervised exercise sessions with continuous electrocardiograph monitoring. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or an outpatient hospital department.
2. Cardiac rehabilitation programs are regulated exercise programs which are effective in the physiological and psychological rehabilitation of many members with cardiac conditions. These services are considered medically necessary for selected members when they are individually prescribed by a physician.

In 2022, under our current contract with WV DHHR, we conducted 26 cardiac rehabilitation reviews. We will continue to provide prior authorization services for cardiac rehabilitation. This program consists of a series of supervised exercise sessions with continuous electrocardiograph

monitoring. Cardiac rehabilitation can be performed in a freestanding physician directed clinic or in an outpatient hospital department. The goals of cardiac rehabilitation are:

- To increase exercise tolerance
- To reduce symptoms of chest pain and shortness of breath
- To improve blood cholesterol levels
- To improve psychosocial well-being
- To reduce mortality

The prior authorization of cardiac rehabilitation services is conducted using InterQual®, local medical policies, and BMS Manual Chapter 519. Prior authorization of cardiac rehabilitation services will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

Our team will refer requests for cardiac rehabilitation to our medical case management nurse for appropriate follow-up in that program, as deemed necessary. This event automatically triggers our Care Management system to create a corresponding episode. This will not only serve the member's best interests by ensuring that he/she receives all needed services and is not subjected to any unnecessary procedures but will also serve the Bureau's need to control costs through utilization management to ensure that services are appropriate, unduplicated, and as non-intrusive as possible. In the event of a denial, nurses in our case management program will be able to provide referrals for other services that may be more appropriate and available to the member.

Kepro actively worked with the BMS during the current contract cycle to define the practitioner groups that may provide Cardiac Rehabilitation as well as the medical necessity review criteria for the service.

A1.1.v. General and Acute Care Inpatient Hospital Admission and Continued Stay Review

1. The Agency reimburses hospitals for medically necessary inpatient services provided to eligible members within coverage limitations on the date of service. Coverage and benefit limitations are revised periodically as necessary due to changes in Federal regulations, fiscal constraints, or WV Agency policies.
2. Inpatient care is covered under the Agency program when it is reasonable and medically necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body part. The services must be consistent with the diagnosis or treatment of the patient's condition and must be rendered in accordance with standards of good medical practice to be considered medically necessary. Inpatient care which does not contribute meaningfully to the treatment of an illness or injury, or to improve the functioning of a malformed body part, is not covered.
3. Nursing and other related services, such as use of hospital facilities, medical and social services, and transportation furnished by the hospital during an inpatient stay are included in the rate of reimbursement. Covered services are limited to those admissions which are prior authorized by utilizing the Agency approved admission criteria and policies.
4. Admissions must be affected upon the written order of a physician who is licensed in the practice of medicine and surgery in the state in which he/she is located and authorized to admit patients to the facility in which the service is rendered.

5. The Agency covers General and Acute Care Inpatient hospital admission and continued stay services for all eligible members. As a condition for reimbursement, the Agency requires that all inpatient hospital admissions receive prior authorization.
a. Covered inpatient services include general acute care admissions and admissions, as well as admissions to Medicare certified distinct part psychiatric and medical rehabilitation inpatient units.
b. Inpatient services are primarily for treatment of acute or chronic illness, injury, or for maternity care. The member's hospital records, and the hospital's utilization review Vendor must document that:
1. Care and services rendered were medically necessary; that the services rendered could only be provided on an inpatient basis (i.e., could not be provided on an outpatient basis or in a lower level of care facility); and
2. That the services rendered were necessary for each day of inpatient care billed to the program.
3. Outpatient charges including observation services incurred with 24 hours of admission must be made a part of the inpatient claim.

We have assisted WV DHHR in General and Acute Inpatient Hospital admissions since 2011, conducting prior authorization for inpatient procedures that are emergent/urgent, unscheduled, or direct admissions for surgical services, or other procedures performed on an inpatient basis.

In our partnership, we work together with the State to identify any opportunities for process improvement, particularly when addressing high volumes. For example, in 2022 we conducted over 7,000 Acute Care Inpatient Hospital reviews for West Virginia. Through those reviews we identified an opportunity to revise our process when reviewing total joint replacement. Working with the Agency, these procedures were re-categorized as an inpatient only service, rather than an outpatient procedure. This change reduced hospital readmissions because of blood clots, wound infections, and other similar conditions which, in turn, proved to be a cost savings for the state.

The prior authorization of general and acute care inpatient hospital admission and continued stay review is conducted using InterQual®, local medical policies, and BMS Manual Chapter 510. Prior authorization of general and acute care inpatient hospital admission and continued stay will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

A1.1.w. Pulmonary Rehabilitation

1. Pulmonary Rehabilitation (PR) is an individually tailored multidisciplinary approach to the rehabilitation of members who have pulmonary disease. PR offers members a chance to reduce hospitalizations, increase their knowledge about pulmonary disease and its management, the ability to control and alleviate the symptoms of pulmonary disease, and the ability to carry out activities of daily living with less shortness of breath. Pulmonary rehabilitation programs include exercise training, psychosocial support, and education, which are intended to improve the member's functioning and quality of life.

We began its Pulmonary Rehabilitation program in 2011. Our program offers members a chance to reduce hospitalizations, increase their knowledge about pulmonary disease and its management, the ability to control and alleviate the symptoms of pulmonary disease, and the ability to carry out activities of daily living with less shortness of breath. Pulmonary rehabilitation programs include exercise training, psychosocial support, and education, which are intended to improve the member's functioning and quality of life. We actively worked with the Bureau for Medical Services

during the current contract cycle to define the practitioner groups that may provide Pulmonary Rehabilitation as well as the medical necessity review criteria for the service.

In 2022, under our current contract with WV DHHR, we conducted close to 40 Pulmonary Rehabilitation services reviews. The prior authorization of pulmonary rehabilitation is conducted using InterQual®, local medical policies, and BMS Manual Chapter 519. Prior authorization of pulmonary rehabilitation services will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

Our program includes the following components:

- A team assessment which normally includes input from the physician, a respiratory care practitioner, a nurse, a psychologist, and a nutritionist
- Member training which includes breathing retraining, bronchial hygiene, medication education and proper nutrition
- Psychosocial intervention addressing the member's emotional support systems, anxiety, and dependency issues
- Exercise training, which includes strengthening and conditioning which may include stair climbing, inspiratory muscle training, treadmill walking and cycle training
- Member follow-up, including a structured and ongoing home pulmonary rehabilitation program

The goals of Pulmonary Rehabilitation are:

- Restore the member to the highest possible level of independent function
- Educate the member and significant others about the disease, treatment options and strategies
- Reduce and control breathing difficulties and symptoms
- Maintain healthy behaviors such as good nutrition and exercise
- Encourage members to be actively involved in their own healthcare.

We will refer requests for Pulmonary Rehabilitation to our medical case management nurse for appropriate follow-up in that program, as deemed necessary. This will not only serve the member's best interests by ensuring that he/she receives all needed services and is not subjected to any unnecessary procedures but will also serve BMS' need to control costs through utilization management to ensure that services are appropriate, unduplicated, and as non-intrusive as possible. In the event of a denial, nurses in our case management program will be able to provide referrals for other services that may be more appropriate and available to the member.

A1.1.x. Chiropractic Services

1. The Agency covers chiropractic services for eligible members. Vendor is to review all chiropractic service requests for services requiring prior authorization regardless of place of service. As a condition for reimbursement, the Agency currently requires prior authorization for more than 20 visits.

Kepro serves as the prior authorization agent for BMS for Chiropractic services. In 2022, under our current contract with WV DHHR, we conducted close to 40 Chiropractic services reviews. We propose to continue to provide this service subject to BMS approval. We understand that prior authorization is required for Chiropractic care beyond the initial 12 services in a calendar year. WV Medicaid coverage of chiropractic services includes the following:

- Coverage is limited to manual manipulation (by use of hands) for subluxation of the spine and certain diagnostic radiological examinations related to chiropractic services.
- Chiropractors may use manual devices in performing manual manipulation of the spine, but no additional payment is available for use of device by Medicaid and Medicaid will not reimburse extra charges for the device itself.
- WV Medicaid limits its coverage of Chiropractic Services to treatment by means of manual manipulation to correct a subluxation of the spine, demonstrated by an x-ray.
- WV Medicaid waives the X-ray requirement for initially covered services for pregnant women and children. Services requested above the initial 12 visits for children require an X-ray.
- Taking the X-ray must occur no more than three months prior to the initiation date of the course of treatment. In certain cases of an acute exacerbation of a chronic subluxation, we will accept an x-ray no older than a year.
- X-ray equipment must be certified radiology equipment that complies with all applicable State and federal requirements.
- Medicaid reimburses chiropractors for the professional and technical components of covered diagnostic radiology services (CPT 72010-CPT 72120) if the chiropractor performs both parts of the procedure.
- Medicaid will provide reimbursement for only one interpretation of an x-ray and will not pay for a second confirmatory x-ray.

The prior authorization of chiropractic services is conducted using InterQual®, local medical policies, and BMS Manual Chapter 519. Prior authorization of chiropractic services will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

We will develop educational trainings for providers regarding chiropractic policy (Chapter 519), available services, service delivery models, and any other topics requested by the Bureau for Medical Services. Technical assistance is provided as requested by individual providers or to all Chiropractic providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will participate in and conduct

training for members and other stakeholders as requested by the Agency. We will participate in conference calls at the request of the Agency.

A1.1.y. Podiatry Services

1. The Agency covers podiatry services for eligible members. Vendor is to review all podiatry procedure/service requests requiring prior authorization.

We understand that podiatry services encompass foot and ankle procedures that are provided by a WV-licensed podiatrist. Our purview includes reviews for surgical foot and ankle procedures that require prior authorization, such as bunionectomies, tarsal-tunnel release, calcaneal spur removal, removal of nail beds (matrixectomy), and hammer toe corrections. A podiatrist or a board-certified MD/DO will continue to conduct required physician-level reviews.

The prior authorization of podiatry services, of which there were 0 in 2022, is conducted using InterQual®, local medical policies, and BMS Manual Chapter 519 and BMS Manual Chapter 520. Prior authorization of podiatry services will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

We will develop educational trainings for providers regarding policy (particularly Chapter 520 and inclusion of podiatry services in Chapter 519), available services, service delivery models, and any other topics requested by the Bureau for Medical Services. Technical assistance is provided as requested by individual providers or to all podiatric providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will participate in and conduct training for members and other stakeholders as requested by the Agency. We will participate in conference calls at the request of the Agency.

A1.1.z. Case Management

1. Some members will automatically be assigned to case management. Those include, and are not limited to organ transplant patients, private duty nursing services members, high risk pregnancies, and members who have had bariatric surgery. Others may be identified based on claims history reflecting inordinately high costs or intensity of services and/or other populations as defined by the Agency or recommended by the Vendor.
2. The Vendor must evaluate referrals from case management to determine the feasibility of achieving significant improvements in member outcomes from coordination of services or fiscal advantages to managing the member services required. Vendor is to coordinate member services upon referral from the Agency as needed. As a condition for reimbursement, the Agency requires that all case management services receive prior authorization.
3. If any members transition from Fee-For-Service to a Managed Care Organization, the Vendor will prepare and send the Case Management Summary to the Managed Care Organization, in which the member is enrolled.

Medical Case Management encompasses coordinating and monitoring healthcare services for members identified by BMS or who receive authorization for a service(s) specifically identified as requiring case management during the authorization period or for some designated period following authorization of the service. The primary goal is to monitor progress during or following

delivery of intensive or high-cost services. We will notify the member and the referring physician requesting prior authorization of the service(s) that trigger medical case management concerning provision of the service. Our electronic submission portal provides alerts for members enrolled in case management; a feature that promotes continuity of care across review areas.

Certain categories of review receive automatic assignment to case management, including organ transplant services, private duty nursing services, high-risk pregnancies, and bariatric surgery patients. Kepro recognizes BMS may add additional review areas for case management, depending upon claims data review indicating utilization of high-cost services, and high utilization patterns. Our team is more than capable of providing these services, as we have managed over 6,500 in 2022 alone.

We recognize the benefits of medical case management its application to additional review areas; we welcome the opportunity to discuss this with BMS. Through our existing scope of work, we have enrolled members receiving adult dental, out of network, and Pulmonary Rehabilitation service, to name a few. Case management staff from the preauthorization unit, hospitals, physician's offices, and BMS may refer patients for case management. Members or their legal representatives may also request case management services. In addition to those services mandated for medical case management services by the Agency, we propose case management follow-up as noted in other service areas of this proposal and described above, i.e., Hospice, and Home Health services. This process describes the relationship of medical case management to the initial prior authorization and the reassessment process.

Notifications related to participation in the medical case management services program include:

1. Notification/Confirmation to Member of Engagement into the medical case management services program. Whether we engage the member/legal representative via telephone or not, we will send a notification letter to the member/legal representative within two business days after the confirming the member status is suitable for the program. The letter will inform members that their current and future providers will also receive notification.
2. Notification/Confirmation to provider(s) of Member's Engagement into the medical case management services program. We will send a notification letter to all treating provider(s) within two business days after the approving the member's case for the program. The letter will also notify members and legal representatives. Any providers treating the member under medical case management services will receive the notification letter within two business days of the member's first date of treatment with the provider.
3. We send Notification/Confirmation of Member's Declination/Discharge of the medical case management services program to the member/legal representative and all treating providers within two business days after receipt of the member's written or verbal notification of the declination or discharge.

We will continue to provide case management support for members receiving medical case management services until one of the following conditions exists:

- The member is stable, has reached maximum potential, and no longer requires case management services
- The member is admitted to long term care
- The member fails to respond to inquiries or to follow treatment plans
- The member is no longer Medicaid eligible

Cost savings is an important part of any medical case management program. Each referral will be evaluated to determine the feasibility of achieving cost savings while achieving significant improvements in member outcomes. Cost savings related to recommendation and/or approval of less costly care options, efficacious and less costly equipment or other cost savings will be reported to the Bureau for Medical Services. We will apply the BMS approved medical necessity criteria for prior authorization of the specific services that trigger medical case management and will deliver medical case management services within nationally accepted standards for case management that are compliant with applicable federal regulations and BMS policies.

We will develop training for providers regarding medical case management, available services, service delivery models, and any other topics requested by the BMS. Technical assistance is provided as requested by individual providers or to all providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will participate in and conduct training for members and other stakeholders as requested by the Agency. We will participate in conference calls at the request of the Agency.

We will also coordinate with Gainwell, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. Kepro will monitor over- and under-utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

A1.1.aa. Expanded EPSDT Services and Criteria Development

1. As required by federal regulations, the Agency program provides Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) services for eligible members up to 21 years of age. The Agency provides expanded health related services through the EPSDT Program. Expanded EPSDT services include any medically necessary, Agency reimbursable, healthcare and/or pharmacy services to correct or ameliorate illnesses and conditions found on screening.
2. Expanded EPSDT services requested shall require prior authorization by the Utilization Management Vendor before services are provided. Referrals for expanded EPSDT services shall be requested by an enrolled West Virginia provider with required documentation of the EPSDT visit/plan of care and necessity for the service and/or referrals as a result of an EPSDT screen for further diagnosis and treatment. The Agency requires PA for non-covered services and/or request for service over service limits. The referring provider is notified of approval of service or need for further medical documentation. Transition to payment requires collaboration with Fiscal Agent for each service on the claim, including any modifiers needed or reimbursement criteria.

We have 30 years of experience performing EPSDT reviews. We currently perform these reviews in six states including West Virginia, Florida, Virginia, and Arkansas. Kepro understands the vital role of EPSDT services in ensuring that children and youth receive appropriate preventive, dental,

mental health, developmental and specialty services, as well as additional health care services that are found to be medically necessary to treat, correct, or ameliorate illnesses and conditions. Additional health care services that are covered under the federal Medicaid program and found to be medically necessary to treat, correct or ameliorate illnesses and conditions, are covered regardless of whether the service is covered in a state's Medicaid plan. Medical necessity reviews on treatments, products or services requested, or prescribed for all members aged 20 years and under are based on compliance with federal EPSDT criteria. Medical necessity is decided based on an individualized, child-specific, clinical review of the requested treatment to 'correct or ameliorate' a diagnosed health condition in physical or mental illnesses and conditions. EPSDT requests may include:

- Any medically necessary service not covered in the Medicaid benefit for which no alternative service to meet the member's need can be found within the covered benefit.
- Enteral Foods requests for 100% G-Tube dependent members or members that obtain more than 90% of daily nutrition from enteral food subsidy.
- Authorization requests for non-covered pharmaceutical products and PADs.
- HCBS waiver members who require services not covered in the waiver or medical programs.

The EPSDT allows members aged 20 and under to receive services outside usual coverage when an EPSDT enrolled physician believes the service is medically necessary. We will ensure that all EPSDT review requests undergo prior authorization and must be fulfilled or provided by a West Virginia Medicaid participating provider. Our team has served more than 100 members during 2022 alone, amounting to more than 150 cases.

Kepro's commitment to serving member needs extends beyond State requirements. For example, throughout the year, Kepro notifies the appropriate West Virginia Children with Special Healthcare Needs (CSHCN) program when existing enteral food authorizations are going to expire. By tracking, monitoring, and following up on expiration dates, Kepro prevents a potential disruption in receiving shipments of life sustaining enteral food.

We will manage all WV DHHR EPSDT requests in the Atrezzo system. The system is designed to allow a provider to indicate that a request is related to an EPSDT screening and requires a clinical review by the one of our clinical reviewers because the request is beyond the scope of the plan, exceeds service limits, or is not a covered benefit.

Atrezzo is configured so that all codes are accepted for members under 21. Each EPSDT review request submitted to Kepro will have a request type and associated work queue within Atrezzo that track when the member is under the age of 21. Atrezzo will check for allowed codes. If a request for a code is not typically allowed, and the member is under 21, Atrezzo will not stop the prior authorization request from being submitted. If the prior authorization request for a member under 21 is for an allowed code, the request will be routed to the respective service type queue in Atrezzo. If the request for a member under 21 includes a code that is not on the allowed codes list, it will be routed to the EPSDT queue.

We will follow the process outlined in **Figure 49 Early, Periodic, Screening, Diagnosis, and Treatment Process** to make prior authorization determinations for EPSDT.

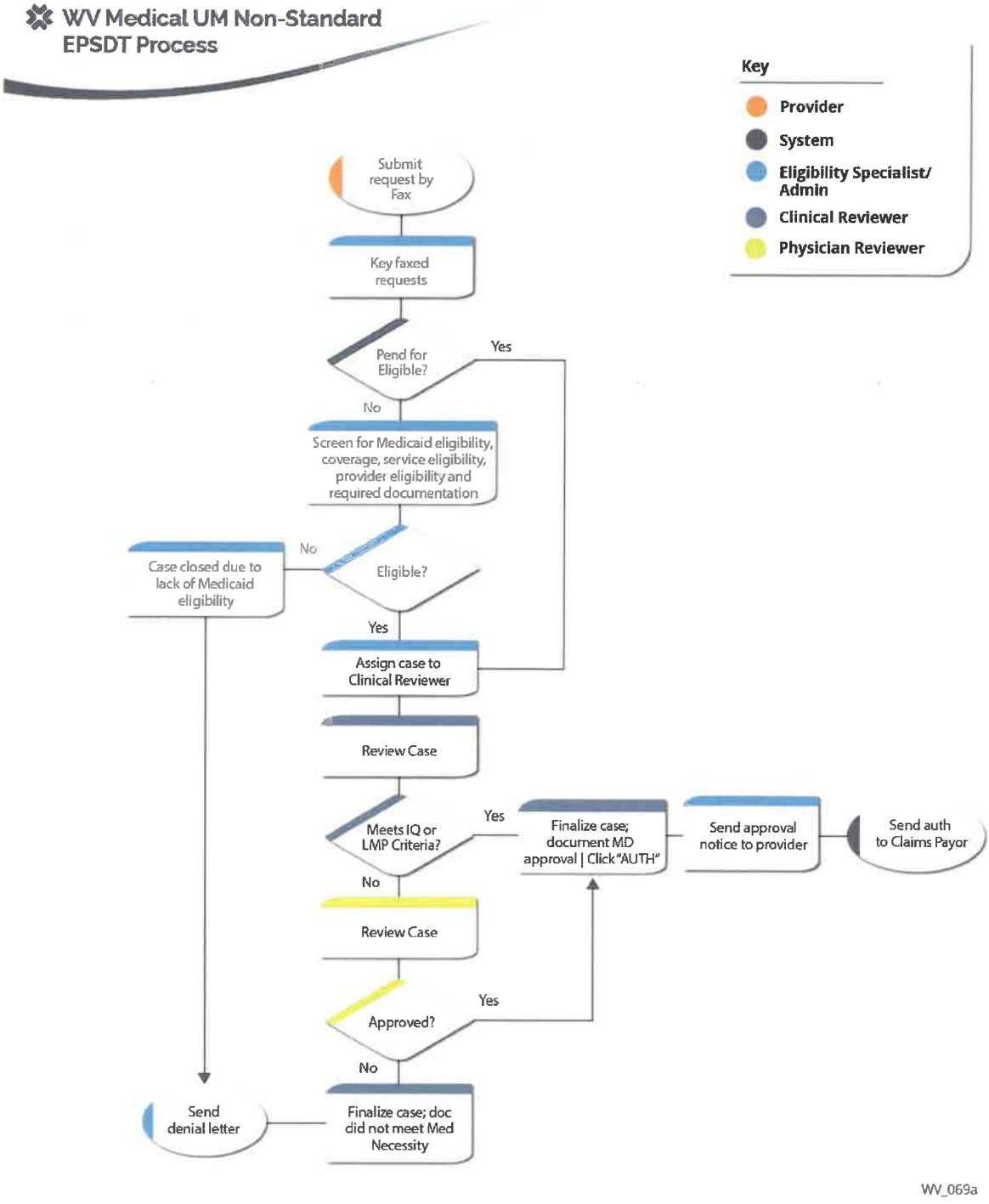


Figure 49. Early, Periodic, Screening, Diagnosis, and Treatment Process
Our process facilitates appropriate preventive, dental, mental health, developmental and specialty services.

As part of the prior authorization of EPSDT, and following receipt, we will review the following:

- Medical necessity and appropriate documentation are submitted.
- Clinical appropriateness per criteria established by BMS.
- Verify that the goods/services are not payable elsewhere in Medicaid or that they requested good/service has been exhausted.
- The appropriate HCPCS codes and rates listed in the West Virginia Medicaid Fee Schedule are used, if the request exceeds service limits; if this service is not covered, pricing is required by Kepro staff.

We will perform prior authorization of EPSDT to determine if the requested service is medically necessary and ensure the provider has submitted the proper documentation with each authorization request.

A1.1.bb. Health Home Services

1. The Agency covers Health Home services to coordinate for members with various identified conditions and risk factors. Health Home services include Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual & Family Support Services and Referral to Community & Social Support Services in a two-tiered service level. Vendor will utilize the Member's annual reassessment to annually determine eligibility for Health Home Services.
As a condition for reimbursement, the Agency requires that all Health Home services receive prior authorization in accordance with current policies.
2. The Vendor shall develop and maintain a secure web-based, electronic review request system for prior authorization and eligibility review of Health Home services that allows for data input by the submitting providers within five (5) calendar days of the referral and in accordance with current policies. The Vendor's system shall have the capability for:
a. Automated criteria/rules-based certification system
b. The ability to process special request if/when needed
c. Produce and/or analyze data for CMS and/or Agency reports at the request of the Agency at no additional cost.
3. The Vendor shall make recommendations and develop program forms upon request by the Agency at no additional cost.
4. In performing Health Home Program service determinations, the Vendor shall use nationally accredited, researched based, criteria in reviewing each prior authorization and eligibility review request. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all Health Home Program services reviewed under the resulting contract.
a. The Vendor shall maintain the capability to update the review criteria Health Home Program services reviewed under the resulting contract. The Vendor shall make recommendations about policies, procedures, and best practices to the Agency annually, regarding what, if any, changes should be made to the criteria that will be used for the following calendar year along with draft forms or modified forms already in use for approval by the Agency.
b. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria recommendations at the time of presenting the recommended changes.
c. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the resulting contract.
d. The Vendor is responsible for any cost associated with the purchase of any review criteria.

5. The Vendor shall determine the medical necessity of the authorization, recertification, and retrospective reviews for Health Home services to eligible members utilizing the Agency approved criteria and policies.
a. Authorization Reviews: The Vendor shall ensure determinations for authorization reviews are completed in accordance with current policies.
b. Recertification Reviews: The Vendor shall ensure determinations for recertification reviews are completed in accordance with current policies.
c. Retrospective Reviews: The Vendor shall ensure determinations for retrospective reviews are completed in accordance with current policies.
d. Consultative Reviews: The Vendor shall ensure determinations for consultative reviews are completed in accordance with current policies.
6. The Vendor shall have the capability to operate multiple health homes and provide prior authorization, quality management and supportive services.
7. The Vendor shall review and determine level of care for members, provide technical assistance, at no additional cost to the Agency, to providers, implementation and ongoing training, provider recertification after the initial attestation, consultation, and research.
8. The Vendor shall provide data analysis and reporting. These activities shall include, but are not limited to the following:
a. Export authorization information to the claims' payor and providers.
b. Produce and analyze data, as requested by the Agency.
9. The Health Home for Bipolar & at Risk for Hepatitis Program is Statewide. The Vendor shall provide the following description and functions in the Expanded Model:
a. Conditions of bipolar & at risk for hepatitis
b. Health Home Comprehensive Services: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual & Family Support Services, Referral to Community & Social Support Services
c. Multidisciplinary team with identified provider qualifications & standards
d. Specified quality measures (Home Health Quality Measures)
e. Payment PMPM for Basic Level 1 HH Service codes for twelve (12) months & PMPM for Intense Level 2 for 30 calendar days
f. ASO Functions
10. The Health Home for Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression is currently in the counties of Boone, Cabell, Fayette, Kanawha, Logan, Lincoln, Mason, McDowell, Mercer, Mingo, Putnam, Raleigh, Wayne, and Wyoming. The Vendor shall be prepared to expand the Health Home for Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression at the request of the Agency. The Vendor shall provide the following description and functions in this Model:
a. The counties of, of Boone, Cabell, Fayette, Kanawha, Logan, Lincoln, Mason, McDowell, Mercer, Mingo, Putnam, Raleigh, Wayne, and Wyoming
b. Conditions of Pre-Diabetes, Diabetes, Obesity, at Risk for Anxiety and/or Depression
c. Health Home Comprehensive Services: Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual & Family Support Services, Referral to Community & Social Support Services
d. Multidisciplinary team with identified provider qualifications & standards
e. Specified quality measures (Home Health Quality Measures)
f. Payment PMPM for standard level of care with authorization every four (4) months
g. ASO Functions
11. The Vendor shall perform the following ASO services for all Health Home Programs
a. Review members eligibility.
b. Review member assessments & service requests to determine program eligibility.
c. Complete roll backs for start/end dates.
d. Initiate & complete members' transfers to new Health Homes.
e. Provide on-going training & technical assistance to providers, at no additional cost to the Agency.

f. Weekly contact with providers to assess their functionality and progress.
g. Staff individual case requests.
h. Conduct annual program recertification.
i. Provide electronic response files to claims payor & providers at no additional cost to the Agency.
j. Provide data analysis & reporting (standard and ad hoc).
k. Maintain & upgrade software specific to Health Homes at no additional cost.
l. Maintain, upgrade, or revise all related tools as needed, e.g., utilization management guidelines, trainings, FAQs, etc.
m. Distribute reports to providers instrumental in managing the program/members, e.g., acute service authorizations lists, pharmaceutical reports & UM activity reports.
n. Provide communication to potential new providers & members in various mediums, such as electronic or paper.
o. Conduct quarterly stakeholder roundtable conferences at no additional cost at a schedule to be mutually agreed upon by the successful Vendor and the Agency.
p. Notify providers of fee for service members receiving authorizations for acute behavioral and/or physical health hospitalizations.

As a healthcare company whose foundations include managing psychiatric services, we support the WV Health Homes project and look forward to the opportunity to continue managing multiple Health Homes. We implemented a Health Home Care Coordination model that integrates social services with physical and mental health. As part of our services, we certify providers yearly to ensure compliance and integrate health home data with the Bureau for Medical Services for CMS Quality and Outcome measures. In 2022 alone, we conducted nearly 17,000 Home Health reviews for West Virginia. Our local office began participating as a stakeholder in the early research and planning stages of WV Health Homes, becoming a standing member of the work committee in January 2013, and worked with the state to operationalize Health Homes in December 2013. From beginning to end, we will continue to support the Bureau and Health Home providers by offering continuous quality data reporting and analysis, technical assistance, training, and consultation regarding outcome measures, clinical issues, and administrative functions.

The current Health Homes program is statewide for individuals diagnosed with bipolar disorder and at risk of Hepatitis as well as in a limited number of counties for those diagnosed with Diabetes and at risk of anxiety/depression. providers cannot be reimbursed by Medicaid for services without obtaining a prior authorization from Kepro, which is associated with the following Health Home services:

- Comprehensive Care Management
- Care Coordination
- Health Promotion
- Comprehensive Transitional Care
- Individual and Family Support Services
- Referral to Community and Social Support Services

Our Health Homes program is comprised of a Health Homes Manager and a Utilization Management (UM) Coordinator. The Health Homes Manager will design, implement, and direct the day-to-day Utilization Management and Prior Authorization operations for the Health Homes

Program. Most significantly, this individual leads the implementation and roll-out of the program - including expansions - across various departments and stakeholders. The Health Homes Manager also works with the BMS to consult, refine, and expand the Health Homes project. The manager also ensures that all UM/PA functions are performed daily at the highest standards, meeting, or exceeding contract deliverables, and maintains consistent communication with BMS regarding the program.

Benefits WV Participants

2019 West Virginia University School of Public Health Study indicated Diabetes Health Home participants:

- See monthly medical costs lowered by $187
- Are 36% less likely to visit an emergency room any given month.
- Are 62% less likely to visit an emergency room for mental health concerns any given month.
- Are 47% less likely to be admitted to the hospital any given month.

The UM Coordinator is also essential to the Health Homes team, as this individual provides a broad range of administrative services support to the Health Homes team and external customers. This position supports the Health Home Manager with day-to-day functions as well as performing primary customer service and training functions. The UM Coordinator provides telephone support to external providers/agencies/facilities, provides technical support, and provides specific training both via webinar and on-site with the provider as well as manages communications with providers and/or members. Our UM Coordinator holds a quarterly round table discussion with providers about any ongoing issues they may be experiencing related to the program. All inquiries and Level I authorizations are also managed by the UM Coordinator, along with credentialing and on-site review scheduling.

In 2014, Kepro established a two-tiered prior authorization system to accommodate service requests for standard and intensive health home services. The same system also functions to annually establish and re-establish the member's eligibility for Health Homes program. For a provider to establish a member's eligibility and obtain a prior authorization, they must input data required by the Bureau to track outcome measures including the CMS-required Adult Quality Measures recommended for Health Homes. This system allows providers to send supporting documentation such as physician's orders and plans of care directly with each submission electronically through the system, although we also accept submissions via the provider portal.

The required data elements must be submitted by the provider through our secure web-based system within five days of a referral and once input, must be updated a minimum of three times per year. Providers may also log on to the secure system to obtain outcomes of Health Home service requests. Kepro communicates prior authorization results to providers and exports authorization and Health Home attribute files to the contracted claims payor via Atrezzo.

We will ensure that any forms requiring modification or creation are approved by the Bureau before implementation.

Medical Necessity Authorizations

Requests for Health Homes services are screened for clinical appropriateness and authorizations that meet the criteria, set forth by the Bureau, are processed for request using the web portal. In the event of a clinical denial, the provider is informed that, based on the review, their request does not appear to meet medical necessity and are then given the opportunity to provide any extra documentation or information. Upon review of any extra information if Kepro still does not determine there is sufficient evidence that the Utilization Management Guidelines criteria are met, the request and supporting documentation are sent to a physician reviewer of the same specialty that the provider has on their Health Home team for review. If the physician reviewer determines the evidence follows UM Guidelines and criteria are met, an authorization will be issued. Conversely, if the physician reviewer determines there is no evidence that the UM criteria are met, a denial is issued, and the determination is sent to the provider and member outlining the specific criteria that were not met; the notice also informs them of the steps needed to initiate a second level review and the member's right to a fair hearing.

Exceeding Standards

Kepro's excellence in achieving client-prescribed review timeliness is evident across our West Virginia programs. We achieved a timeliness rate of 100% in 2022 for our Health Homes program.

If the level one physician reviewer denied the service and a second level review is requested, the service request and all the supporting documentation will be sent to a different physician with appropriate credentials. If the second physician upholds the denial, the provider and member will be notified, and the notice will outline the criteria on which the decision was based as well as information regarding the member's right to a fair hearing.

If a member seeks a fair hearing, we will have the required staff available to coordinate and/or participate in the hearing. Any policy/administrative denials issued to providers and members will indicate the specific policy or administrative reason for the denial and the member's rights to a fair hearing.

Recertification/Retrospective Consultative Reviews

We have also implemented the required annual provider certification for the Health Homes program. The certification date is established for each Health Home based upon the date of their first admission, which becomes their annual renewal date. Based on this date the provider is sent a notification 60 days prior to the review and again at 30 days prior. Fourteen days before the review the Health Home provider is sent a secure email containing a 10% sample of members. If 10% of their member roster is less than 10 then 10 individuals will be reviewed.

On the day of the review, the Kepro Program Manager meets with the Director to review the recertification process and then begins reviewing the clinical and personnel records utilizing the tools approved by the Bureau. At the completion of the review, an exit conference is held to discuss the early findings. Once Kepro finalizes the report, it is sent to BMS for approval. If we find

no deficiencies, a certification letter along with a copy of the review tools are sent to the provider's executive director and the claims payor is notified of their continued certification.

If the provider does not receive full recertification status, the provider will receive both verbally and by secure email, a provider Certification Status Letter along with the Plan of Correction (POC) recommendations. The POC will need to be completed by the provider within 30 calendar days of receipt and submitted to Kepro WV Health Homes Program Director or RN Reviewer. We will then review the POC within three business days and if all the recommended POC criteria are met it will then be presented to BMS for approval. The WV Health Homes provider will then be notified verbally and by secure email of the POC approval and full recertification.

If the request does not meet recommended POC criteria, the provider will be notified verbally. The POC will be returned by secure email, the provider must complete and return the POC to Kepro for further review within three business days. The Kepro WV Health Homes Program Director will review the POC and make a recommendation for either approval or denial of POC to the Bureau. The provider will be notified verbally and by secure email of the final decision.

Criteria

We will continue to work with the Bureau regarding the use of national and/or evidence-based criteria for use in the Health Homes Utilization Management System and provide the Bureau feedback from the Health Home providers gathered through the provider roundtables.

Approval of Modifications

If at any time the review criteria need to be modified or updated by Kepro the Bureau's approval will be obtained first. We acknowledge the Bureau may specify a different criterion or guideline must be used at any time and Kepro will be responsible for the associated cost of modifications.

A1.1.cc. Long-Term Acute Care (LTAC)

1. The Agency covers Long-Term Acute Care for all eligible members. All Long-Term Acute Care services require prior authorization.

Long-term acute care hospitals provide extended medical and rehabilitative care to individuals with complex clinical problems, requiring hospital level of care for extended periods. All long-term acute hospitalizations require prior authorizations. In compliance with WV Medicaid policy, providers of this service must meet Medicare's conditions for acute care hospitals and have an average stay greater than 25 days.

We have performed prior authorization for long-term acute care since 2020 per BMS request. At the height of the pandemic, bed shortages in acute care hospitals were a critical factor in WV and across the nation. LTAC services permitted ICU ventilation beds to be available for those most critical because of COVID-19.

The prior authorization of long-term acute care services is conducted using InterQual®, local medical policies, and BMS Manual guidelines. Prior authorization of LTAC services will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

A1.1.dd. School-Based Health Services

1. The Vendor will complete retrospective reviews on the school-based health services based upon claims data at intervals approved by the Agency.

Kepro conducts on-site and desk documentation provider reviews for specific school-based health services targeted by the Bureau for Medical Services. We have provided WV DHHR retrospective School Based Health Services reviews for over seven years. We know the critical role we play, as our reviews are the primary means of monitoring the quality of the school-based health services within West Virginia.

All Lead Education Agencies (LEA) are established with Kepro as providers and are assigned a Trainer Consultant who will conduct the retrospective reviews. The Trainer Consultants will continue reviewing the service documentation of each LEA office on an 18-month cycle, using a minimum 20% sample of each service billed by the LEA for the period under review. The trainer reviews to ensure the county provided services sufficient in extent, duration, and scope as well as appropriately documented services; they also ensure the provider was properly credentialed. Additionally, required technical assistance and training will be scheduled at the time of the review (or within 10 business days if scheduling during the review is not practicable). All reviews will review documentation per BMS policies, and address CMS quality assurance standards.

At the completion of each review, an exit conference will be held with the provider's choice of staff to discuss a summary of the findings and/or deficiencies found. Any provider review below a satisfactory threshold, as identified by BMS, will trigger a Plan of Correction (POC) to be submitted by the provider within 30 business days of the review and which addresses all deficiencies noted in the review. Site visits associated with an Incident Management Report, complaint data, or to monitor a Plan of Correction (POC) will be scheduled outside of the normal review cycle. These reviews may include face-to-face member/legal representative and staff interviews to validate documentation as necessary to address the inciting event or issue.

Following the exit summation, Kepro gives the provider an electronic draft exit report and a POC to be completed by the provider, if applicable. A POC must contain how each deficiency will be corrected, processes that will be enacted to prevent re-occurrences, and the expected completion date of each deficiency.

The LEA must also identify their training needs on the POC. When potential disallowances are identified, the provider will have 30 calendar days from receipt of the draft exit report to send their POC back to Kepro. After the 30-day comment period has ended and we have deemed the POC acceptable, BMS will be given the provider's POC and report draft to review. BMS will then issue a

final report to the provider's Executive Director, copying Kepro. The final report will reflect the provider's overall performance, details of each area reviewed and any disallowance, if applicable, for any inappropriate or undocumented billing of Services. If no potential disallowances are identified during the review, then the provider will receive a final letter and a final report from BMS. Kepro Trainer Consultants will work with each LEA to provide the training and technical assistance documented on the LEA's Plan of Correction either on site or via webinar. Utilizing the same review tools and consistent claims sampling methodology each retrospective review will enable scores to be monitored over time for improvement. Once the Bureau approves the POC, the Training Consultant will review the provider a minimum of one more time within the 18-month period and assess the POC.

Medical Necessity as defined in BMS Manual Chapter 538 applies to Services and Supplies that are:

- Appropriate and medically necessary for the symptoms, diagnosis, or treatment of an illness
- Provided for the diagnosis or direct care of an illness
- Within the standards of good practice
- Not primarily for the convenience of the member or provider
- The most appropriate level of care that can be safely provided

Medical necessity must be demonstrated throughout the provision of services. For these types of services, the following five factors will be included as part of this determination:

1. Diagnosis (as determined by a physician, PA, APRN, or licensed, supervised, or school psychologist)
2. Level of functioning
3. Evidence of clinical stability
4. Available support system
5. Service is the appropriate level of care

Chapter 538 contains the service definitions, benefit limits, admission/continued stay/discharge criteria, clinical and service exclusions, required credentials and the documentation requirements. When manuals are modified by the Bureau, guidelines are updated, and retrospective review tools are concurrently modified to ensure all requirements are addressed for each service. The review tools are approved by the Bureau and published on the website.

A1.1.ee. Inpatient Rehabilitation Services

1. The Agency covers inpatient rehabilitation services for all eligible members. The Agency requires that all inpatient rehabilitation services receive prior authorization.

We understand inpatient rehabilitation services are a valuable resource to the individuals who qualify. Successful rehabilitation will lead to a more independent member. Utilization management with case management follow-up of these cases, of which we have conducted more than 200 for

West Virginia in 2022, assists BMS in containing cost and delivering medically necessary rehabilitation in the appropriate setting and in the most cost-effective manner.

Prior authorization is obtained by the inpatient facility or the attending physician on behalf of the facility. Adjunct services provided by inpatient physician (e.g., pathology, Emergency Room, anesthesia, radiology, and laboratory) are covered under the prior authorization unless a specific exception is noted. Inpatient authorizations are DRG driven.

The prior authorization of inpatient rehabilitation services is conducted using InterQual®, local medical policies, and BMS Manual Chapter 510. Prior authorization of inpatient rehabilitation services will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process is located in Section A1.1.a Inpatient/Medical Surgical Services.**

A1.1.ff. Specialty Medications/Physician Administered Drug Services

1. The Vendor must provide authorizations for specialty medications/physician administered drugs.
2. The Vendor must apply evidence-based clinical guidelines to drive utilization for the clinically appropriate and safe use of high-cost specialty medications to ensure the value of therapy is optimized at the lowest possible cost.
3. The Vendor must capture the necessary clinical information to enable meaningful analysis and reporting to the Agency in a mutually agreed upon format.
4. The Vendor must agree to provide authorization reviews for specialty medications at the request of the Agency.
5. The Vendor must make recommendations on any and what changes to make to review criteria to the Agency six (6) months after implementation and annually thereafter.
6. The Agency will provide a list of specialty drugs that the Vendor must provide authorizations within thirty (30) calendar day of contract award. This list may be updated annually, or throughout the year as medications are introduced in the market.
7. Specialty medications are physician-administered drugs, billed as medical claims that can fall into any one of more of the following categories:
   a. Prescribed for a member with a complex or chronic medical condition, including medical, behavioral, or developmental condition that may have no known cure, is progressive, and/or is debilitating or fatal if left untreated or under-treated;
   b. Treats rare diseases;
   c. Requires additional patient education, adherence, and support beyond traditional dispensing activities;
   d. In an oral, injectable, inhalable, or infusible drug product;
   e. Has a high monthly, annual, or per treatment episode cost.

Kepro's history with covering high dollar, specialty medications began in 2018. At that time, three drugs were required to be prior authorized. Our work with BMS has grown to a total of 18 specialty medications through 2022, during which we conducted over 60 special medication/physician administered drug service reviews for West Virginia.

Kepro understands the importance of clinically sound, safe use practices related to high-dollar medications to reach optimal therapeutic value at the lowest possible cost. As such, our team works closely with BMS on development and revisions of medical necessity criteria stemming from evidenced based clinical guidelines. We look forward to continuing our partnership with BMS regarding the 18 current specialty medications and any additional requested by the bureau and will

provide a current listing of specialty drugs within 30 days of award. We also understand and will comply with the requirement to submit potential medication additions to BMS for consideration six months following implementation.

The prior authorization of specialty medications/physician administered drug services is conducted using InterQual®, local medical policies, and BMS Manual Chapter 518. Prior authorization of specialty medications/physician administered drug services will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

A1.1.gg. Applied Behavioral Analysis (ABA) Services

1. The Vendor must provide authorizations for Applied Behavioral Analysis services in accordance with Agency policy.

We authorize ABA services for WV Medicaid within the behavioral health program and through EPSDT services. All requirements are followed for WV Medicaid members including:

- Members must be between the ages of 18 months through age 20 with a primary diagnosis of autism spectrum disorder (ASD) prior to their eighth birthday, and
- Are referred for necessary diagnostic and treatment services identified during an EPSDT encounter with a health professional practicing with scope and practice.

We will verify provider participation requirements with WV Medicaid and certification by the Behavior Analyst Certification Board, ensure diagnostic requirements and timelines are met, and both an annual physician order and functional assessment of adaptive skills is present. Additionally, a copy of the Consent to Release Information and Bill Medicaid form or other "Statement of Assurances" must be included.

All ABA services require prior authorization and clinically reviewed for medical necessity according to evidenced based guidelines, local medical policies approved by BMS and Medicaid policy. In 2022 alone, we conducted just under 900 ABA reviews for West Virginia. Requests for continuation of services are reviewed also for progress achievement and effectiveness of treatment provided.

The prior authorization of Applied Behavioral Analysis (ABA) services is conducted using InterQual®, local medical policies, and the BMS Manual. Prior authorization of ABA services takes place in Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

A1.1.hh. General Authorization for all programs

1. The Vendor shall be responsible for printing/copying and delivery of outreach and program administration materials at no additional cost.
2. The Vendor shall attend and participate in Agency Fair Hearings as requested by the Agency at no additional cost.

3. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive and review requests for documentation, including itemized and unaltered invoices for manually priced procedures, and request additional information as needed to complete timely reviews and issue completed prior authorizations. All prior authorizations shall adhere to State Code §33-25A-8s, which can be found at: http://www.wvlegislature.gov/wvcode/ChapterEntire.cfm?chap=33&art= 25A&section=8S, and Agency policies.
4. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review forms and request additional medical documentation required for prior authorization and eligibility review of inpatient medical/surgical services to eligible members utilizing the Agency approved criteria and policies.
5. The Vendor shall have a form which is placed in an easily identifiable and accessible place on the health maintenance organization's webpage and contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health maintenance organization requires a prior authorization. This list shall also delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated at least quarterly to ensure that the list remains current.
6. The Vendor shall determine the medical necessity for urgent/emergent and non-emergency inpatient admission prior authorizations, continued stays, and retrospective reviews for inpatient medical/surgical services to eligible members utilizing the Agency approved criteria and policies.
7. Urgent/Emergent Admission Reviews: Urgent/emergent admissions are defined as admissions to an inpatient hospital setting resulting from the sudden onset of a medical condition or injury requiring acute care and manifesting itself by acute symptoms of sufficient severity that the absence of immediate inpatient-hospital care could result in:
a. Permanently placing the member's health in jeopardy.
b. Serious impairment to bodily function; or
c. Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequence.
8. The Vendor shall have the capability and established procedures to receive urgent/emergent admission reviews post-admission for admissions that are not planned or elective and conduct prior authorizations when the member has not been discharged. The Vendor shall ensure determinations for urgent/emergent admission reviews are completed in accordance with current policies.
a. Non-Emergency Admission Reviews: Non-emergency admissions are admissions for planned or elective admissions and the member has not been hospitalized. The Vendor shall have the capability and established procedures to receive non-emergency admission review requests and conduct prior authorizations prior to the planned date of admission. The Vendor shall ensure determinations for non-emergency admission reviews are completed in accordance with current policies.
b. Weekend and Holiday Admission Reviews: Weekend admissions are those admissions where the member was admitted on a Friday, Saturday, or Sunday. Holiday admissions are defined as those admissions where a member is admitted on a state-observed holiday. The Vendor shall have the capability and established procedures to receive weekend and holiday admission review requests and conduct prior authorizations post-admission when the member has not been discharged. The Vendor shall ensure determinations for weekend and holiday admission reviews are completed in accordance with current policies.
c. Continued Stay Reviews: Continued stay reviews are subsequent reviews performed to determine if continuation of services is medically necessary and appropriate. The Vendor shall have the capability and established procedures to receive continued stay review requests for additional inpatient days of care for admissions previously certified and conduct prior authorizations on or before the next review point (i.e., the last certified day). The Vendor shall have the capability and established procedures to provide all hospital providers with a daily listing of members whose certification expires within 48 hours.
d. The Vendor shall ensure determinations for continued stay reviews are completed in accordance with current policies.
e. Retrospective Reviews: The Agency provides retrospective eligibility for a member that was not eligible for benefits at the time of hospitalization. Retrospective reviews cover those admissions where the member was admitted and discharged; certification was not obtained while the member was hospitalized. The Vendor shall

have the capability and established procedures to receive retrospective review requests and conduct eligibility reviews. The Vendor shall ensure determinations for retrospective reviews are completed in accordance with current policies

9. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, and other forms or documentation, including itemized invoices for manually priced procedures required for prior authorization and eligibility review.

10. The Vendor shall determine the medical necessity of precertification and retrospective reviews to eligible members utilizing the Agency approved criteria and policies.

a. Authorization Reviews: The Vendor shall ensure determinations for authorization reviews are completed in accordance with current policies.

b. Retrospective Reviews: The Vendor shall ensure determinations for retrospective reviews are completed in accordance with current policies.

11. The Vendor shall have the capability to develop provider educational trainings and provide technical assistance, at no additional cost to the Agency, regarding policies and available services to members and providers. It shall include, but not be limited to:

a. Participation in conference calls with providers and development and implementation of statewide trainings and webinars at the request of the Agency.

b. Develop a reference manual for members and providers. The manual will provide guidelines on policies, as well as procedures to obtain prior authorization, seek clarification on policies, and procedures to file complaints.

c. Develop and maintain a website with updated information, instructions, updates, code lists, bulletins, links to other needed information and/or websites, and any announcements or new information that needs made available to providers.

d. Develop and implement outreach programs to train members and providers on policies and authorizations.

e. Provide a member and provider support line and tracking for inquiries regarding coverage of services, prior authorization status, and answer any questions regarding issues or problems with prior authorization requests.

f. Provide support via phone, letter, email, or fax to the Agency with any issues/inquiries that arise that are referred from providers, facilities, legislature, members, and/or any other government offices or officials.

g. Make recommendations and develop program forms upon request and need of the Agency.

h. Communicate to and educate providers on any program announcements, policies or payment changes to providers and members, as necessary, at no additional cost to the Agency.

i. Represent the Agency regarding UM policies, and/or criteria at meetings, conferences, and educational seminars, as needed per the Agency.

12. Vendor shall coordinate with Fiscal Agent to ensure adequate and timely claims processing. Vendor shall have capability to exchange necessary data with Fiscal Agent to allow adjudication of claims for prior authorized services to providers.

13. Vendor shall create reliable process for monitoring potential over- and under-utilization of services and produce performance reports to identify both providers and members with utilization patterns that fall outside the norms that, if warranted this can lead to, but not be limited to:

a. Further analysis

b. provider education

c. Development of interventions, which can include outbound telephone calls to educate members regarding appropriate use of services, importance of preventive care and/or a referral to case management.

14. In performing medical necessity determinations, the Vendor shall use nationally recognized, research based, standardized, clinical criteria in reviewing each prior authorization and eligibility review request. If not nationally accredited, researched based criteria exist, the Vendor shall develop criteria based on current research available. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all services reviewed. The Vendor shall maintain the capability to update the review criteria for services reviewed under the

resulting contract. The Vendor shall make recommendations to the Agency annually or as needed, regarding what, if any, changes should be made to the criteria that is currently being used or will be used for the following the calendar year. The recommendations shall be included in the Vendor's annual report and communicated to the Agency.

a. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria annually.

b. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the resulting contract.

c. The Vendor is responsible for any cost associated with the purchase of any review criteria.

15. The Methodology section of the Technical Proposal must provide detailed information on the Vendor's process for determining medical necessity, including: 1) a description of the recommended review criteria for each service; 2) a description of the review instrument(s) for each service; and 3) a description of the Vendor's capability to develop an automated rules- driven certification system.

16. Specific codes or services may be subject to change due to changes in national codes, changes in federal or state regulations, or changes in state Agency policies.

17. Each of the broad general service areas listed below have a number of different components which will be subject to medical necessity review, authorization, and reporting. The Bureau utilizes MCO services for a part of its population. For those services which are MCO covered, and for members who are assigned to an MCO, the utilization review prior approval requirements are the responsibility of the MCO, (subject to the coverage, rules, and authorization procedures specific to the MCO) not to be subject to review by the potential Vendor bidding on this RFP.

18. The Methodology section of the Technical Proposal must provide information on the Vendor's experience that clearly demonstrates how the Vendor will meet stated requirements and describe in detail the Vendor's experience administering similar UM programs for acute and ancillary services for commercial and/or government health care programs.

19. In performing medical policy coverage recommendations, the Vendor shall use nationally accredited, research based, standards of care in determining recommendations. If not nationally accredited, research-based, standards of care exist; the Vendor shall develop recommendations based on current research available. Policy recommendations shall take into consideration, the WV State Plan, any applicable federal regulations and should make comparisons of other State Agency policies. The Agency shall have prior approval of the proposed policies.

20. The Vendor shall have policies and established procedures to verify eligibility prior to authorization of any services.

21. The Vendor and State shall discuss policy changes during Agency and Vendor meetings.

Along with Kepro's vast experience and deep expertise conducting utilization management and prior authorization reviews, we bring to WV DHHR our clinical reviewers who are well-trained in URAC, InterQual® clinical guidelines, and person-centered review processes. All reviews are conducted with a primary focus on optimizing the services available for each individual's needs to facilitate achieving the best health status and outcome. Our methodology is built into our rules-driven, automated system; by incorporating InterQual® and other WV-preferred review criteria directly within our automated system, configured for each review type, we ensure consistent and thorough application of our criteria across all reviews.

Our expert clinical reviewers ensure medical necessity and compliance with WV DHHR's policies with a keen focus on quality and clinically appropriate services and treatment setting with each review. Our clinical reviewers ensure the authorization reviews are person-centered, clinically appropriate, and reflect an optimal level of quality services rendered. Our authorization reviews

determine if beneficiaries are receiving the appropriate care and services or if they may be better served in a lower level of care or with alternative services to meet their individual needs. The end result of the Kepro advantage is that the individual is provided the best option of service to achieve their best health status and outcome. WV DHHR can be confident that it is maximizing its taxpayer investment in the best holistic care approach available for each member based on that member's unique circumstances.

The volumes we have handled company-wide for reviews, appeals, and hearings for the last five years are shown in **Table 17 Kepro Review and Appeals Experience** below, which represents our experience and expertise.

Type	2018	2019	2020	2021	2022
Medicare Discharge Appeals	88,733	74,164	67,075	99,482	148,995
Reconsideration Appeals	10,000	10,000	10,160	10,160	24,803
Medical Review Appeals	13,400	9,764	10,327	16,448	21,615
Total Appeals	**112,133**	**93,928**	**87,562**	**126,090**	**195,413**
Prior Authorization Reviews	1,884,615	2,860,060	2,874,498	3,112,778	3,302,709
Prior Authorization Reviews (Pharmacy)	2,406,556	4,876,987	4,347,143	4,031,080	4,132,547
Compliance Reviews	8,273	2,034	0	89	0
Quality of Care	86,149	175,948	118,525	108,627	79,470
Reconsiderations	116	31	111	128	10,562
Standard of Care	3,369	3,566	3,485	3,982	4,399
Witness Hearings	5,206	4,673	3,575	4,501	4,245
Specialty Reviews	13,721	448	174	448	466
Total Reviews	**4,408,005**	**7,923,747**	**7,347,511**	**7,261,633**	**7,534,398**
Total Reviews + Appeals	**4,520,138**	**8,017,675**	**7,435,073**	**7,387,723**	**7,729,811**

Table 17. Kepro Review and Appeals Experience
We have a wealth of experience with a range of review types and appeals

Receipt of Prior Authorization Requests

Depending on program policy, Kepro offers the highest flexibility by offering providers the convenience of submitting prior authorization requests via multiple modalities including the Atrezzo portal, telephone, fax, and mail. **Figure 26 Process for Receiving and Processing Prior Authorization Requests located in Section A1.1.a Inpatient/Medical Surgical Services** outlines the

initial prior authorization (PA) request workflow in Atrezzo, whether the request is submitted through the portal or entered manually into the system by staff.

When a prior authorization request is submitted via fax, telephone, or mail our Customer Service Representative (CSR) retrieves the intake information and enters relevant details into Atrezzo. The CSR will record the date of receipt as the date a mailed, telephonic, or faxed request was received, except for requests received after business hours. For requests received after business hours, the date of receipt will be recorded as the next business day. Atrezzo will then automate the remainder of the process, including Medicaid eligibility checks and sending communications to the provider automatically. If the request requires clinical review, the request is automatically routed via Atrezzo workflows to the appropriate clinical review work queue. **Table 18 Medicaid Client Prior Authorization Requests by Method** breaks down the method of prior authorization submission requests for a large Medicaid client in 2021.

Submission Method	2021 Percentage
EDI	0.03%
Fax	4.42%
Mail	0.01%
Phone	4.64%
Provider Portal	90.90%

Table 18. Medicaid Client Prior Authorization Requests by Method
We have worked with providers to get most PA requests submitted online.

Atrezzo Provider Portal Submission Process

Kepro applies the following step-by-step process for prior authorization requests received via the Atrezzo provider portal, telephone, fax or mail. Kepro provides a master code list that indicates all allowable codes for providers to obtain prior authorization, which is available on the website and includes the code, units, and benefits. We understand that final prior authorization processes are subject to WV DHHR approval.

Step 1: Prior Authorization Request and File Upload

Prior authorization requests can be submitted via the Atrezzo Provider Portal or received via fax, mail or a phone call to our CSRs and directly entered into Atrezzo. Requests submitted directly to the Provider Portal are immediately queued for review or immediately approved using auto approval logic if criteria are met. In circumstances where prior authorization requests are received via telephone, fax, or mail instead of our Provider Portal, CSRs will input the requests into Atrezzo upon receipt. Atrezzo is optimized to prevent duplicative data entries, therefore any requests entered via portal or telephone, mail or fax are entered into one Atrezzo module.

Did You Know?

In 2021, the Atrezzo provider Portal received more than 1.14 million total service lines/ procedures.

All prior authorization requests and supporting documentation are housed in our Atrezzo system—from start to finish our clinical staff and providers can view all information and documentation for a specific request through a single, web-based system. When a request for a prior authorization is received either by phone, mail or fax, our CSRs immediately create a case in Atrezzo. providers can add/upload supporting documentation, either by uploading documentation directly into Atrezzo, or by sending to us via mail or fax and CSRs upload the information into the system. We pend a case when the authorization requires clinical review and supporting documentation, and we request the additional information from the provider. To ensure providers submit the required additional information in a timely manner, we utilize notifications and alerts ensuring submissions are reviewed within the review types required timeframe.

As shown in **Figure 50 File Upload Screen**, uploading files into Atrezzo is a simple, efficient process for providers.

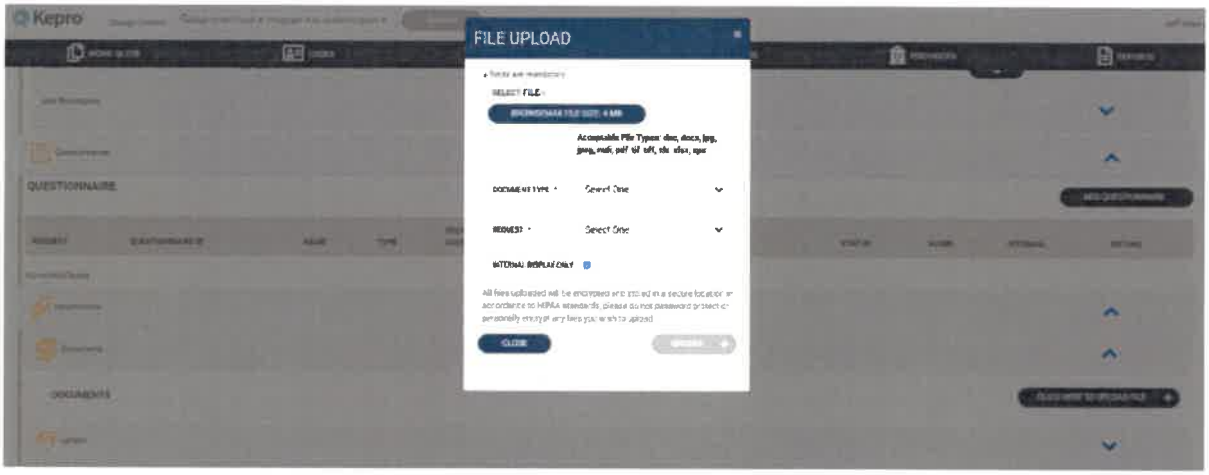


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Figure 50. File Upload Screen
From this view, relevant documentation can be uploaded into the Provider Portal.

Maintaining all Documentation in an Electronic Record Format - All documentation is housed within Atrezzo, regardless of how it arrives to Kepro. providers and Kepro staff upload files to a case and can enter clinical documentation and other notes directly into the case even if it is submitted via electronic data interchange. In addition, providers can call, mail, or fax in information. Fax images are housed in Atrezzo, along with any uploaded documents. Staff-entered information provided by phone or mail is scanned and uploaded. Anyone with Atrezzo client access, which includes physician consultants and WV DHHR staff, can view any and all documentation online from within the case.

Kepro's secure Provider Portal facilitates communications between medical providers and our clinical review staff. Our design of the Atrezzo system is based on years of interaction with the various provider communities. We continuously look for ways to make the system more efficient and easier to use for providers, and their staff. Owning this system allows us to implement enhancements that providers and WV DHHR are requesting in a cost-effective and timely manner.

Process for Marrying Prior Authorization with Supporting Documentation - All documentation related to a specific case is available in one place for ease of review, as shown in **Figure 51 Documentation Screen.**

Figure 51. Documentation Screen

Documentation is centralized in this screen to ensure ease of access to case information.

Step 2: Case Creation

Once a provider submits a request for services either through the Provider Portal, or via telephone, mail or fax, our Customer Service Representatives use the Create Case screens to create a case workflow and initiate a first level review. **Figure 52** is a sample **Case Creation Screen.**

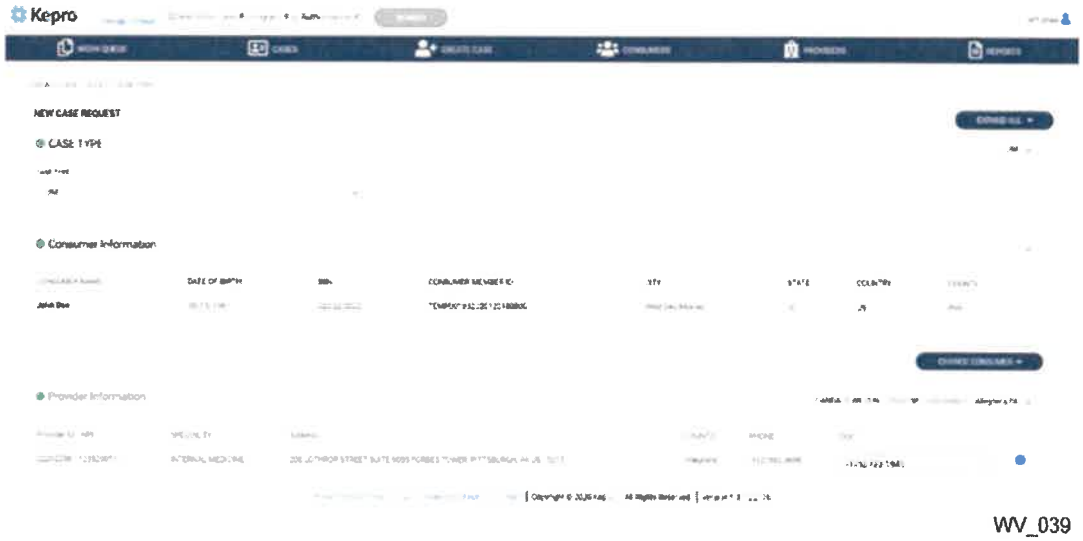


Figure 52. Case Creation Screen

A clinical reviewer creates a case in Atrezzo to initiate a first level review.

From here the system captures all relevant information for a case (e.g., physician/facility information, clinical information such as service details, diagnosis codes and procedure codes). From this interface (shown in **Figure 53 Case Information Screen**) both clinical reviewers and providers can see all the relevant information captured for each case.

Figure 53. Case Information Screen

Atrezzo allows both clinical reviewers and providers to see all information relevant to the case.

Figure 54 Clinical Information Expanded View provides an expanded view of the clinical information area. From here reviewers can look at service details, diagnosis codes, and procedures specific to each case.

Figure 54. Clinical Information Expanded View

Clinical reviewers can expand desired service details, diagnosis codes, and procedures specific to the case.

Figure 55 Service Details Screen provides a view of the service details for a case.

WV_042

Figure 55. Service Details Screen

Within Atrezzo, the clinical reviewer can drill down to specific service level details of a case.

Figure 56 Document Screen provides an expanded view of Documents, which falls under the Attachments area, where all relevant documentation is uploaded for review.

WV_043

Figure 56. Document Screen

Atrezzo allows for easy upload of clinical documentation for review.

Figure 57 Interactions Screen shows a breakdown of the interactions portion of the communications area, which also includes notes and alerts.

WV_044

Figure 57. Interactions Screen

Atrezzo's popular Interactions Screen enables efficient communication of pertinent case information

Step 3: Ensure Documentation is Complete and Request Additional Information as Needed

Once we receive the supporting documentation from a provider, a clinical reviewer evaluates the documentation and determine if it is complete or if additional information is needed. If the documentation does not include all the required documents, we will contact the provider requesting additional information in the manner and timeframes required by WV DHHR. The clinical reviewer will call, fax, or email the provider, indicating the information needed and the timeframe the provider must return the information.

We will request the provider submit the missing information within approved timeframes via the Atrezzo Provider Portal, fax, or mail to Kepro. The use of the Atrezzo Provider Portal is an important feature of our system that improves record submission by making it possible to upload materials 24/7 and immediately validate acceptance of the upload. Our call center is also available to assist providers during office hours, and we will scan the records into the system if we receive them in hardcopy format. Our administrative process validates that the records are complete and ready to review. If needed information is still missing, we will notify the providers and request them to submit just the specific materials. If providers do not submit the requested documentation in response to the first and second requests, we will close the case and indicate "Reject – Insufficient Information."

Additionally, provider training will focus on educating providers to the required components in submitting complete medical records. Ensuring providers are well educated in key processes and procedures, including the submission of complete documentation, is key to our ongoing, successful partnership with our state program providers.

Step 4: Review

Once all the needed documentation is gathered each review is conducted by a qualified reviewer. When performing clinical review all reviewers first ensure all applicable program and administrative requirements and policies are met. The reviewer then evaluates clinical information submitted and any supporting documentation. The reviewer evaluates the information using applicable first level review clinical decision support tools, such as InterQual® criteria or other WV DHHR preferred criteria; these criteria indicate appropriate length of stay, medical necessity, and triggers for continued stay based on the member's medical status. Regardless of service type requested, we will adhere to the policies and procedures set forth in federal and state policies such as the Code of Federal Regulation (CFR) and specific state requirements.

Upon review of all medical documentation received for each review, if all required criteria are not met such as whether the services were rendered at an appropriate level of care or if quality of care concerns have been identified, the reviewing clinician will refer the case to the Medical Director or Physician Consultant within a matching specialty for a second level review.

Clinical Criteria Review Screens - Figure 58 InterQual® Interface Screen shows our clinical review: InterQual® Interface screen. Using this screen, reviewers can view the InterQual review conducted on a request, the Criteria Subset chosen, Status, Review Date, Modified By, and Date.

Figure 58. InterQual® Interface Screen
This screen displays the Healthcare InterQual® review conducted on a PA request.

The screen shown in **Figure 59 InterQual® Criteria Recommendations Screen** enables users to view what clinical information was documented as well as the results of the InterQual® review.

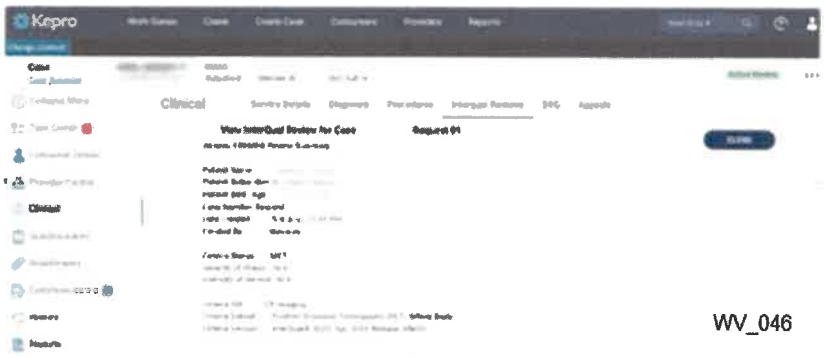


Figure 59. InterQual® Criteria Recommendations Screen
Shows the results of the Healthcare InterQual® review.

Figure 60 Sample Outcome Screen is a sample outcome screen for a clinical review. This screen enables users to view the completed review (e.g., Approved, Denied, Pended, Void), along with dates of service, units, price, and frequency.

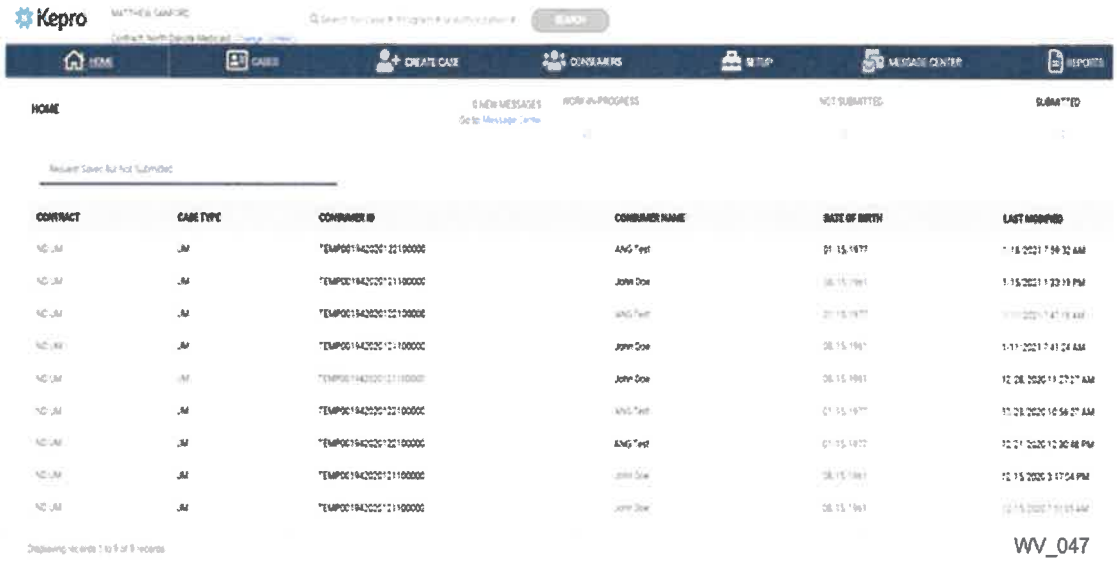


Figure 60. Sample Outcome Screen

Users can view the review outcome as well as dates of service, units, price, and frequency.

From start to finish Atrezzo captures all relevant case information, interactions, and supporting documentation, making it a one-stop resource for both clinical reviewers and providers alike.

Step 5: Determination and Notification

Once the determination has been made regarding an approval, denial or partial denial, communication is automatically sent to the State's MMIS through data file transfer. We will generate applicable notification letters to providers and members per contract and policy guidelines.

Approvals – Approval notifications are delivered in real-time to providers when the Provider Portal is used for prior authorization request submissions. Notifications contain a unique case identifier and clearly outline the dates and services/treatment approved. Confirmation of authorization includes approval notes, admission or onset of care, the number of days or units of service, next anticipated review time (end date of authorization), total number of days or services approved.

Denials – Following the entry of the denial decision into Atrezzo, the communication is automatically sent to the submitting provider via portal notification. In addition, a notification letter is mailed to the member within 24 hours of the determination. Denials will include all necessary service authorization request information for the member and provider to take next steps toward an appeal or submission of additional information to support the request.

Atrezzo Provider Portal

Access to a provider portal through Atrezzo has further streamlined the daily workload for providers and reviewers in utilization management. Our portal allows providers to submit requests 24-hours, 7 days a week, attach documentation, complete review specific forms, communicate electronically with Kepro staff (including the clinical reviewers), and manage and track requests for authorization. In 2021 alone, our portal reported over 27,000 enrolled providers and over 87,000 provider users, as well as handled over 50,000 provider portal submissions each month. For our West Virginia contract, 1,810 providers are enrolled for portal use, and Kepro hosts a total of 5,154 individual West Virginia-specific provider users. These features also further support Kepro's data-driven approach to reporting. Our Provider Portal has proven to be a differentiator for Kepro, helping to drive a 95% customer satisfaction rate measured by annual provider Surveys.

A key component of Atrezzo's Provider Portal is the improved collaboration between WV DHHR Operations staff, provider relations staff, and Kepro operations staff, resulting in a high level of provider satisfaction and acceptance of the portal process. The shift away from fax to portal benefits our Medicaid clients and provider communities by eliminating the delay and uncertainty inherent in a fax-based system. Atrezzo is configuration-based, allowing for rapid implementations and updates to the WV UM and PA program without the need for extensive IT support or software development.

Authorization requests are also accepted from providers via fax or mail per WV DHHR guidelines. When our staff receive and enter a provider's submission into Atrezzo, the same rules engine and embedded workflows are employed, affirming WV DHHR requirements and timeliness standards.

The following key features of the Atrezzo Provider Portal ensure a streamlined authorization process, leading to ease of use for providers:

- ✓ **Robust Rules Engine** – Requires only necessary fields be completed based on the requirements of the UM/PA request, minimizing the information required by the provider to request authorization.
- ✓ **Embedded Workflows** – Streamline the authorization submission process for providers and ultimately ease administrative burden.
- ✓ **Automated Notifications** – providers receive real-time notifications such as insufficient information or incomplete submission and authorization and denial decisions and notifications.

- ✓ **Real-time Communication with Kepro clinical reviewers** – providers can communicate directly with clinical reviewers via the Portal, removing the need to contact the Call Center for questions or status inquiries.

Atrezzo's Workflow and Task Driven Activities

Atrezzo's internal algorithms and rule-based workflow functionality supports the life cycle of all types of authorization requests beginning from the provider's submission of request and continuing through provider validation, member eligibility, clinical review, service type validation, determination, notification, and completion of the case. Atrezzo's workflow functionality for authorization requests includes the following six core components:

1. **Submission Validation.** Submission validation rules confirm that the request requirements are met, member and provider eligibility, benefits validation, service type requirements, and other client-specific data elements related to the submission of the request.
2. **Rules-Driven Authorization.** After passing the Submission Validation ruleset, each service request is evaluated to see if it meets the criteria for Rules-Driven Approval. If the criteria are met, then the service line is marked as approved. If the criteria are not met, no action is taken. If all services requested are marked as Approved by the Rules Driven Authorization ruleset, the Case is closed and is not pushed to a clinician's queue for review.
3. **Request Routing.** Requests not completely approved by the Rules-Driven Authorization are evaluated based on the type of request and routed to the corresponding clinician or administrative staff, depending on the requirements.
4. **Clinician Review.** The workflow supports clinicians conducting an initial review for medical necessity. If the clinician does not find the request to contain information to support medically necessity, the workflow triggers a referral to a physician for a peer-to-peer review. If all services have a decision (approve or deny), then the ruleset marks the services to be extracted and sent to the claim's payor in the next scheduled extract.
5. **Authorization Rules.** Authorization Rules recheck the request to confirm that the rules required for submission are followed by validating, at the time of approval or denial, that the business rules are still being followed.
6. **Notifications.** Notification of determination is automatically generated to provider(s) based on configured rules specific to the client.

Atrezzo's Task Driven activities are managed through custom workflow configuration, moving the task automatically through the process from receipt of request to decision and completion. Each workflow step is tracked with a date/timestamp. The end-to-end authorization request, review process through decision and notification is facilitated by workflow queues that allow for pooled resources to work the items based on the rules established for that team. When a request is submitted there are business rules that route the request to the appropriate queues. These rules can be specific to attributes such as review type, and urgency. If the queue or team requires an additional level of assignment the system has algorithms to assign to specific team participants in

a round robin, random or custom rule approach. Custom rules can include things like capacity limits, risk level or complexity.

Through workflow and task-driven functionality, Atrezzo monitors and alerts Reviewers of authorization turnaround times (TAT). Authorization Dashboards are used by Kepro UM staff and can be used by WV DHHR as well. The Dashboard includes several visual indicators to alert users of turnaround times and priority. Elements that are critical are indicated by color (typically red for past due). Each request type has a configurable turnaround time that is measured starting upon initial submission. There are scenarios where the time is suspended such as when the request is pended back to the submitter for additional information. The dashboard allows for sorting by remaining time as well as other parameters.

Atrezzo's task driven timeliness tracking includes:

- Timeliness tracking of an authorization begins immediately upon submission
- Timeliness tracking automatically starts and stops the clock when pended or returned
- Dashboard reflects visual color indicators for requests that are approaching due date/time and past due date/time

We have the capability to exchange necessary data with the Fiscal Agent to allow adjudication of claims for prior authorized services to providers. Our extract files include authorization data that is exported to the fiscal agent to load into their system for claims processing and payment.

Auto Approvals

Atrezzo supports auto-approvals by utilizing rule-based algorithms for Authorization requests submitted through the Portal or when entered manually by our staff. We use ICD-10, HCPCS, demographic information, provider specialties and other information as necessary to create client specific rules for auto approvals. Atrezzo employs a series of checks and balances when reviewing authorization requests such as providing warnings if services requested have been previously authorized, or if a provider is not approved to provide services or if information is not sufficient to complete the request. Upon submission of the authorization request the configured auto-approval workflow will drive the approval of the request. Atrezzo, whether entered by a CSR or via the Provider Portal by the provider, provides real-time auto-approval notification.

Our auto-approval algorithms are developed by our highly experienced staff of clinicians with support from our Data Scientists. They are reviewed by panels of physicians yearly to determine accuracy and reflect national clinical guidelines. During the Implementation Phase we will collaborate with WV DHHR to configure your preferred auto-approvals by service type as well as share our extensive library of auto-approval service types that can be adopted or modified.

EPSDT Screening

Atrezzo allows clinical reviewers to easily verify if service was identified during the performance of an Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) screening. Atrezzo is configured so

that all codes are accepted for members under 21. Atrezzo will check for allowed codes. If a request for a code is not typically allowed, and the member is under 21, Atrezzo will not stop the prior authorization request from being submitted. If the prior authorization request for a member under 21 is for an allowed code, the request will be routed to the respective service type queue in Atrezzo. If the request for a member under 21 includes a code that is not on the allowed codes list, it will be routed to the EPSDT queue.

General Authorization Process

All decisions made by the Kepro clinical reviewer to authorize, modify, or deny a given request will be based on medical necessity, as well as program policy criteria. For the WV UM and PA program we use InterQual® criteria in addition to contract, State, and CMS required guidelines for authorizations of inpatient and outpatient services and items to ensure the services requested are clinically appropriate and medically necessary.

We bring to WV DHHR our decades of experience, clinical expertise and understanding of UM and PA services across multiple service types and treatment settings to deliver operational excellence in all levels of Utilization Review. We show the standard prior authorization review process in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**, displaying the overall process points for key activities and determinations.

The Authorization Review process begins upon receipt of request for services. Kepro's clinical reviewer receives the request automatically in real-time via Atrezzo and reviews the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR program policy. Using these criteria will ensure that services and items planned are consistent with appropriate care. If InterQual® guidelines are not available for a specific service, we. have a large library of local evidence-based policies that can be adapted for WV DHHR's consideration.

If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo. The provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to the physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo, and the clinical reviewer finalizes the case. If the case was created by the provider via the Provider Portal, an email notification is automatically sent to the provider.

We have the experience necessary to coordinate all the logistical pieces involved in medical necessity determinations and whether a covered benefit or service is medically necessary. Our expertise is in coordinating these pieces in a manner that ensures uniformity, accuracy, and timeliness for all review types, review mechanisms, or geographic locations.

The UM and PA program provides review of medical necessity and appropriateness of care through application of standardized screening criteria to ensure services are authorized only when medical necessity is met, and services are a covered benefit; this ensures that WV DHHR only pays for the appropriate clinical care which decreases claims associated with inappropriate inpatient and outpatient services. Our primary program goal is to ensure members receive the best quality care they are eligible to receive in the most appropriate setting while focusing on a whole person-centered care and services.

Medical necessity reviews follow our prior authorization process and are conducted in the best interest of the member and medical appropriateness. These reviews are provided for medical reasons rather than primarily for the convenience of the individual, their caregiver, the health care provider, or for cosmetic reasons.

Our properly credentialed, licensed, and qualified clinicians will combine our high standards of quality and expertise with administrative rules of WV DHHR when making medical necessity determinations using InterQual®, a nationally recognized Clinical Determination tool. We have extensive experience reviewing prior authorization requests from providers for services outlined in this RFP. clinical reviewers will perform the initial review of the case to evaluate the proposed services based on an individualized assessment of the member's medical needs, ensuring medical necessity and appropriateness of the setting as outlined above. clinical reviewers do so by comparing the information contained in the request, including ICD-10, HCPCS, service type and member demographics such as age, against the appropriate InterQual® Criteria and other applicable West Virginia Medicaid rules to ensure requested services are reasonable and are required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or unhealthy practice. They must also fall in line with the terms of the service, amount, scope, and duration based on evidence-based medicine.

The clinical reviewer, using InterQual®, indicates whether the condition of the member meets the severity of illness and intensity of service requirements for the level of care and the type/number of services requested to arrive at a review determination. As part of the review, the clinical reviewer will assess whether the requested service is provided in the most appropriate location, with regard to generally accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided.

Kepro reviews demographic information and all relevant clinical information submitted by the provider that would justify the need for inpatient services. Examples of justification include:

- Clinical information of chief complaint
- Previous treatment to substantiate the need for hospitalization and level of service for the requested admission/procedure
- History of present illness
- Vital signs/Blood Pressure
- Results of physical exam
- Diagnostic testing results including lab and radiology results
- Diagnoses
- Treatment plan and level of care
- Physician's plan of care including medications information including dose/route/frequency, all treatment modalities, monitoring and diagnostic tests, discharge plan

The clinical reviewer's approval of the requested services is based on medically necessary care and the member's benefit plan. Depending on the review type, the clinical reviewer approves the case when the following are present:

- Services are a covered benefit
- Appropriate severity of illness clinical factors
- Appropriate treatment elements in services provided or planned
- Appropriate treatment setting (e.g., can the member be better served in a lower level of care)
- Medical necessity based on InterQual and/or other clinical guidelines used by WV DHHR.

Severity of illness includes measuring objective clinical indicators through presenting signs and symptoms as well as abnormal findings in the clinical picture of the member. Intensity of services includes evaluation of diagnostic, monitoring, and therapeutic services that can be administered only at a specific level of care and the treatment plan implemented for the member. Severity of illness and intensity of services rules, per InterQual® guidelines, are consistently applied to all clinical reviews and determinations. The clinical reviewer communicates the approval determination to the provider through the provider portal and/or via fax or autogenerated letter.

If clinical reviewer does not believe that the request meets medical necessity based on InterQual® guidelines, the request and accompanying documentation are sent to a physician reviewer. The physician reviewer makes a determination based on acceptable, current evidenced based practice, and, if required (per URAC, for all inpatient services) or requested, a Peer-to-Peer discussion with the requesting provider to better understand why the provider is requesting the services. The physician reviewer's determination is then communicated to the provider verbally and through the Provider Portal and/or via fax or autogenerated letter. For all adverse determinations, the member receives the denial notification via certified mail.

We are knowledgeable and consistent with our application of medical necessity for EPSDT services. We also understand the sensitivities of EPSDT services sought for under-aged beneficiaries, stakeholder groups, and the communities we serve. As an example, to better serve our Colorado HCPF client following the transition from a previous UM Program vendor, we learned that EPSDT

services previously sought through the incumbent vendor were often inconsistent with the application of medical necessity, creating disruption for the beneficiaries and HCPF. We developed an intensive EPSDT training plan for mandatory participation by our clinical reviewers and physician reviewers to ensure each Clinician was individually trained upon hire and received annual continuing education and training on EPSDT guidelines. We also established templated verbiage surrounding EPSDT that physician reviewers use in their determination; this templated language is used to document and confirm that they applied EPSDT criteria to the decision.

We will conduct all urgent and emergent reviews within the required timeframes. The medical record review will also include a review of each urgent/emergent admission to determine if the admission was a non-emergency admission. If the clinical information presented does not meet InterQual® guidelines and the clinical reviewer determines the hospital designated emergency admission is non-emergent, the case will be referred to a physician reviewer. If the physician reviewer concurs with the clinical reviewer decision, the clinical reviewer will deny admission for lack of medical necessity. The clinical reviewer will also validate that concurrent review has been completed as required. Failure to meet these requirements for pre-authorization or concurrent review will result in denial of the admission or days in question by the clinical reviewer.

Requests for weekend and holiday admissions, in addition to retrospective requests, will receive eligibility verification and clinical review by the date of receipt. Behavioral Health admission requests must be accompanied by the MCM-1 form, which certifies this level of care is the most appropriate; this WV form is utilized to meet the independent evaluation requirement in 42 CFR.

To ensure beneficiaries move through the continuum of care appropriately based on medical need criteria, **Continued Stay Reviews** are provided throughout all levels of care. We have provided Continued Stay Review Management for decades. Our extensive experience in Continued Stay Review Management includes contracts in Maine, West Virginia, South Carolina, Minnesota, and Florida. As such, we can provide Continued Stay Review to support WV DHHR as required. We will conduct Continued Stay Reviews within Atrezzo using the utilization review process outlined shown previously in **Figure 25 Prior Authorization Review located in Section A1.1.a Inpatient Medical/Surgical Services.**

A nurse conducts reviews of medical record information to determine if the need for continued stay and to provide notice and/or reconsideration for denied participants. Additionally, this review ensures quality assurance and multidisciplinary team requirements pursuant to state requirements.

Using an algorithm based on approved criteria, Kepro assesses the medical necessity and appropriateness of the recipient's continued stay. Where the medical record documentation does not substantiate the need for continued stay, the attending physician and/or direct care staff is contacted and requested to supply additional documentation in the recipient's record to justify the continued stay.

Our Retrospective Review process follows a similar process to prior authorization review. The retrospective review includes reviewing the member's medical record that corresponds with the date of initial service and subsequent treatment to validate medical necessity throughout the member's length of stay in the inpatient setting. We will ensure the plan of care is consistent with WV DHHR policy. Daily documentation specific to treatment goals and objectives, anticipated LOS and discharge planning activities must be evident for each day of hospitalization. For inpatient reviews after discharge and prior to billing, the hospital will submit a request for processing. Our Retrospective Review Process is illustrated in **Figure 27 Retrospective Review Process located in Section A1.1.a Inpatient/Medical Surgical Services**.

Our clinical reviewer begins the retrospective review by reviewing the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR required rules. Using these criteria will ensure that services and items planned are consistent with the provisions of appropriate care. If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo and the provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo and the provider receives automatic real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to a physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo and notification is automatically sent to the provider via the Provider Portal and/or notification is autogenerated via Atrezzo and can be viewed as well as downloaded from the Provider Portal. For all adverse determinations, the member receives the denial notification.

Over-and Under-Utilization of Services

We maintain a reliable process for monitoring potential over- and under-utilization of services and produce performance reports to identify both providers and members with utilization patterns that fall outside the norms. Our Health Intelligence (HI) team stands ready to provide WV DHHR with insightful review of Medicaid covered services and FFS claims to identify over- and under-utilization of services and other data and trends to mee the goals of the organization. Our HI team, working in collaboration with our Executive Director and Project Managers, gathers and analyzes data to include both pertinent and comprehensive findings as well as presents recommendations to WV DHHR. We bring our expertise to WV DHHR, including collaborating with outside agencies for review of value-based payment models and bringing multiple managed care, fee-for-service, and agencies together to meet the goals of the organization.

We monitor provider utilization patterns primarily through our monthly reporting. It is our practice to review and discuss reporting and concerns with WV DHHR regarding any potential concerning trends. We will exercise our longstanding, tenured relationship with BMS and WV providers to continually focus on quality and appropriate utilization of cases to ensure the most appropriate services are identified. Any concerning practices regarding over or under-utilization will be discussed with BMS and further explored.

Exceeding Standards

Our Stakeholder Engagement Model leverages our current successful outreach models with Nebraska Department of Health and Human Services, Maryland Developmental Disabilities Council, among other organizations.

In addition to provider monitoring, member services receive ongoing evaluation to ensure appropriate WV Medicaid benefits are appropriately distributed. Our case management process allows us to identify repetitive services or high-cost services that may be repetitive; we also locally review UM reports and provider monitoring so that if issues arise, we can discuss provider performance with the Bureau.

Stakeholder Engagement

Our overarching approach to stakeholder engagement is standardized across UM and Waiver programs and has ensured Kepro maintains a pulse on stakeholder needs. Kepro's approach has been honed over years of experience with hundreds of clients and uses continuous improvement and identification of best practices as its foundation for education, training, and outreach.

With each client, we begin by identifying the relevant stakeholders. Stakeholders impacted by this program will include not only WV DHHR staff, but also related agencies and providers. Additionally, we estimate some level of secondary communication to State government, members, and the public. We also anticipate variations in operational impacts to users based on not only different technology environments in the various offices, but also different office types (eligibility, service delivery, claims). Finally, we recognize that the dynamics between WV DHHR and its district offices adds a layer of organizational complexity. Our stakeholder analysis approach will ensure that these differential impacts to various stakeholders and end-users are duly identified, analyzed, and addressed through custom change enablement actions.

We will implement our collaborative engagement strategy by working with WV DHHR stakeholders to define initial requirements, review and resolve issues, and refine and update requirements as the contract dictates. Kepro's Stakeholder Engagement Model, including our Stakeholder Advisory Council, serves as a feedback loop to improve the quality and ultimately the outcomes of the program where we promote transparency and avenues for ongoing input from key stakeholders. We understand that consistent and open collaboration with WV DHHR is essential to successful implementation of the UM and waiver program. We prioritize continuous two-way communication from the start to ensure stakeholders are empowered with the information and resources they need to fully participate in UM implementation activities and to meet program requirements.

We also embrace partnerships with community stakeholders as the most effective means of improving the quality of services that ultimately benefits Medicaid members. We will work in close collaboration with WV DHHR to identify key stakeholders such as human service providers, families, and advocates to ensure that together, we lay the foundation for strong working relationships and ongoing program buy-in. We will provide the following necessary components to successfully engage stakeholders in the delivery of WV DHHR UM and waiver services in West Virginia to achieve person-centered excellence. Our communication, outreach, and training plan include the following six components:

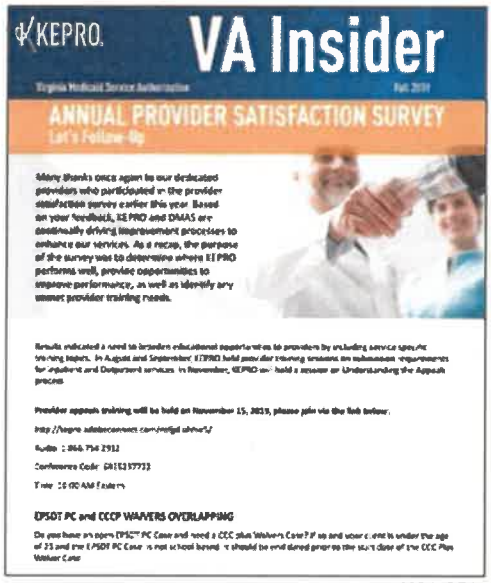
1. Gain Insights about Challenges: We will conduct stakeholder listening sessions to understand the current needs of WV DHHR stakeholders, discuss communication strategies, and learn about any concerns related to the program. We use stakeholder advisory councils and workgroups for insight into implementation and ongoing processes.

2. Implement a Formal Stakeholder Engagement Plan: We will implement a formal stakeholder engagement plan during implementation, building on and learning from the listening sessions, existing WV DHHR efforts and best practices. Using our proven experience and successes, we will draft the plan and submit to WV DHHR for approval. We will verify key stakeholders and develop training/meeting agendas and materials for all key groups. We will work with WV DHHR to encourage stakeholders to attend trainings/meetings where they will learn about program requirements and strategies to fully participate in UM activities. We believe that transparency in our process garners stronger relationships and cooperation amongst stakeholders. Accordingly, we strive to make the process accessible and efficient for all involved.

3. Ensure Initial and Ongoing Communication with providers: We prioritize communication with providers every step of the way to provide program updates and support. Communications and educational materials will be routinely customized to meet WV DHHR needs, including purchased educational brochures and internally created documents. These types of targeted educational materials include content based on WV DHHR input and trends we have identified as an educational need. Educational materials, to include the WV DHHR logo and content requested or approved by WV DHHR, are updated at least quarterly. We create a customized newsletter, with a consistent level of quality and success within the program. In addition to our healthcare expertise, training is a foundation to Kepro's approach to providing successful programs. During the implementation, we will review and obtain approval from the WV DHHR for all planned communication. Once approved, we will engage with key stakeholders to explain the program, our role, and any changes occurring within the program. Kepro's communication strategies to engage and foster collaborative relationships with stakeholders to include:

- Targeted educational materials based on stakeholder feedback and best practices.
- Communication through email, website postings, virtual and in-person meetings and presentations, Town Halls, phone-based and in person technical assistance, newsletters (see

Figure 61 Newsletter Example) and "hot topic" alerts (see **Figure 62 Example of "Hot Topics" Provider Notifications** below).



WV_051

Figure 61. Newsletter Example

Customized provider newsletter emphasizes continued engagement and promotes training and other resources

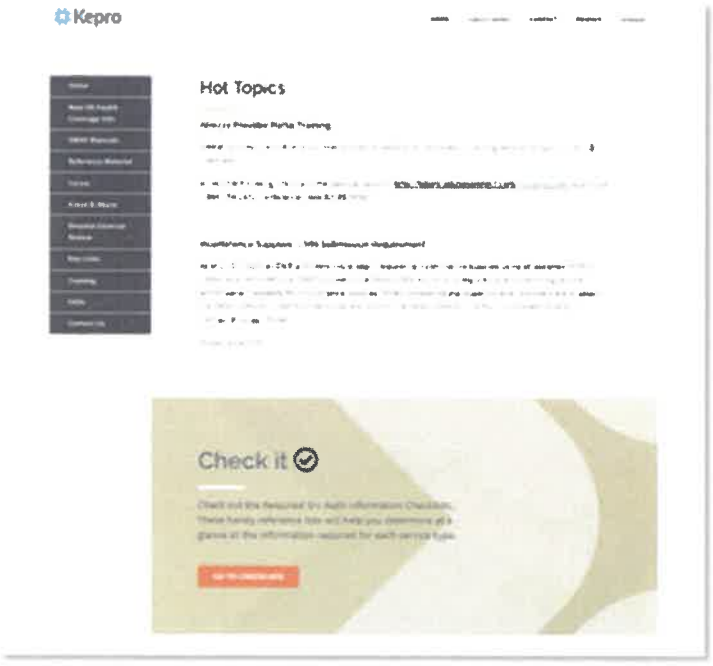


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Figure 62. Example of "Hot Topics" provider Notifications

"Hot Topics" alerts within Provider Portal identify upcoming changes that may impact authorizations and reviews.

4. Implement Stakeholder Trainings: One of the most important components to the implementation of the program will be education and buy-in from WV DHHR and the stakeholders that we jointly identify as integral to the program's success. Each review type has a dedicated web training for Atrezzo submissions according to review areas. These trainings are recorded and available on our website for providers to access at any time. We will collaborate with the WV DHHR to finalize our short and long-term Training Plans for all facilities impacted. Once approved by the Agency, we will address the training needs of our internal team, WV DHHR staff, and provider staff to ensure successful implementation and ongoing operations. Initial and ongoing specific training topics will include but are not limited to 1) How to submit requests; 2) Requests for additional information; 3) Best practices in submitting records; 4) Transmission of determinations; 5) Peer-to-Peer reviews; 6) Discharge planning Coordination; 7) Appeals processes; 8) Medical Necessity Criteria. Our stakeholder engagement strategy will be governed by the following core principles:

Did You Know?

Between Fiscal Years 2016 and 2022, Kepro developed and facilitated over 500 provider trainings reaching over 10,000 participants.

- **Responsive**. We engage with key stakeholders early and often to identify issues, and act upon the feedback received.
- **Inclusive**. We foster dialogue and collaboration with stakeholders representing various specialties, settings and services, and tailor our operations to meet their unique needs and address any concerns.
- **Transparent**. Transparency in our process garners stronger relationships and cooperation. We make information readily available to stakeholders to promote meaningful collaboration.
- **Proactive**. Using data insights on UM and waiver practices to provide suggestions on rules or policies.
- **State-Informed**. We will work with WV DHHR on all materials and communications.

5. Establish a Community Stakeholder Advisory Council: As part of our commitment to West Virginia and the ongoing success of the WV DHHR's program, we will work with WV DHHR to identify the appropriate stakeholders and members of the stakeholder council. Once identified, we will meet with and recruit key community stakeholder organizations to join our Community Stakeholder Advisory Council. We will design the Council to provide actionable feedback and local leadership about the direction and challenges of the program. This Council will be facilitated by our Vice President for Public Affairs, Michael Wolf. Mr. Wolf brings 18 years' experience in the healthcare industry with specific focus healthcare communications and policy development. This includes 5+ years of experience in outreach and engagement of multiple stakeholder groups while serving as the Secretary of Health in the Commonwealth of Pennsylvania, including facilitating the Pennsylvania State Health Improvement Plan and implementation of CMS State Innovation Model funding. His primary responsibility will be to engage key community stakeholders in creating the Community Stakeholder Advisory Council, among other duties.

6. Administer Annual Stakeholder Surveys: Annual Stakeholder Surveys are conduced which include questions around provider and WV DHHR satisfaction, ease of reaching a Kepro staff member, Kepro staff helpfulness and knowledge, timely processing of requests, effectiveness of web-based and in-person trainings provided, and overall satisfaction with our services. Results of these surveys are thoroughly addressed with WV DHHR and incorporated into our team's training efforts to ensure subsequent improvement the following reporting period. A similar survey process is performed with current state contracts in West Virginia, Colorado, Florida, Virginia, and South Carolina and has found it to be vital for quality improvement. In West Virginia, we received recent provider Satisfaction scores of 92% and 90%.

Appeals and Fair Hearing Participation

We have provided appeals and fair hearings support across several of our clients for more than three decades. Our current appeals management policies and processes can be customized to address any necessary support of the appeals process for WV DHHR's needs. This support includes research, administrative support, written statements, and documentation, as well as providing Our experienced appeals staff and subject matter experts for testimony where appropriate to defend WV DHHR decisions.

Our deep knowledge in this arena has taught us how important it is for all providers and residents to know their rights to an appeal, evidentiary hearing, and fair hearing and for the process to serve them. To ensure we prioritize our clients, we adapt our Fair Hearing process to accommodate client-specific requirements ensuring determinations comply with due process and support WV DHHR needs. We will provide our experienced staff and subject-matter experts for testimony when asked to support the WV DHHR Fair Hearing process and provide the documentation necessary to defend decisions. We will also provide staff to represent the State through written and personal testimony as well as research and documentation in UM/PA appeal matters, grievances, and court cases. Licensed Behavioral Health Services Utilization Management Technical Requirement

This section describes the requirements for the development, implementation, and operation of a UM program for behavioral health services including but not limited to:

a. Inpatient Psychiatric Services
b. Targeted Case Management
c. Licensed Behavioral Health Center Services
d. Behavioral Health Outpatient Services
e. Psychiatric Residential Treatment Facility Services
f. Inpatient Psychiatric Services for Individuals under 21 years of age
g. Behavioral Health Services Criteria Development

The Methodology section of the Technical Proposal must provide information on the Vendor's experience that clearly demonstrates how the Vendor will meet stated requirements and describe in detail the Vendor's experience administering similar UM programs for behavioral health services for commercial and/or government health care programs.

The Vendor must have certification as a Utilization Review Resource for the State of West Virginia.

We have extensive experience providing utilization management functions for the West Virginia behavioral health services identified in the RFP. While each service is discussed in detail below, it

is necessary to identify the common approach that we use to support compliance with state and federal medical necessity requirements. As the BMS is aware, we are currently transitioning to a new UM system. Details below apply to both applications; however, our Atrezzo application has additional benefits for the provider to further improve submission efficiencies.

Since our initial contract award in 2000, we have tailored development of our system to meet the needs of the State of West Virginia. Existing behavioral health providers utilize electronic modes of submission (such as web-based and file layouts) which present several benefits for providers:

- Access to the system 24 hours a day, 365 per year (except for periodic system maintenance).
- A reduction of data entry errors.
- Ability to copy basic case information such as demographics for concurrent reviews to reduce time and maintain data quality.

This data driven, web-based application accommodates a variety of WV Medicaid behavioral health providers by providing a submission mechanism for prior authorization requests that relies on business and clinical rules, a means of eligibility determination for a date of service, and as a utilization management tool. With migration of the behavioral health program, the ability to view integrated member information across WV programs (e.g., behavioral health, medical services) becomes more robust.

Did You Know?

Kepro has provided close to 600 behavioral health trainings since 2015 for an average of approximately 5,000 participants annually. Training topics are dependent on provider need and have included Service Planning, Assessment Services, Crisis Stabilization Services, and Peer Recovery Support Services.

All behavioral health providers currently submit requests via the electronic portal or by EDI file interchange, as previously directed by the Bureau. We propose to continue this requirement to maintain submission efficiency and data consistency. providers who have a large volume of requests (e.g., Comprehensive Behavioral Health providers) elect to submit through electronic data interface (EDI). This submission method allows providers to gather information in-house and extract one or more files to us each day rather than direct data entry of each request into the website. A number of our current behavioral health providers with higher volumes of requests use this feature, which eliminates the need for manual data entry and streamlines their work processes.

Requests are subject to eligibility determination to ensure only eligible fee-for-service members can attain an authorization under the WV Medicaid, or Bureau of Social Service systems. providers are notified in the event eligibility is not present for a member along with any other funding sources available. An automatic authorization may occur for an eligible member depending on the service requested and the case disposition and the authorization history.

We have extensive experience providing utilization management functions for the West Virginia behavioral health services identified in the RFP. While each service is discussed in detail below, it is necessary to identify the common approach that we use to support compliance with state and

federal medical necessity requirements. As the BMS is aware, Kepro is currently in the process of transitioning to a new UM system. Details below apply to both applications; however, our Atrezzo application has additional benefits for the provider to further improve submission efficiencies.

Since our initial contract award in 2000, we have tailored the development of the Atrezzo Care Management system to meet the needs of the State of West Virginia. Existing behavioral health providers utilize electronic modes of submission (such as web-based and file layouts) which present several benefits for providers:

- Access to the system 24 hours a day, 365 per year (except for periodic system maintenance)
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Did You Know?

Today we provide Medicaid Behavioral Health program services across 17 states including: Arkansas, California, Colorado, Florida, Illinois, Maine, Minnesota, Mississippi, Nebraska, New Hampshire, North Carolina, North Dakota, Oregon, South Carolina, Tennessee, and West Virginia.

All behavioral health providers currently submit requests via the electronic portal or by EDI file interchange, as previously directed by the Bureau. We propose to continue this requirement to maintain submission efficiency and data consistency. providers who have a large volume of requests (e.g., Comprehensive Behavioral Health providers) elect to submit through electronic data interface (EDI). This submission method allows providers to gather information in-house and extract one or more files to Kepro each day rather than direct data entry of each request into the website. Several our current behavioral health providers with higher volumes of requests utilize this feature, which eliminates the need for manual data entry and streamlines their work processes.

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Prior authorization and eligibility review will occur within 48 hours of the request, in accordance with current federal and state policy guidelines, as directed by BMS. Acute inpatient services for adults and adolescents are reviewed within 24 hours, also in accordance with current federal and

state policy guidelines, as approved by BMS. From this point we may place the request in one of two statuses: authorize the request and place it in "pend – additional information" status to wait for documentation from the provider or place it in "rejected – insufficient information" if no additional documentation was received, or an incorrect service was requested. Requests that do not automatically authorize are placed in a "pend" status for further clinical review by a qualified behavioral health professional. From this point, we may authorize the request, place it in pend – additional information status waiting for documentation from the provider, place it in "rejected – insufficient information" due to an incorrect service requested or other factor, or place it in "denied" status following completion of the physician review process or when an administrative policy denial is issued. WV licensed psychiatrists perform both levels of physician reviews to ensure medical necessity requirements are achieved. Kepro electronically transmits final case dispositions to the provider and claims payor in the prescribed format.

A1.2. Licensed Behavioral Health Services Utilization Management Technical Requirement

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The Vendor must have certification as a Utilization Review Resource for the State of West Virginia.

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A1.2.a. Inpatient Psychiatric Services

1. The Agency covers inpatient psychiatric services for all eligible members as a condition for reimbursement, the Agency requires that all inpatient hospital admissions receive prior authorization.

We have issued prior authorizations for Inpatient Psychiatric services for WV Medicaid members since July 1, 2010. This includes acute inpatient psychiatric hospitalization for adults and for members under the age of 21. In 2022, we conducted over 1,900 inpatient psychiatric service reviews for WV Medicaid fee-for-service members.

Did You Know?

Our behavioral health experience dates back 21 years with our West Virginia Medicaid contract offering behavioral health services including medical necessity reviews, level of care assessments, care coordination, case management, and BH provider oversight and training.

Providers use the web-based, rules driven system for prior authorization requests and submit supporting documentation to demonstrate medical necessity. Documentation requested for clinical review must be received from the provider within three business days from notification to achieve timely determinations. Requests that do not meet medical necessity upon review from our RN's are submitted for physician review.

Our system notifies the provider at the time of submission whether WV Medicaid eligibility is present for a date of service. In the event eligibility cannot initially be determined by the application, the request is reviewed by our Eligibility Specialists to ensure the accuracy of the eligibility determination. When eligibility is not found for the member, we will notify the provider of the absence of funding by Medicaid or any other funding source.

Request may be identified as urgent/emergent or non-emergent, voluntary or involuntary, depending on the individual member's clinical presentation. Those identified as urgent/emergent are indicated within the system for prompt clinical review. Each authorization request, whether a new admission, continued stay or retrospective admission request, is reviewed according to Bureau approved medical necessity criteria and/or national criteria (e.g., InterQual). Non-emergency admission requests submitted prior to a planned date of admission will be reviewed; however, we anticipate the volume to be low based upon criteria to qualify for inpatient acute services.

providers receive authorization notifications, which contain the authorization number, beginning date of service, number of days authorized, and the end date of the authorization. providers are encouraged to submit for continued stay prior to the end date of the existing authorization to minimize the possibility of non-authorized days. We will provide a daily listing to notify the hospitals 48 hours in advance of the end date of any existing inpatient psychiatric authorization. Continued stay requests will be clinically reviewed on the date of receipt resulting in an authorization or provider notification when further clinical documentation is needed. Continued stay authorization request for those members who have been discharged will be reviewed within 24 hours.

Requests for weekend and holiday admissions, in addition to retrospective requests, will receive eligibility verification and clinical review by the date of receipt. Requests for inpatient psychiatric services for members under age 21 must be accompanied by the MCM-1 form, which certifies this level of care is the most appropriate; this WV form is utilized to meet the independent evaluation requirement in 42 CFR.

A1.2.b. Targeted Case Management

1. The Agency covers mental health services when providing Targeted Case Management for all eligible members. For additional information on coverage, see Administrative Code. As a condition for reimbursement, the Agency requires that all Targeted Case Management services receive prior authorization. Specific procedures requiring prior authorization should be in accordance with current policies.

In 2022, we conducted just under 1,500 targeted case management service reviews for West Virginia Medicaid fee-for-service members. We will prior authorize targeted case management services for WV Medicaid fee-for-service eligible members and have done so for the last 22 years. Service requests will be clinically reviewed according to WV approved criteria and policies. We have an extensive history with the WV Medicaid providers. This background includes reviewing plans of care and documentation notes for case management, providing training, and conducting individual documentation reviews to promote accurate service provisions.

We will continue to adhere to WV approved criteria and policies. All authorization requests, regardless of a new admission, continued stay, or retrospective status, will be reviewed to ensure criteria are met.

We recognize the requirement that a member have only one provider of TCM at a time unless approved by the Bureau. We will identify and resolve instances of more than one provider providing targeted case management services. The selected provider will receive authorization to provide TCM services after all eligibility and medical necessity criteria have been met.

A1.2.c. Licensed Behavioral Health Center Services

1. The Agency covers mental health services when provided by one of the fifteen (15) regional community mental health centers or a licensed behavioral health center located around the state, by the community services division of a state hospital or other certified community mental health center for all eligible members. For additional information on coverage, see Administrative Code. As a condition for reimbursement, the Agency requires that certain mental health services receive prior authorization. Specific services requiring prior authorization are identified in the Agency's provider manuals.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, plans of care, and other forms or documentation required for prior authorization and eligibility review of community mental health center services.
3. The Vendor shall have the capability and established procedures for determining the medical necessity of community mental health center services to eligible members utilizing the Agency approved criteria and policies.
a. Authorization Reviews: The Vendor shall have the capability and established procedures to ensure the number of mental health services reasonably required to treat the member's condition. Procedures must include information regarding specific discharge plans and a plan to monitor progress. The Vendor shall ensure

authorization of services provided by community mental health centers are completed in accordance with current policies.
b. Continued Stay Reviews: The Vendor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed in accordance with current policies.
c. Crisis Residential Reviews: The Vendor shall have the capability and established procedures to ensure determinations for crisis residential reviews are completed in accordance with current policies.
d. Retrospective Reviews: The prior authorization of the services included in the code list will be in lieu of any retrospective review, except in the case of retroactive eligibility.

We have a tenured and successful relationship with the WV Licensed Behavioral Health Centers, which began in late 2000. In our long-term partnership, we have collaborated with the State to develop and implement defined and documented procedures that support all required reviews. We are happy to continue following all approved procedures, prior authorizing required services for fee-for-service members and adhering to policies detailed in WV Medicaid Chapter 503. We will also continue to accept retrospective service requests due to retroactive Medicaid eligibility.

Providers submit documents to convey clinical and demographic information on the WV Medicaid funded member. Submissions from this provider group currently occur through the web-based Provider Portal or via Electronic Data Interchange (EDI). Several years ago, the Bureau for Medical Services mandated submissions for this group occur through the above formats. Eligibility review occurs through this module and the system conveys the results to the provider. The level of data required for submission is dependent on the service selected and whether the service has previously been authorized. Supporting clinical documentation will be requested and reviewed to determine medical necessity for the service in question. providers will supply clinical information including, but not limited to, current clinical presentation, progress status of the member, and potential discharge plans and timeline. Clinical review, for both initial and continued stay requests, will be based on WV Medicaid policy, evidenced based criteria (e.g., InterQual and ASAM), and local policies established in conjunction with BMS.

We are familiar with Crisis Residential Services for WV Medicaid fee-for-service members. We will continue to apply policies and criteria to support medical necessity determinations.

A1.2.d. Behavioral Health Outpatient Services

1. The Agency covers psychological services when done by licensed psychologist, licensed professional counsellor, and/or licensed independent clinical social worker located around the state. As a condition for reimbursement, the Agency requires that certain services receive prior authorization. Specific services requiring prior authorization are identified in the Agency's provider manuals.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, plans of care, and other forms or documentation required for prior authorization and eligibility review of services.
3. The Vendor shall have the capability and established procedures for determining the medical necessity of services to eligible members utilizing the Agency approved criteria and policies.
a. Authorization Reviews: The Vendor shall have the capability and established procedures to ensure the number of services reasonably required to treat the member's condition. Procedures must include information regarding specific discharge plans and a plan to monitor progress. The Vendor shall ensure authorizations of services provided by are completed in accordance with current policies.

b. Retrospective Reviews: The prior authorization of the services included in the code list will be in lieu of any retrospective review, except in the case of retroactive eligibility.
c. Investigations: An investigation must take place within five (5) business days at the request of the Agency when clinical issues/concerns are reported to the bureau. The report on the investigation is due within fourteen (14) calendar days from the date of the exit.

In 2022, we conducted just under 23,000 behavioral health outpatient service reviews for West Virginia Medicaid fee-for-service members. We perform prior authorization review and eligibility determination for WV Medicaid fee-for-service members seeking services detailed in Chapter 521. Services identified in the WV Medicaid psychological manual as requiring prior authorization are submitted using the Kepro application. provider types included in WV Medicaid Chapter 521 are: Physicians and their Extenders; Licensed and Supervised Psychologists; Social Workers holding credentials of LICSW, LCSW, and LGSW; and Licensed Professional Counselors.

We will review all requests, along with supporting documentation from the provider, plans of care and any other documentation the provider believes demonstrated medical necessity for the requested service. All provider types above are accustomed to submitting requests via our electronic submission portal, as approved by BMS. We will continue to receive requests in the existing approved format. We will perform retrospective submission reviews related to retroactive Medicaid eligibility.

Did You Know?

In 2022, we conducted just under 17,300 licensed behavioral health center service reviews for West Virginia Medicaid fee-for-service members.

Medical necessity determination occurs through review of clinical information and application of evidenced based criteria (e.g., InterQual or ASAM) and WV local guidelines or policies. We will review criteria sets with BMS for respective services for approval. The level of data required for submission is dependent on the service selected and whether the service has previously been authorized. providers will supply clinical information including, but not limited to, current clinical presentation, progress status of the member, and potential discharge plans and timeline.

Continued stay review considers all the above components. Each item is reviewed for changes or modifications in the clinical presentation, either demonstrating progress or a lack thereof, and whether services alone or in combination are sufficient to meet the assessed needs of the member.

We understand that BMS may become aware of concerning issues pertaining to behavioral health outpatient providers. At the request of BMS, we will begin an investigation within five business days for the purpose of gathering information from all parties. A summary report will be provided to BMS within 14 calendar days from completion of the investigation.

A1.2.e. Psychiatric Residential Treatment Facility Services

1. The Agency covers psychiatric residential treatment facility (PRTF) services for members under age twenty-one (21) when the child does not require emergency or acute psychiatric care but does require supervision and treatment on a twenty-four (24) hour basis. As a condition for reimbursement, the Agency requires that PRTF services receive prior authorization.

2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, independent evaluations/pre-discharge recommendation, and other forms or documentation required for prior authorization and eligibility review of PRTF services.
3. The Vendor shall determine the medical necessity of preadmission, continued stay, and retrospective reviews for PRTF services to eligible members utilizing the Agency approved criteria and policies.
a. Preadmission Reviews: The Vendor shall have the capability and established procedures to ensure determinations for preadmission reviews are completed in accordance with current policies.
b. Continued Stay Reviews: The Vendor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed in accordance with current policies.
c. Retrospective Reviews: The Vendor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed in accordance with current policies.

We will continue to work with both in-state and out-of-state Psychiatric Residential Treatment Facilities (PRTF) to promote the most appropriate level of care. In 2022, we conducted over 50 PRTF service reviews for West Virginia Medicaid fee-for-service members, applying BMS-approved, evidence-based criteria (e.g., InterQual and ASAM) and policies to ensure member needs are met.

WV Medicaid Chapter 531 indicates the PRTF service consists of members who are under the age of 21 with a severe and persistent behavioral health condition. Emergent admissions are not appropriate for a PRTF; in that case, a higher level of care should be pursued. Children appropriate for admission must have previous treatment exposure and failure at a less restrictive Level of care. Initial requests must be accompanied by the MCM-1 form, which certifies the level of care is the most appropriate. This form is utilized to meet the independent evaluation requirement in 42 CFR.

We will review clinical documentation submitted by any mode of receipt for eligible Medicaid fee-for-service members. Since 2010, providers have submitted electronically through the Provider Portal. Doing so allows a shorter timeline from receiving an authorization to clinical review and responses shared with providers. Requests reviewed will include clinical information and any subsequent documentation submitted by the provider. Authorization is based upon the diagnostic condition, symptom acuity, level of functioning and progress to date and/or the likelihood of progress occurring.

Our staff member will serve as the Bureau for Medical Services representative to perform multi-agency certification reviews along with the Bureau for Children and Families and the West Virginia Department of Education. We also provide information to the Bureau regarding members involved in the clinical review team process with the Bureau for Social Services.

Requests are reviewed for medical necessity by registered nurses. Authorizations are not issued without determining eligibility, medical necessity and an appropriate MCM-1 document. Submissions can occur for preadmission reviews, continued stay reviews and retrospective reviews.

We will complete on site reviews of all providers receiving an authorization for PRTF services at least one time in an 18-month cycle. A 10% sample will be utilized for each review or a minimum of three charts- whichever is greater. The retrospective reports consisting of a policy review,

clinical review, and areas that need to be improved to meet WV's standards will be provided to BSS and BMS within 30 business days of the exit conference.

A1.2.f. Inpatient Psychiatric Services for Individuals under 21 years of age

1. Vendor is to Review admission referrals from professional medical practitioners, and make a determination based on the referral information treatment plan, and in light of nationally accredited, researched based, criteria; that the services required by the member can only be provided in an inpatient setting. This requires certifying medical necessity for initial admission and designating an initial length of stay and performing periodic re-certifications for continued stay until the member has either aged out of the rehabilitation service or reached maximum rehabilitation potential. The Vendor will serve as the Bureau for Medical Services agent in preforming multi-Agency certification reviews along with the Bureau for Social Services and the West Virginia Department of Education. As a condition for reimbursement, the Agency requires that PRTF services receive prior authorization.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, independent evaluations/pre-discharge recommendation, and other forms or documentation required for prior authorization and eligibility review of inpatient rehabilitation services for individuals under 21 years of age.

We will continue to review information from providers to determine the appropriateness of admission for WV Medicaid members under the age of 21. Nationally accredited, research based, and BMS-approved criteria will be utilized when evaluating appropriateness this level of care at the time of admission and continued stay. For this program, we conducted over 300 Inpatient Psychiatric Service reviews for WV Medicaid fee-for-service individuals under 21 years of age.

Admission referrals, the proposed treatment plan, and a review of supporting clinical documentation supplied by the provider (e.g., independent evaluations or pre-discharge recommendations) will be reviewed to make a determination. All requests must be accompanied by the MCM-1 form, which certifies this level of care is the most appropriate; this WV form is utilized to meet the independent evaluation requirement in 42 CFR.

Authorization requests are reviewed for those members with established WV Medicaid fee-for-service eligibility at the time of service. The Atrezzo system notifies the provider at the time of submission whether WV Medicaid eligibility is present for a date of service. In the event we cannot initially determine eligibility by the application, the request is reviewed by our Eligibility Specialists. When we cannot find eligibility for the member, we notify the provider that Medicaid or other funding sources are absent.

Request may be identified as urgent/emergent or non-emergent, voluntary, or involuntary, depending on the individual member's clinical presentation. Those identified as urgent/emergent are indicated within the Atrezzo system for prompt review. Each authorization request, whether a new admission, continued stay or retrospective admission request, is reviewed according to Bureau approved medical necessity criteria and/or national criteria (e.g., InterQual). Non-emergency admission requests submitted prior to a planned date of admission will be reviewed; however, we anticipate the volume to be low based upon criteria to qualify for inpatient acute services.

Providers receive authorization notifications, which contain the authorization number, beginning date of service, number of days authorized, and the end date of the authorization. Authorization requests for this service are addressed by our registered nurses. Providers are encouraged to submit prior to the end date of the existing authorization to minimize the possibility of non-authorized days. Continued stay requests will be clinically reviewed on the date of receipt resulting in an authorization or provider notification when further clinical documentation is needed. Continued stay authorization requests for those members who have been discharged will be reviewed within 24 hours.

Requests for weekend and holiday admissions, in addition to retrospective requests, will receive eligibility verification and clinical review by the date of receipt. All requests must be accompanied by the MCM-1 form, which certifies this level of care is the most appropriate; this WV form is utilized to meet the independent evaluation requirement in 42 CFR.

Partial Hospitalization Services

We have provided prior authorizations for partial hospitalization services since July 2010. Medical necessity is determined based upon state and national criteria, as approved by the Bureau. Requests are submitted via the Provider Portal, which collects data regarding diagnosis, symptom acuity, and functional abilities associated with the behavioral health condition.

WV Medicaid eligibility is established prior to issuance of authorizations. We inform the provider of the eligibility status prior to submission of requests and identifies if any other payor source is available. Requests that pend for eligibility and clinical review will be addressed, yielding either an authorization, closure, or review status to await further documentation.

Federally Qualified Health Centers and Rural Health Clinics

We began working with these providers in October 2013 at the request of the Bureau for Medical Services. Our system application reports total authorized encounters along with the specific behavioral health service eligible for use during those encounters. Eligibility is determined prior auth the issuance of any authorizations. These two provider types received training on medical necessity determination and use of the electronic Atrezzo module.

We continue to perform timely medical necessity reviews and utilization management services. Auto adjudication is possible for these services so long as no other authorization exists by any provider. Requests that pend for eligibility and clinical review will be addressed, yielding either an authorization, closure, or review status to await further documentation. As with other review areas detailed in this section, retrospective review submissions are allowable in accordance with WV Medicaid policy.

Recognizing this provider type is not specifically included in this RFP, we welcome the opportunity to discuss inclusion of these providers per BMS direction.

A1.2.g. Behavioral Health Services Criteria Development

1. In performing medical necessity determinations, the Vendor shall use nationally accredited, researched based, criteria in reviewing each prior authorization and eligibility review request. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all behavioral health services reviewed under the resulting contract.
a. The Vendor shall maintain the capability to update the review criteria for behavioral health services reviewed under the resulting contract. The Vendor shall make recommendations to the Agency annually, regarding what, if any, changes should be made to the criteria that will be used for the following calendar year. The recommendations shall be included in the Vendor's annual report required in Appendix 3.
b. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria annually.
c. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State of West Virginia and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the resulting contract.
d. The Vendor is responsible for any cost associated with the purchase of any review criteria.
2. The Methodology section of the Technical Proposal must provide detailed information on the Vendor's process for determining medical necessity, including: 1) a description of the recommended review criteria for each service; 2) a description of the review instrument(s) for each service; and 3) a description of the Vendor's capability to develop an automated rules- driven certification system.
3. The Methodology section of the Technical Proposal must provide a detailed description of the Vendor's approach to designing, developing, and employing medical necessity criteria through a secure web-based prior authorization system.

We have demonstrated experience with outcomes and evidenced-based practices and has provided consultation to DHHR about areas of implementation of targeted best practices. We will continue this approach across the entire scope of work for the Bureau, ensuring the promotion of evidence-based practice through use of current, nationally recognized criteria, such as InterQual, ASAM, and Local Medical Policies. Current changes within the West Virginia Medicaid behavioral health system warrant the most effective and efficient service practices. We are familiar with West Virginia Medicaid policies and demonstrated their ability to research covered and non-covered services for potential modifications or service array inclusion. Our team looks forward to continued consultation in these areas to promote an effective and efficient service delivery system.

We will review criteria continually and make recommendations to the Bureau for any potential changes. Changes will not be implemented without the Bureau's approval. If there is no comparable national criterion that meet WV service definitions. We will obtain approval for criteria used for medical necessity determination. We will utilize criteria approved by BMS and be responsible for any incurred cost.

We will continue to utilize state and national criteria, where present, to determine medical necessity for services. Each service will be detailed in Utilization Management guidelines that provide admission, continued stay, and discharge criteria. Service exclusions and documentation requirements are also conveyed in these guidelines to assist providers in recognizing medical necessity criteria to be achieved.

A review of services and applicable review criteria varies across provider types. Services differ across Licensed Behavioral Health Centers and Behavioral Health Outpatient, resulting in use of both nationally recognized and local West Virginia-approved criteria. We have collaborated with BMS through our current work to ensure each service is reviewed according to WV Medicaid policy and direction of BMS. Details are provided below regarding review criteria and applicable assessment instruments. We can access or gain Information on new and emerging criteria or areas of BMS Interest.

A1.3. Dental and Oral Health Services UM Technical Requirements (Medicaid)

This section describes the requirements for the development, implementation, and operation of a UM program for dental services to include:

a. Dental Services
b. Oral and Maxillofacial Surgery Services
c. Orthodontia Services
d. Dental Services Criteria Development

The Methodology section of the Technical Proposal must provide information on the Vendor's experience which clearly demonstrates how the Vendor will meet stated requirements and describe in detail the Vendor's experience administering similar UM programs for dental services for commercial and/or government health care programs. Children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontics, prosthodontics, maxillofacial prosthetics, oral and maxillofacial services, and orthodontics. Orthodontia services, covered for children up to 21 years, must be medically necessary, and require prior authorization before the service is provided. Orthognathic surgical procedures associated with orthodontic treatment shall be covered even if the member exceeds 21 years of age AND the needed surgery is documented in the original orthodontic request. Covered dental services for enrolled adults 21 years of age and older are divided into two levels of service: 1) emergent procedures to treat fractures, reduce pain, or eliminate infection and 2) diagnostic, preventative, and restorative services. Prior authorization may be required for specific emergent services and when service limits are exceeded. Services classified as diagnostic, preventative, and restorative in nature will require authorization prior to services being rendered and have a coverage limit of $1,000 per member per calendar year. Members are responsible for payment of service cost exceeding the $1,000 yearly limit. Remaining balances at the end of the year CANNOT be carried over to the following year. Services classified as cosmetic in nature are not covered for adults over the age of 21.

We have performed prior authorization of dental and orthodontal services for 11 years in West Virginia, and for nearly 10 years in Minnesota and Florida with established UM processes that benefit our clients and their members. In 2021, we conducted a total of nearly 30,000 reviews serving over 9,000 unique members.

In West Virginia, our accomplishments in prior authorization for adult dental services speak for themselves:

- ✓ **$891,946** Total amount paid for specified codes for 2022
- ✓ **$2,524,711** Total amount paid for specified codes for 2021
- ✓ **$3, 416,658** Total paid for expanded adult dental services since January 2021

- ✓ **1,450** unique members with claims served during the current year
- ✓ **241** unique providers with claims served during the current year

Our long-term experience with dental services fits well into WV's historical work with BMS.

In our time providing these services we have resolved thousands of member and provider claims and ensure that state funds are appropriately managed and utilized.

Our experience with the state has underscored the importance of monitoring and tracking services as well as benefit limits. As such, every Adult Dental prior authorization request is followed with our Case Management system. Enrolling these members in case management assists both the member and provider in managing the $1,000 benefit plan, as well as any other services the individual may receive.

A1.3.a. Dental Services

1. Children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontic, and prosthodontics services. When covered services are required and initiated before the member's 21st birthday, the service shall be completed within the timeframe established
by the treatment plan. Covered dental services for enrolled adults 21 years of age and older are divided into two levels of service: 1) emergent procedures to treat fractures, reduce pain, or eliminate infection and 2) diagnostic, preventative, and restorative services. Services classified as diagnostic, preventative, and restorative in nature will require authorization prior to services being rendered and have a coverage limit of $1,000.00 per member per calendar year. The $1,000.00 cap shall be tracked by the Vendor and required coordination with the MCO's. The Agency requires prior authorization for the following benefits:
a. Specific dental procedures as determined by the Agency;
b. Manually priced procedures;
c. All services under the adult dental benefit $1,000.00 cap.
2. The Vendor shall develop, implement, and maintain a UM program, which includes prior authorization, retrospective review, and eligibility review of dental services requests. Retrospective authorization is available in the following circumstances:
a. A procedure/service denied by the member's primary payor providing all requirements for the primary payor have been followed, including appeal processes; or
b. Retroactive eligibility; or
c. Retrospective review is available for members in instances where it is in the dental practitioner's opinion that a procedure that requires prior authorization is medically necessary and per recommended dental practices delaying the procedure may subject the member to unnecessary or duplicative service if delivery of the service is delayed until prior authorization is granted. In these instances, a request for prior authorization must be made by the provider within ten (10) business days of the date the service is performed. If the procedure(s) does not meet medical necessity criteria upon review by the Utilization Management Vendor (UM) the prior authorization request will be denied, and the provider will not be reimbursed for the service by the Agency or the member. Prior authorization is also available for medical necessity review before the service is provided.
d. A request for retrospective authorization is submitted the next business day following an Emergent procedure/service occurring on weekends, holidays, or at times when the UM is unavailable.
3. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, and other forms or documentation required for prior authorization review of dental services.
4. The Vendor shall determine the medical necessity of the authorization utilizing the Agency approved criteria and policies for dental services to eligible members. The Vendor shall have the capability and established

procedures to ensure determinations for authorization reviews are completed in accordance with current policies. In rare cases, this could include retrospective reviews.

5. The Vendor shall return original radiographs and photographs submitted by providers through the prior authorization process to the submitting provider.

6. The Vendor shall establish and maintain a procedure for the dental provider to contact the Vendor's Dental Director to discuss dental cases that have been denied or modified.

In 2022, we conducted a total of just under 17,000 dental service reviews for West Virginia. Currently prior authorization is required for dental services specified by the Agency in BMS Medicaid Policy Manual Chapter 505. Services requiring PA include, but are not limited to prefabricated crowns, root canals, and other dental surgeries performed in the office setting. As required, a lead dental consultant will be appointed to evaluate training needs, assist with criteria development, and assist other dental consultants. Our prior authorization process for Adult Dental services is outlined in **Figure 63 Prior Authorization of Adult Dental Services**.

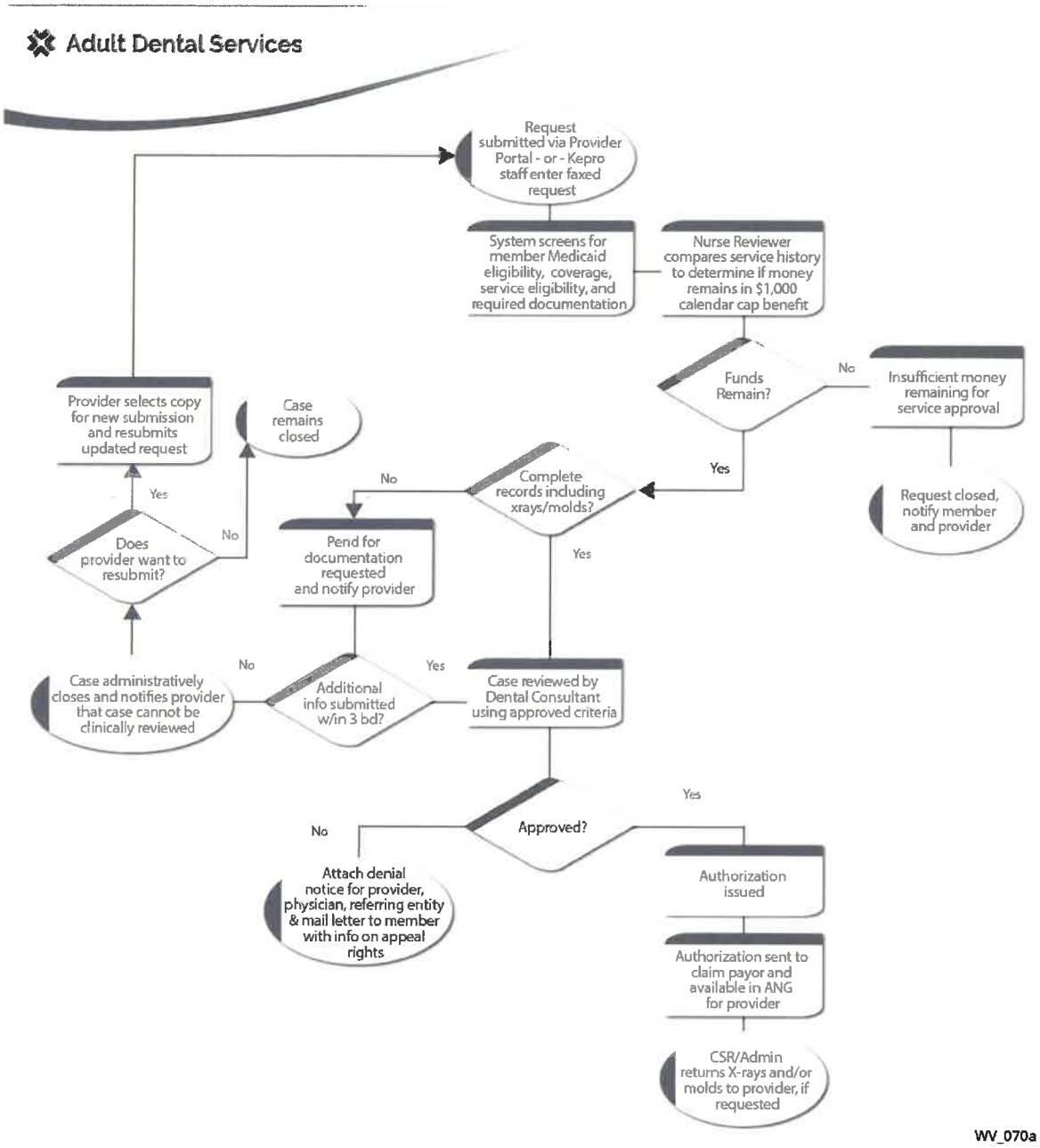


Figure 63. Prior Authorization of Adult Dental Services

Kepro's excellent performance stems from our strong connection with clients and members.

The prior authorization process begins upon receipt of the prior authorization request for Adult Dental services submitted through the Provider Portal or staff-entered fax requests. Once entered into the system the request is reviewed automatically and in real-time via Atrezzo, which verifies member eligibility for the requested services and reviews clinical information for service-specific criteria. If the request for services meets medical necessity and funds remain from the benefit amount allotted, the clinical reviewer evaluates the records to ensure that documentation is complete. If no funds are available, the request is closed and Kepro notifies the member and provider.

> "Kepro Dental Reviewers continue to be my best resources when working through any dental issues with either clients or providers. Thanks everyone... especially "OUR" great partners at Kepro!"
>
> ***Hank Jensen, Customer Care Specialist HIV Benefits & Eligibility Unit – Disability Services Division***

If funds are available, a Dental Consultant will review the case and, if criteria are met, approve the authorization. Once authorization is issued it is sent to the claim payor and is made available in the Atrezzo for the provider. At the end of the authorization process, X-rays, and molds, if applicable, are sent to the provider by request. For all adverse determinations, the member receives a denial notice via USPS with information on their appeal rights.

If clinical information is not sufficient, the clinical reviewer pends the request and notification is sent to the provider via the Provider Portal requesting additional clinical information. If the additional information received meets criteria, the request for authorization is approved. If additional information is not received, the request is administratively closed, and we will notify the provider that the case cannot be clinically reviewed. In cases where additional information does not meet criteria, the process follows the same denial procedure as above.

A1.3.b. Oral and Maxillofacial Dental Surgery Services

1. The Agency covers dental care that is an adjunct to treatment of an acute medical or surgical condition, services of oral surgeons and dentists in connection with surgery related to the jaw or any structure contiguous to the jaw or the reduction of any fracture of the jaw or any facial bone, and related emergency dental extractions and treatment.
As a condition for reimbursement, the Agency requires prior authorization for specific procedures shall be in accordance with current policies.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, and other forms or documentation required for prior authorization review of dental surgery services.
3. The Vendor shall return original dental molds/models, radiographs and photographs submitted by providers through the prior authorization process to the submitting provider.
4. The Vendor shall determine the medical necessity of the authorization utilizing the Agency approved criteria and policies for dental surgery services to eligible members. The Vendor shall have the capability and established procedures to ensure determinations for authorization reviews are completed in accordance with current policies. In rare cases, this could include retrospective reviews.

Our experience providing Oral and Maxillofacial Dental Surgery Services is extensive and we will perform all activities necessary to meet the prior authorization requirements of this section. In 2022 we conducted 527 reviews of these services, which may be provided in the office setting or in an outpatient surgical setting. When provided in the office setting the appropriate Current Dental Terminology (CDT) code is authorized. For procedures provided in outpatient surgery settings, the equivalent Current Procedural Terminology (CPT) is used.

The process for oral and maxillofacial dental surgery services review, outlined in Chapter 505 of the BMS Manual, will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.** This process corresponds to the workflow for any outpatient surgery and appropriate medical justification and documentation must be provided to support the surgical request.

A1.3.c. Orthodontia Services

1. The Agency covers orthodontia-related services for children up to 21 years, which are medically necessary. Orthodontia-related services are only covered for EPSDT eligible members who meet pre-qualifying criteria. As a condition for reimbursement, the Agency requires prior authorization be in accordance with current policies.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, and other forms or documentation required for prior authorization review of orthodontia services.
3. The Vendor shall return original dental molds/models, radiographs and photographs submitted by providers through the prior authorization process to the submitting provider.
4. The Vendor shall determine the medical necessity of the authorization and retrospective reviews utilizing the Agency approved criteria and policies for orthodontia services to eligible members. The Vendor shall have the capability and established procedures to ensure determinations for authorization reviews are completed shall in accordance with current policies.

We will perform all prior authorization reviews as required for Orthodontia Services and will meet all requirements of this section. In 2022, we conducted nearly 400 orthodontia service reviews for West Virginia Medicaid fee-for-service members. Currently prior authorization is -required for all orthodontia services to ensure the member meets the required eligibility criteria, including eligibility for EPSDT. Orthodontia services, covered for children up to 21 years, must be medically necessary, and require prior authorization before the service is provided. BMS reimburses one treatment of comprehensive orthodontia (CDT Codes D8070, D8080, and D8090) per lifetime per member. If any of the comprehensive orthodontia codes are billed, then none of the remaining can be billed; they are a one per lifetime limit for any of the three and are not looked at as per code lifetime limit.

Orthognathic surgical procedures associated with orthodontic treatment shall be covered even if the member exceeds 21 years of age and the needed surgery is documented in the original orthodontic request. Requests for prior authorization of orthodontia services must include:

- Patient's name, address, Medicaid number and date of birth
- Provider name, address, provider number, fax, and phone numbers

- Ordering physician's name and phone number
- Date patient examined
- Complete diagnosis
- Current treatment status
- Recommendations for comprehensive orthodontic treatment
- Comprehensive orthodontic treatment procedure code
- Post-treatment stabilization procedure code
- Total fee (usual and customary charge)
- Orthodontist signature and date
- Additional information required for assessing handicapping malocclusion
- Dental molds and/or x-rays as appropriate

Currently we use Chapter 505, BMS Approved Policy, and Dental Consultant Review for medical necessity review of requests. Orthodontia services review will take place within Atrezzo using the utilization review process outlined in **Figure 25 Prior Authorization Review Process located in Section A1.1.a Inpatient/Medical Surgical Services.**

A1.3.d. Dental Services Criteria Development

1. In performing medical necessity determinations, the Vendor shall use nationally accredited, researched based, clinical criteria in reviewing each prior authorization and eligibility review request. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all dental services reviewed under the resulting contract.
2. The Vendor shall maintain the capability to update the review criteria for dental services reviewed under the resulting contract. The Vendor shall make recommendations to the Agency six (6) months after implementation and annually thereafter, regarding what, if any, changes should be made to the criteria that will be used for the following calendar year. The recommendations shall be included in the Vendor's annual report required in Appendix 3.
3. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria annually.
4. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State of West Virginia and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the resulting contract.
5. The Vendor is responsible for any cost associated with the purchase of any review criteria.
6. The Methodology section of the Technical Proposal must provide detailed information on the Vendor's process for determining medical necessity, including:
   a. Description of the recommended review criteria for each service;
   b. Description of the review instrument(s} for each service;
   c. Description of the Vendor's capability to develop an automated rules-driven certification system, if any.
7. The Vendor shall work with the Agency to develop a clinically sound, evidence-based, medical necessity criteria for all dental services prior to implementing the UM program.
8. The Methodology section of the Technical Proposal must provide a detailed description of the Vendor's approach to medical necessity criteria for dental services that consider the following sources in the development and revision of dental policies: 1} current published medical literature from peer-reviewed publications; 2} evidence-based policies developed by national organizations and recognized authorities; and 3} generally accepted standards of dental practice.

In the next contract cycle, the Bureau for Medical Services has requested the development of more robust Dental Services criteria. We will use its WV Dental and Orthodontic Consultants and consultation with practitioners within West Virginia to develop and recommend revised West Virginia Dental criteria that is based on review of:

- Current published medical necessity criteria for dental service that is peer-reviewed
- Evidence-based guidelines or criteria developed by national organizations and recognized dental authorities
- Compliance with the requirements of the State Plan, the current dental policy manual, Chapter 505, and other federal and state guidelines

We will submit the criteria for BMS approval and will implement the criteria once it is approved by BMS; we understand that we are responsible for the cost of new review criteria. Upon criteria approval, we will conduct technical assistance webinars to educate providers on the selected criteria set and its' application. We review dental criteria annually in collaboration with our Dental Consultant and BMS for their approval. BMS has incorporated Kepro criteria into reviews conducted by Managed Care Organizations, underscoring the value we bring in establishing and implementing review criteria.

A1.4. Bureau for Medical Services-Optional Services (Medicaid)

This section details optional services.
a. Clinical/Medical Consulting Services
b. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID} Eligibility
c. Aged and Disabled Waiver (ADW} Functions
d. Personal Care Functions
e. Ambulance Transportation
f. Online Case Management System with integrated Incident Reporting/Management (IMS) for Home and Community-Based Services (HCBS)

A1.4.a. Clinical/Medical Consulting Services

1. The Vendor shall have the capacity and established procedures for clinical/medical consultation at an established hourly rate through the Vendor's Medical Director or Dental Director, as appropriate, to assist the Agency in addressing medical necessity issues, researching new technology, developing medical policies, addressing quality issues, etc.
2. At the request of the Agency, the Vendor may also provide clinical/medical consultation for various types of healthcare practitioner participating in the Agency program. Healthcare practitioner types may include, but are not limited to, medical doctors, doctors of osteopathy, podiatrists, chiropractors, nurse practitioners, certified registered nurse anesthetists, nurse midwives, dentists, therapists, optometrists, and mental health practitioners. All consults conducted by the Vendor shall be performed by a consultant of the same provider type and/or specialty.
3. The Vendor shall have a written program which outlines the program structure and accountability and includes, at a minimum, procedures, and process for clinical/medical consultations through the Medical Director or Dental Director, as appropriate, and consultant advisors of the same provider type and/or specialty or as directed

by the Agency and mechanisms providing the Agency with consultant review summaries in accordance with current policies.

4. The Agency may assess penalties in the amount of up to $500.00 per fifteen (15) calendar day period each report, data or other material is late, unavailable, or unacceptable as specified in Appendix 4 of this RFP.

We will provide clinical/medical consultation services to the Agency at an hourly rate by utilizing our local WV Medical Director, Dr. Paul Kuryla or, depending on the specialty, one of our expert Physician Consultants. We are well equipped today with specialty-matched practitioners who stand ready to provide consultation services as defined in the RFP. In addition to our local WV Medical Director and Physician Consultants, we maintain a national Physician Panel of over 4,500 contracted practitioners who are board-certified and actively practicing within their specialty domain. Our Physician Panel physician specialties include, but are not limited to, the following areas of practice:

- General, Family and/or Internal Medicine
- ENT
- General Surgeon
- Geneticist
- Nephrologist
- Neurologist
- Neurosurgeon
- Oncologist
- Orthopedist
- Urologist
- Pathologist
- Pediatrician
- Podiatrist
- Radiologist
- Thoracic Surgeon
- Cardiologist
- Obstetrics & Gynecology
- Chiropractor
- Ophthalmology
- Dentist
- Orthodontist
- Spinal Cord Injury Specialist

We also offer the Agency access to our local WV licensed allied professional staff for consultation as needed. These identified individuals are subject matter experts (SMEs) in their area of expertise with a wealth of WV Medicaid policy knowledge and knowledge across the various Home and Community Based Waiver programs, Children's Services (BSS and Medicaid programs), Behavioral Health Services, Health Homes, and other programs.

Our written program for the Agency will outline our Consultative Services program structure and accountability and will include, at a minimum, procedures, and process for clinical/medical consultations through the Medical Director or Dental Director, as appropriate, and consultant advisors of the same provider type and/or specialty or as directed by the Agency and mechanisms providing the Agency with consultant review summaries in accordance with current policies.

Our process for Consultation Service requests will begins with our clinical staff as the contact team for incoming requests. Upon receipt of all requests, our staff direct the Agency requestor to complete a Consultation Request form. Upon receipt of the written request, the steps below are then followed:

- A Consultation Request form is completed by the Agency, which outlines the type of consultation desired; the target audience for the consultation report; and the timeframe for completing the consultation.
- We develop a scope of work, which includes the delivery date for the consultation report, the format of the report and target audience, the scope of the consultation, and the consultant(s) or SME assigned to complete the report.
- The assigned consultant prepares a consulting plan which outlines how information is to be gathered (e.g., literature search, focus groups etc.) and the proposed number of hours to complete the consultation by the specified due date.
- The Agency approves the consultation plan/scope of work.
- Upon completion of the consultation, the report is delivered to the Agency.

A1.4.b. Intermediate Care Facility for Individuals with Intellectual Disabilities Eligibility

1. The Vendor is expected to receive approximately 517 ICF/IID re- certifications annually for services provided in ICF/IID Facilities throughout West Virginia.
2. The Vendor shall provide administrative operational functions necessary to support the medical eligibility process for the ICF/IID program.
3. The Vendor shall be able to demonstrate a guaranteed of ongoing quality assurance and improvement within the eligibility process for ICF/IID.
4. The Vendor shall demonstrate ability to provide at least one (1) WV licensed psychologist for determining eligibility for levels of care ICF/11D.
5. The Vendor shall demonstrate the ability to determine ICF/11D eligibility initially within ninety (90) calendar days of admission to an ICF/11D facility and annual redeterminations within thirty (30) calendar days of the anniversary date of initial eligibility.
6. The Vendor shall be able to demonstrate ability to conduct and document/onsite reviews of Inventory for Client and Agency Planning (ICAP) for accuracy in scores that are used to establish anchor dates with start and stop dates for eligibility whining the ICF/IID facilities.
7. The Vendor shall demonstrate the ability to provide the Agency fiscal claims agent with information required to generate prior authorizations for services which include, the ICAP level scores and start and stop dates for ICF/11D facility participants.
8. The Vendor shall demonstrate the ability to utilize evaluations (Medical, psychiatric, psychological, etc.) submitted by the applicant in order to determine the level of care for ICF/IID facilities.
9. The Vendor shall demonstrate the ability to perform on-site reviews of ICAP assessments per each facility on an annual basis.
10. The Vendor shall demonstrate the ability to visit 100% of all ICF/11D facilities in the first year of the contract and then 33% per additional contract year.
11. The Vendor shall demonstrate the ability to notify in writing, the individual/member or legal representative, local county DHHR office and provider within program timelines regarding the eligibility decisions and appeal rights for ICF/11D facilities.
12. The Vendor shall demonstrate ability to conduct all clerical and/or administrative functions associated with the determination of eligibility for ICF/11D facilities. Functions should include written notification of eligibility, tracking of applicants, requests for information regarding eligibility, tracking of eligibility decisions and tracking of fair hearing status.

We are excited to leverage our extensive resources and knowledge in the IDD Waiver services space to support WV DHHR's ICF/IID Eligibility program. Our experienced resources will be aided

by our knowledge and familiarity with West Virginia's IDD member population. As the current administrator, we have a 12-year partnership with the IDD Waiver services program, providing us unmatched experience and understanding of the program's requirements, needs and expectations.

We will also leverage the experience and best practices we have established while conducting ICF/IID services for our Florida client.

ICF Experience

We have conducted ICF work since 2018 for the Florida Agency for Persons with Disabilities. We provide on-site review and assessment for level of care and reimbursement for individuals with intellectual and developmental disabilities entering and residing in Intermediate Care Facilities, within Medicaid Handbook guidelines. Our work with the contract includes:

- **Utilization Reviews** – On-site and Chart reviews
- **Continued Stay Reviews** – On-site and Chart reviews
- **Initial Matrix Reviews** – On-site and Chart reviews
- **Rereview/Redetermination Matrix Reviews** – On-site and Chart reviews

Our team conducted over 5,500 reviews during the 2021-2022 fiscal year for those in intermediate care facilities. Reviews are conducted by trained professional healthcare staff, including a physician, who have experience with this population, and specially trained by Kepro in Florida's policies and procedures.

Success with Florida's ICF program is evidenced within our quarterly performance reporting. In the last three reported quarters for 2022, we achieved an average of 100% compliance across all Service Level Agreements required by the state agency.

IDD Waiver Expertise

We are already familiar with the ICF/IDD program in West Virginia, as the eligibility criteria are the same for the IDD Waiver program. We are familiar with all aspects of the IDD Waiver program, including:

- Tracking applications
- Performing administrative functions
- Administering the ICAP and communication with Fiscal Claims Agent
- Tracking fair hearings
- Conducting provider reviews

Based on our experience conducting provider reviews for the IDD Waiver program, we can conduct site and document reviews to ensure implementation and quality of services. Monitoring will include health and welfare, service plan, and personnel files reviews. Reviews for IDD Waivers are already conducted on-site for the WV DHHR program which would allow for medical and site safety

reviews; Kepro's clinical staff are experienced in such face-to-face reviews and are more than qualified to meet West Virginia's needs.

We are fully prepared to take on the additional work as requested by the Bureau related to the ICF/IDD program. We are confident that with our knowledge of ICF/IDD eligibility criteria, our experience performing ICF work in Florida, and our local and companywide IDD Waiver expertise, we will successfully administer the ICF/IDD scope of work.

Our experience also includes determining Waiver program Eligibility, Level of Care reviews, authorizing and monitoring Service plans, referring members and caregivers to appropriate services, providers and community resources, training, and technical assistance to IDD providers, and providing care coordination for individuals determined to be priority. In each of our programs, we work closely with the member, family, caregivers, providers, and other relevant stakeholders – with the goal of ensuring the member receives the services and supports to thrive in their home and community of choice.

Our team brings unmatched clinical and human service expertise and meaningful experience working with members with IDD, Autism, and Serious Mental Illness (SMI). This experience means we are particularly sensitive to the unique and varied needs of these individuals and assures WV DHHR that our highly qualified and trained Interviewers will assess members based on their person-centered support need. A sample of our relevant IDD and Assessment program experience and expertise is shown in **Table 19. Kepro IDD and Assessment Program Experience and Expertise**.

State	Scope of Services
Pennsylvania **Department of Human Services** **2018-Present**	We conduct Standardized Needs Assessment for the IDD Waiver population, performing 800 SIS-A assessments monthly using SISOnlineTM. We are responsible for multi-stakeholder assessment scheduling, conducting quality review of each assessment, coordinating with 1200 State support coordinators and case managers, and producing quality reports on a monthly, quarterly, and annual basis to the State.
West Virginia **Department of Health and Human Resources** **2004-Present**	We provide comprehensive management services for IDD Waiver members and the population including conducting Standardized Needs Assessments, statistical budget modeling, service plan authorization, quality assurance audits, and assistance with Quality Framework reporting. Although the program previously including use of the SIS assessment from 2004-2017, the State moved to using the ICAP for assessments. We complete nearly 6000 ICAP assessments annually.
Maryland **Department of Health** **2006-2014**	We conducted initial and annual in-person IDD assessments utilizing the SIS to support person-centered service pans. We were responsible for multi-stakeholder assessment scheduling,

State	Scope of Services
	conducting quality review of each assessment, coordinating State program coordinators, and producing quality reports on a monthly, quarterly, and annual basis to the State. We also conducted on-site audits of IDD providers for quality, compliance, and services provided to IDD members.
Pennsylvania **Southwest Pennsylvania Health Care Quality Unit** **2005-Present**	We provide training to IDD individuals, family members, and direct service providers to improve the physical and behavioral health care and safety of members with IDD and/or Autism. The scope includes needs assessment, development of training, scheduling and delivery of in-person and on-line training, as well as maintenance of a website with training archives.
Florida **Agency for Health Care Administration** **2016-Present**	We review Level I screenings, identifies Level II referrals, schedules assessments for IDD members, conducts in-person assessments, determines nursing facility Level of Care and/or need for specialized services, and produces data-driven quality reports on a monthly, quarterly, and annual basis to the State.
California **Department of Health Care Services** **2015-2018** **2020-Present**	We review Level I screenings; identifies Level II referrals; schedules assessments for IDD members, conducts in-person assessments, determines nursing facility Level of Care and/or need for specialized services, makes recommendations for Plans of Care, evaluate potential for community-based services, conducts 100% quality assurance reviews for Level II assessments, and produces data-driven quality reports on a monthly, quarterly, and annual basis to the State.
Oregon **Oregon Health Authority** **2010-present**	We provide comprehensive care coordination for individuals with IDD. We conduct in-person assessments, develop care plans, and provide care coordination.

Table 19. Kepro IDD and Assessment Program Experience and Expertise
We will draw on our expertise to best serve WV DHHR.

We offer a range of IDD and Assessment experience and will apply the best practices and lessons learned from these contracts to benefit the IDD Waiver member population.

ICF/IID Process

Our extensive IDD Waiver services in the state have laid the groundwork in place to take on WV DHHR's ICF/IID program, including annual facility visits and on-site ICAP assessments. We are also familiar with the ICF/IID program in West Virginia, as the eligibility criteria are the same for the IDD Waiver program, which we currently administer.

We have a West Virginia-licensed psychologist in place, and we will work with the State to determine an appropriate number of clinical staff to conduct the on-site assessments. We will ensure that any clinical staff on-boarded to this program have the necessary Inventory for Client and Agency Planning (ICAP) experience. Our current roster of nurses within West Virginia is deeply familiar with the assessment, as the tool is used extensively in our IDD Waiver service program.

We are fully prepared to take on the additional work as requested by the Bureau related to the ICF/IID program. To satisfy WV DHHR's ICF/IID program requirements, we will:

- Provide administrative operational functions necessary to support the medical eligibility process for the ICF/IID program. Our experience in operations and administration of the IDD Waiver, Nursing Facility and other programs will prove useful.
- Conduct quality assurance and improvement activities within the eligibility process for ICF/IID. We will assess, recommend improvements, implement changes/training, etc. and continually reevaluate for effectiveness of quality improvement activities.
- Provide a WV licensed psychologist to determine eligibility for ICF/IID levels of care
- Determine ICF/IID eligibility within 90 days of admission to an ICF/IID facility and annual determination evaluations within 30 days of the anniversary date of initial eligibility.
- Conduct and document on-site reviews of Inventory for Client and Agency Planning (ICAP) assessment implementations for accuracy in scores that are used to establish medical eligibility and service level within ICF/IID facilities. Our experience with on-site reviews in IDD and TBI Waivers proves a quality experience conducting provider reviews.
- Provide the fiscal claims agent with information required to generate a prior authorization for services that include the ICAP level score and start/stop dates for ICF/IID facility participants. **We recommend that because of our familiarity with generating authorization we be permitted to enter the authorization directly into the claims payor system.
- Use evaluations submitted by the applicant to determine the level of care for ICF/IID facilities.
- Perform an on-site review of ICAP assessments at each ICF/IID facility annually.
- Visit 100% of all ICF/IID facilities in the first year of the contract and then 33% per additional contract year.
- Notify in writing, the individual/member or legal representative, local county DHHR office and provider within program timelines regarding eligibility decisions and the right to appeal the decision through Medicaid Fair Hearing.
- Conduct all clerical and/or administrative functions associated with the determination of eligibility for ICF/IID facilities. Functions will include written notice of eligibility decisions, tracking of applicants and eligibility decisions, providing information regarding eligibility upon request, and tracking Medicaid Fair Hearing status.

A1.4.c. Aged and Disabled Waiver (ADW) Optional Services

1. Plan, advertise, and produce provider meetings up to four (4) times per year which will be either face-to-face or by virtual platform upon the request of the Agency to include hospitality and conference room rental if face-to-face. If virtual, the Vendor must use a platform that is accessible for large groups of providers.
2. Assist with planning and facilitate monthly virtual meetings/conference calls with provider agencies to include announcements, updates, and policy clarifications. Maintain written Frequently Asked Questions (FAQs) regarding IDDW policies and procedures and make the FAQs electronically available to stakeholders.
3. Develop and maintain a member handbook and a provider reference guide of all available Case Management and service providers and the services offered in each county. The handbook and reference guide are to be kept up to date and available to members electronically or in printed format upon request at no additional cost to the Agency.
4. The Vendor shall conduct quality assurance activities with members, families, case management and service agencies, the Fiscal/Employer Agency vendor, stakeholders, and the general community, as necessary and at the request of the Agency. All quality review tools/materials must be approved by the Agency in advance, including whether the reviews will be on-site, virtual or desk reviews. These activities shall include, but not limited to the following:

a. Notify the Agency of the schedule of the quality review cycle at least a quarter in advance.
b. Conduct initial and annual certification reviews of new and existing IDDW providers to include on-site and desk review as requested by the Agency.
c. Conduct quality reviews of all ADW providers at to verify compliance with current policies, appropriate utilization management and documentation of authorized services. This includes, but is not limited to, notifying the provider agencies of reviews based upon timelines established by the Agency, identifying issues that potentially result in disallowances of provider agency claims payments and calculating the disallowance amounts. This review shall include providers with active/enrolled ADW members at the time of the specified review period. The findings of the quality reviews shall be verbally presented to the agency at the time of the review and provided in writing to the agency at the completion of the review. The Vendor will track the agency's Plan of Correction (when applicable).
d. Conduct a quality review of the self-directed program annually to verify compliance with current policies. The findings of the quality review shall be verbally presented to the Fiscal/Employer vendor at the time of the review and provided in writing to the vendor at the completion of the review. The Vendor will track the vendor's Plan of Correction (when applicable).
e. Conduct follow up reviews to monitor the implementation of approved Plans of Correction. Follow up reviews may be conducted on site or virtually six (6) months following the approval of the Plan of Correction or at a timeline specified by the Agency.
f. Provide the Agency with a monthly comprehensive report of findings of the quality reviews including identification of trends.
g. Manage and facilitate the ADW Quality Improvement Advisory (QIA) Council including quarterly meetings as needed to include travel expenses and overnight stays for members on the QIA Council if they live more than sixty (60) miles away from the location of an in-person meeting. This is to include hospitality and conference room rental. These meetings may be face- to- face or by virtual platform as determined by the Agency. If virtual, the Vendor must use a platform that accommodates large groups. Large groups are defined as up to five hundred (500} participants.

5. Conduct interviews of members annually using a mutually agreed upon sample of enrolled members. The Agency will determine the interview tool and whether the interviews will be face-to-face or by telephone.
6. Receive, track, triage or investigate complaints submitted by providers, members, or other stakeholders. Complaints will be reported to the Agency each month.
7. Perform daily monitoring of ADW member incidents reported via the state's Incident Management System (IMS). Investigate critical incidents as needed to protect members' health and welfare. Provide monthly and quarterly reporting of incidents to the Agency.

8. Report and follow up with the DHHR Protective Services Unit when member abuse, neglect or exploitation is suspected.
9. Report suspected Fraud to the DHHR Office of Program Integrity (OPI) and follow-up as required with the Medicaid Fraud Control Unit.
10. Provide the Agency with a monthly comprehensive report on incidents and follow-up activities.
11. Make recommendations regarding enhancements to the IMS and assist with development of specifications and testing of the system as needed.
12. Provide ongoing technical assistance, at no additional cost to the Agency, to provider agencies and stakeholders upon request of the Agency via email, telephone, or other requested medium.
13. Manage and report monthly, during the regular monthly contract meeting, on the Centers for Medicare and Medicaid Services (CMS) quality measures.
14. Maintain current Freedom of Choice/Agency Selection forms.
15. Maintain a current provider agency register that includes services provided by each agency by county with provider agency contact information in the format to be determined by the Agency.
16. Maintain ADW provider agency files, information, and reports related to agency certification, quality reviews, complaints, incidents, and other provider data.

We conduct medical evaluations for the Aged and Disabled Waiver (ADW) program, and we have completed this work for WV DHHR since 2009. We are familiar with the program policies and procedures, participate in contract management meetings, and provide the majority of data for the Bureau as reported in our secure and comprehensive system. Today, we perform the majority of the outlined ADW optional functions in the IDD Waiver and TBI Waiver programs. Using this experience as a foundation, we will implement the appropriate practices to meet all the optional requirements defined in **Section A1.4.c.** We manage part of the program enrollment (medical eligibility) for the ADW program, and we meet all WV DHHR requirements for this work, as we already manage a portion of program enrollment (medical eligibility) for the ADW program. We currently receive financial eligibility for persons on the managed enrolment list and all data is tracked within our system.

Did You Know?

Kepro scored 4.97 out of 5 in all categories in the 2022 West Virginia Aged and Disabled Waiver Member Satisfaction Survey.

We will plan and produce provider meetings up to four times per year either virtually or face to face as well as assist with any monthly meetings or conference calls with agencies statewide. Our team will maintain any FAQ documents for the WV Aged and Disabled Waiver Program.

During the initial and reevaluation assessments, we can disseminate the approved ADW Member Handbook. We will maintain and update this handbook and submit to the Bureau for approval with any updates. We will conduct quality assurance activities requested including desk reviews, on-site reviews, and virtual reviews. We already complete provider reviews for the TBI Waiver/IDDW programs and we will perform all tasks outlined, including notifying the Agency, conducting certification reviews, conducting quality reviews of the self-directed program, performing follow-up reviews, and providing the Bureau with detailed reports of findings. We will manage and facilitate the ADW Quality Improvement Council quarterly meetings either virtually or face to face. We can accommodate large groups of 500 participants.

We will conduct interviews of members annually either face to face or by telephone as well as track and investigate complaints submitted by providers, members, and other stakeholders. Our quality assurance plan also includes daily monitoring of ADW incidents via the IMS. We will investigate critical incidents and report all findings monthly to the Agency.

We will report and follow up with the DHHR when abuse, neglect, or exploitation is suspected. Additionally, we will report Fraud to the DHHR Office of Program Integrity and follow up with the Medicaid Fraud Control unit as needed. As part of this process we will provide the Agency with monthly incident reports and follow up activities. Our team will also make recommendations for IMS enhancements and assist with development of specifications and testing of the system if needed.

Our staff is prepared to provide ongoing technical assistance to provider agencies and stakeholders upon the request of the Agency. We will also manage and report CMS quality measures monthly at contract management.

We will maintain Freedom of Choice/Agency Selection Forms, a current provider agency register that includes each agency by county with provider contact information, and WV Aged and Disabled Waiver Program agency files, information, and reports related to agency certification and quality.

A1.4.d. Personal Care Functions

1. Plan, advertise, and produce provider meetings up to four (4) times per year which will be either face-to-face or by virtual platform upon the request of the Agency to include hospitality and conference room rental if face-to-face. If virtual, the Vendor must use a platform that is accessible for large groups of providers.
2. Assist with planning and facilitate monthly virtual meetings/conference calls with provider agencies to include announcements, updates, and policy clarifications. Maintain written Frequently Asked Questions (FAQs) regarding IDDW policies and procedures and make the FAQs electronically available to stakeholders.
3. Develop and maintain a member handbook and a provider reference guide of all available Personal Care agencies and the services offered in each county. The handbook and reference guide are to be kept up to date and available to members electronically or in printed format upon request at no additional cost to the Agency.
4. The Vendor shall conduct quality assurance activities with members, families, and agencies, the Fiscal/Employer Agency vendor (if applicable), stakeholders, and the general community, as necessary and at the request of the Agency. All quality review tools/materials must be approved by the Agency in advance, including whether the reviews will be on-site, virtual or desk reviews. These activities shall include, but not limited to the following:

a. Notify the Agency of the schedule of the quality review cycle at least a quarter in advance.
b. Conduct initial and annual certification reviews of new and existing Personal Care agencies to include on-site, and desk review as requested by the Agency.
c. Conduct quality reviews of all Personal Care agencies to verify compliance with current policies, appropriate utilization management and documentation of authorized services. This includes, but is not limited to, notifying the provider agencies of reviews based upon timelines established by the Agency, identifying issues that potentially result in disallowances of provider agency claims payments and calculating the disallowance amounts. This review shall include providers with active/enrolled members at the time of the specified review period. The findings of the quality reviews shall be verbally presented to the agency at the time of the review and provided in writing to the agency at the completion of the review. The Vendor will track the agency's Plan of Correction (when applicable).

d. Conduct a quality review of the self-directed program annually to verify compliance with current policies (upon availability of self-directed PC services). The findings of the quality review shall be verbally presented to the Fiscal/Employer vendor at the time of the review and provided in writing to the vendor at the completion of the review. The Vendor will track the vendor's Plan of Correction (when applicable).
e. Conduct follow up reviews to monitor the implementation of approved Plans of Correction. Follow up reviews may be conducted on site or virtually six (6) months following the approval of the Plan of Correction or at a timeline specified by the Agency.
f. Provide the Agency with a monthly comprehensive report of findings of the quality reviews including identification of trends.
5. Conduct interviews of members annually using a mutually agreed upon sample of enrolled members. The Agency will determine the interview tool and whether the interviews will be face-to-face or by telephone.
6. Receive, track, triage or investigate complaints submitted by providers, members, or other stakeholders. Complaints will be reported to the Agency each month.
7. Perform daily monitoring of PC member incidents reported via the state's Incident Management System {IMS). Investigate critical incidents as needed to protect members' health and welfare. Provide monthly and quarterly reporting of incidents to the Agency.
8. Report and follow up with the DHHR Protective Services Unit when member abuse, neglect or exploitation is suspected.
9. Report suspected Fraud to the DHHR Office of Program Integrity (OPI) and follow-up as required with the Medicaid Fraud Control Unit.
10. Provide the Agency with a monthly comprehensive report on incidents and follow-up activities.
11. Make recommendations regarding enhancements to the IMS and assist with development of specifications and testing of the system as needed.
12. Provide ongoing technical assistance, at no additional cost to the Agency, to provider agencies and stakeholders upon request of the Agency via email, telephone, or other requested medium.
13. Manage and report monthly, during the regular monthly contract meeting, on the Centers for Medicare and Medicaid Services (CMS) quality measures.
14. Maintain current Freedom of Choice/Agency Selection forms.
15. Maintain a current provider agency register that includes services provided by each agency by county with provider agency contact information in the format to be determined by the Agency.
16. Maintain ADW provider agency files, information, and reports related to agency certification, quality reviews, complaints, incidents, and other provider data.

We conduct medical evaluations for the Personal Care Program and we have completed this work since 2018. Our staff already attends contract management, provides most program data from the web portal, and is knowledgeable of program policies and procedures. Our current work meets all DHHR requirements. We are prepared to expand our services within the program should the Bureau choose to implement any the defined optional services. We understand and will comply with all requirements outlined for Personal Care Functions. We will plan and produce provider meetings up to four times per year either virtually or face to face as well as assist with any monthly meetings or conference calls with agencies statewide. As part of these efforts our team will maintain any FAQ documents for the WV Personal Care Program.

During the initial and reevaluation assessments, We can disseminate the approved PC Member Handbook. We will maintain and update this handbook and submit to the Bureau for approval with any updates.

We will conduct quality assurance activities requested including desk reviews, on-site reviews, and virtual reviews. We already complete provider reviews in multiple other programs. We are prepared

to perform all task outlined including notifying the Agency, conducting certification reviews, conducting quality reviews of the self-directed program, performing follow-up reviews, and providing the Bureau with detailed reports of findings.

Regarding the PC review process, we will conduct interviews of members annually either face to face or by telephone. Our team will also track and investigate complaints submitted by providers, members, and other stakeholders.

As part of our quality assurance plan, we will perform daily monitoring of PC incidents via (IMS). We will investigate critical incidents and report all findings monthly to the Agency. Our plan will also include reporting on and following up with DHHR when abuse, neglect, or exploitation is suspected. All fraud discovered will be reported to the DHHR Office of Program Integrity and we will follow up with the Medicaid Fraud Control unit as needed. Any incident reports and follow up activities will also be included monthly. We will make recommendations for IMS enhancements and assist with development of specifications and testing of the system if needed.

Our staff is prepared to provide ongoing technical assistance to provider agencies and stakeholders upon the request of the Agency. We will manage and report CMS quality measures monthly at contract management. We will also maintain Freedom of Choice/Agency Selection Forms, a current provider agency register that includes each agency by county with provider contact information, as well as WV Personal Care agency files, information, and reports related to agency certification and quality.

A1.4.e. Ambulance Transportation

1. The Vendor shall develop, implement, and maintain a 'UM program, which includes prior authorizations for ambulance transports from Ambulance providers.
2. The Vendor shall ensure the Ambulance provider meets all Agency requirements and utilizes the appropriate mode of transport for the requested trip type.

Trip Types: Specific authorization standards unique to specific trip types are defined as follows:

a. Single Trips Requests: The Vendor shall require that requests for non-emergent ground Ambulance Services to a single appointment be made via a toll-free telephone number. Other methods of single trip requests may be allowed with the Agency approval.

b. Standing Order Trip Requests: The Vendor shall establish procedures to handle trip requests so that Members are not required to continually make arrangement for repetitive appointments. The Vendor shall include in its procedure to recertify the need of a Standing Order with the Medical provider at least every thirty (30) calendar days.

c. Return Trip After Emergency Transports: In limited situations, a Member may be transported by emergency medical air ambulance (fixed-wing or helicopter) or emergency medical ground ambulance to a medical facility. Upon discharge, if the Member requires transport home via ambulance, the Vendor shall process the ambulance transportation authorization request for the one-way transport for the Member.

d. Air Ambulance Transports: The Vendor shall process utilization/prior authorization/retrospective authorization requests for all air transports.

e. Hospital to Hospital Transports: In limited situations, the medical care required for a Member cannot be provided at a specific facility or within the State of West Virginia. The Agency has enrolled specialty hospitals

located elsewhere in the United States. The Vendor shall process utilization/prior authorization/retrospective authorization requests for all hospital-to-hospital transports to these facilities.
3. The Vendor shall evaluate the most appropriate transport method based on the Member's medical condition, the reason for the transport, the urgency of the transport, and the destination of the transport.
The Vendor may propose a method to prior authorize air ambulance transportation flights. The Vendor shall make provisions for retrospective reviews of authorization requests for air ambulance transports in emergencies that occur after business hours, on weekends, and on holidays.
4. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, evaluations, and other forms or documentation required for prior authorization and eligibility review of ambulance transportation services.
5. The Vendor shall refer all non-emergency medical transportation requests to the appropriate resource, such as the NEMT Broker, when the Member's medical need does not require an ambulance level of transportation.

We implement comprehensive guidelines governing our delivery of Ambulance Transportation Services. Our processes include strict adherence to InterQual® criteria, CMS regulations, and can easily accommodate client criteria or requests. We will modify and adapt our processes based on updates to applicable state regulations to ensure continued compliance with the latest version of official controlling policies and regulations. As part of quality program, governing regulations are monitored on a routine basis to ensure processes are up to date.

For emergency air transportation program specifically, we have provided authorization for these services for our State Medicaid partners since 2015. We have completed more than 2,100 total authorizations covering fixed and rotary wing transport vehicles, averaging 695 requests per year from 2019 through 2021. In our work with West Virginia, we put that practice to good use and with WV DHHR's guidance, created a prior authorization process for all emergency transportation services as required by Chapter 524.

Non-Emergency Ambulance Transport

- This may be provided to obtain treatment or diagnosis for a health condition if the use of any other transportation could endanger the member's health or well-being
- Non-emergency transportation must be prior authorized as medically necessary before the service is provided
- Non-emergency transport will be evaluated based on the member's medical condition, the reason for the transport, the medical necessity of the transport for treatment and/or diagnosis, and the destination of the transport
- In some cases, a physician may order ambulance transportation to a hospital or medical facility based on a member's medical condition; in these instances, the order must be attached to the request and the medical necessity will be based on information provided by the ordering physician
- Medical transport of bed confined individuals may be approved when the following are met:
  - The patient condition is such that any other means of transportation is contraindicated
  - The patient is unable to get up from bed without assistance, and is unable to ambulate, and unable to sit in a chair or wheelchair or can only be transported by stretcher
  - The patient's symptoms and physical or functional status require monitoring for safety

- Transportation from one hospital facility to another may meet NEMT guidelines when medically necessary to obtain diagnostic or therapeutic services (e.g., MRI, CT scan, acute interventional cardiology) not available at the originating facility. The provider of the specialized service must be the nearest facility to the originating facility that is capable of performing the required service. All of the following conditions must be met for approval:
  - The patient is a registered inpatient in an acute care hospital
  - The required specialized services are considered medically necessary and covered by Medicaid
  - The required service is unavailable in the facility where the patient is registered
- NEMT requests will be evaluated and authorized as either single trip requests or standing order trip requests
- Non-emergency transport requests that do not meet requirements will be referred to the Agency's NEMT broker when it is determined the member does not require ambulance transport to be safely transported to the requested service. The denial letter sent to the member will include information regarding how to contact the NEMT vendor and arrange transportation
- NEMT may be approved retrospectively in the following instances: the patient is pronounced dead while in route or upon arrival at the hospital or final destination, or the patient was pronounced dead by a legally authorized individual (physician or medical examiner) after the ambulance call was made but prior to pick up. In all other instances prior authorization must be received for NEMT in an ambulance

Emergency Ambulance Ground Transports

- The retrospective request must meet medical necessity criteria for emergency ambulance transport as approved by the Agency
- The patient's condition must be such that any of form of transportation is medically contraindicated
- The medical necessity criteria will be applied to the following ground transportation (ambulance) services: emergency room transports/return trip after emergency transport with appropriate order and Certificate of Medical Necessity (CMN); Hospital to Hospital Transports
- The transport must meet one of the following classifications: Advanced Life Support; Basic Life Support-Emergency; Interfacility Transport requiring medical supplies and equipment; Paramedic Intercept
- The member must be transported to the nearest hospital with the appropriate facilities for the treatment of the patient's illness or injury
- The criteria will be based on the Agency's Medical Necessity Chart for Ground Ambulance and Medicare criteria and will be approved by the Agency prior to implementation

Emergency Air Transports

- Air transportation - Fixed Wing (airplane) or Rotary Wing (helicopter) - will be retrospectively approved if the patient's medical condition at the time of transport indicated that immediate and rapid ambulance transportation was required (e.g. life-threatening injury that requires stabilization in a medical facility; pick-up location cannot be easily reached by ground transportation; long distances or other obstacles, like heavy traffic, will impede timely medical attention if ground ambulance is utilized)
- Medical necessity criteria are applied in instances of air transport and must be met

Non-covered ambulance or medical transport services

- When medical necessity guidelines are not met
- If the patient is pronounced dead before the ambulance is called the service is not considered medically necessary
- Ambulance transportation is primarily for the convenience of the member, their family or caregiver or their physician
- Transportation to any service not covered by West Virginia Medicaid
- Transportation to any provider not enrolled with West Virginia Medicaid
- Transportation using inadequate or inappropriate level of staff personnel on board transporting vehicle
- Services provided when the request was for post transportation authorization and was not received timely or did not meet established criteria
- Transportation to a service considered not medically necessary, even if the destination is an appropriate facility
- Transportation of members who do not meet the medical necessity requirements for level of service billed
- Transportation provided when the member refuses the appropriate mode of transportation.
- Transportation to a service that requires prior authorization but has not been prior authorized

A toll-free number will be established for transportation requests. Additionally, the system application will be expanded to include transportation requests. The provider may select non-emergency transport or emergency transport. If emergency transport is selected, then ground or air transport may be selected. providers may direct data enter (DDE) requests or fax requests to be keyed by our staff. providers will register with Kepro and must be licensed as an Emergency Medical Services (EMS) agency by the West Virginia Office of EMS and be Medicare Part B certified.

Medical necessity criteria will be developed in conjunction with the Agency and a representative provider group within 90 days of program award. Criteria will be congruent with Chapter 524 Appendix A. Ground Ambulance Medical Necessity and will comply with all state and federal guidelines related to ambulance transportation. After approval of criteria, providers training webinars will be conducted to include the following:

- Covered services, criteria, and guidelines for authorization
- Registering with Kepro
- Obtaining authorization
- Timelines for obtaining prior authorization for NEMT ambulance transport and retrospective authorization for emergency transport
- Other topics requested by the Agency

We will implement the transportation program within 90 days of Agency sign-off on requirements and criteria. provider training will be offered during this period to ensure providers are prepared for implementation of the process. Training and technical assistance will be provided on an ongoing basis following the implementation of the program.

An overview of the process is as follows:

1. The provider submits a request for NEMT or emergency ambulance or air transport
2. Member Medicaid eligibility is verified for the date(s) of service
3. Request is reviewed for completeness: physicians orders, CMN, plan of care, evaluations, and other required documentation
4. Complete NEMT requests are routed to a transportation specialist who applies approved NEMT criteria, if approved the authorization is recorded in C3. If denied, the request is routed to a RN and is screened for approval based on medical information provided. If approved the authorization is recorded in C3. If the nurse cannot approve the request, it is sent to a physician for final review, if approved the approval is recorded in C3, if denied the appropriate denial letter is attached in C3 for the provider and is mailed to the member. The letter will include the member's appeal rights and information for contacting the NEMT vendor
5. NEMT requests are screened for appropriateness for medical case management based on member diagnosis and frequency of trips
6. Complete emergency requests for ground or air ambulance are routed to a RN. Medical necessity criteria are applied based on medical information provided. If approved the authorization is recorded in C3. If the nurse cannot approve the request, it is sent to a physician for final review, if approved the approval is recorded in C3, if denied the appropriate denial letter is attached in C3 for the provider and is mailed to the member. The letter will include the member's appeal rights and reason for denial
7. Emergency ground and air ambulance requests are screened for appropriateness for medical case management based on member diagnosis and utilization history

Hierarchical Conditions for Air Ambulance Service Transports

We will comply with the hierarchy to issue an Authorization Number or a Denial for Air Ambulance Services:

1. Medical Necessity - Medical necessity is only established when the participant's condition is such that the time needed to transport a participant by ground, or the instability of transportation

by ground, poses a threat to the participant's survival or seriously endangers the participant's health. Following is an advisory list of examples of cases for which use of air ambulance could be justified. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed: Intracranial bleeding-requiring; neurosurgical intervention; Cardiogenic shock; Burns requiring treatment in a burn center; Conditions requiring treatment in a Hyperbaric Oxygen Unit; Multiple severe injuries; or Life-threatening trauma. Any potential adverse determination is referred to a physician reviewer who may opt to contact the requesting/treating provider to best determine medical necessity of Air Ambulance Transport that may not be adequately reflected in the medical records submitted at the time of the request.

2. Time and Distance – Staff measure time and distance qualifiers against the condition and needs of the participant. Differing Statewide Emergency Medical Services (EMS) systems determine the amount and level of basic and advanced life support ground transportation available; this assessment considers the transit time to reach the participant, transit time to an emergency facility, as well as patient's condition. However, there are very limited emergency cases where ground transportation is available, but the time required to transport the patient by ground as opposed to air endangers the participant's life or health. As a general guideline contractors should consider air transportation to be appropriate. when it would take a ground ambulance 30-60 minutes or more to transport a participant whose medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the participant's illness/injury. While these are the initial guidelines in place we can incorporate any State requirements and amendments into our processes and procedures.

3. Appropriate provider - Air ambulance transport is covered for transfer of a participant from one hospital to another if the medical appropriateness criteria are met, defined as: transportation by ground ambulance would endanger the participant's health and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. A participant transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage is not available for transport from a hospital capable of treating the patient because the participant and/or the participant's family prefer a specific hospital or physician. Coverage is also available only to providers that meet State qualifications required for air ambulance. In addition, we will ensure that the provider meets the qualifications for air transport, if applicable, per MD regulation.

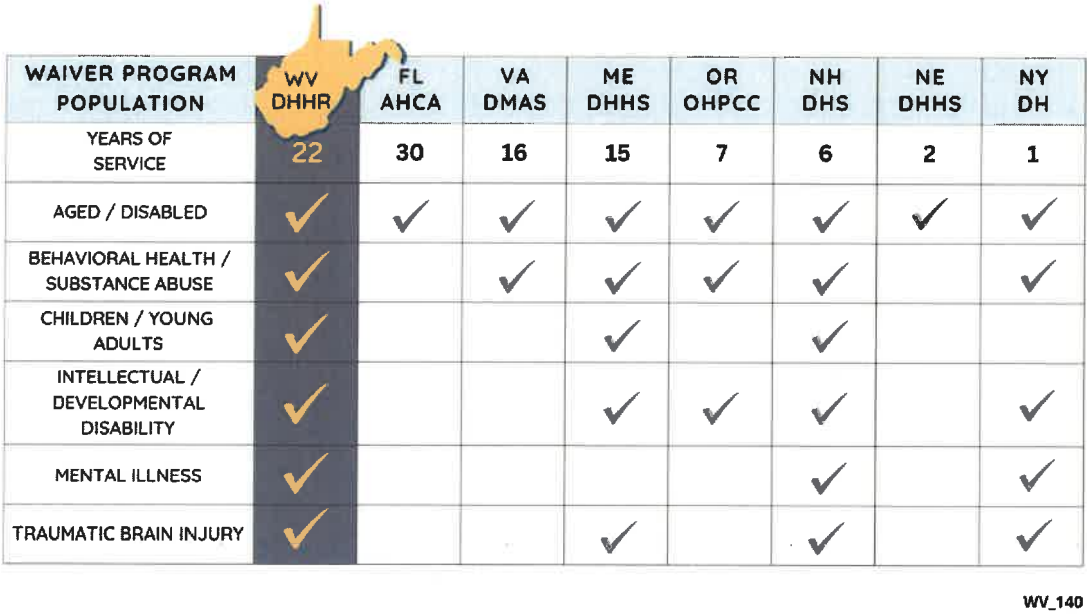
4. West Virginia Medicaid provider – We will ensure that, if the requesting organization is an Air Ambulance Service provider, the organization is active and contracted as a Maryland Medicaid provider. By ensuring that the provider Maryland Medicaid status for Air Ambulance we ensure that the provider is qualified and meets all safety requirements.

5. Fixed Wing – After satisfying the above criterion, we will seek CM approval prior to authorizing. We will not make an approval determination without CM approval. The CM must first approve the request before we inform the requester of the approval.

A1.4.f. Case Management System with Incident Reporting/Management System (IMS) for HCBS

1. The Vendor shall develop, implement, and maintain an Online Case Management System that includes an integrated Incident Reporting/Management System {IMS).
a. The Vendor's Online Case Management System and IMS shall restrict access to program members' data to the member's current chosen Case Management agency, service agency/agencies, the F/EA vendor for members that choose to self-direct services, and state administrators.
b. The Vendor's Online Case Management System shall import data from program members' medical eligibility assessments and pre-populate the strengths and needs sections of the members' Service Plans.
c. The Vendor's Online Case Management System shall allow the Case Manager to create their assigned members' service plans using a catalogue of standard goals and objectives that may be individualized to the member and/or created entirely by the Case Manager.
d. The Vendor's Online Case Management System shall prepopulate the direct-care documents that reflect the duties/tasks to be performed by the members' caregivers.
e. The Vendor's Online Case Management System shall include notifications to the Case Management agency, service provider agency, F/EA vendor and state administrator users regarding due dates for member eligibility, annual service plan, service plan reviews, etc.
f. The Vendor's Online Case Management System shall be integrated with the Vendor's system for authorization of services to ensure the type and quantity of authorized services is consistent with the services addressed on the member's service plan.
g. The Vendor's Online Case Management System and IMS shall include the ability for Case Management agencies, service provider agencies, the F/EA vendor and state administrators to create standard and ad hoc reports.
h. The Vendor's IMS must integrate with the Online Case Management System but also allow reporting and management of incidents for members that do not have a Case Manager (i.e., Personal Care members).
i. The Vendor's IMS shall provide standard and ad hoc reports that perform trend analysis and may be downloaded into editable documents.
j. The Vendor's IMS shall issue notifications to the appropriate users regarding follow-up and documentation as required by HCBS policies.

Our proprietary Atrezzo Care Management Solution was designed with our mission at the forefront – to improve the quality of life and clinical outcomes for the vulnerable populations we serve. Atrezzo is a proven Care Management platform, implemented for 31 state Medicaid agencies as a flexible, intuitive, and highly automated system that streamlines processes and reporting for clients and providers. Atrezzo successfully supports multiple state Medicaid HCBS waiver programs today, as shown in **Figure 64 Atrezzo Usage with Waiver Programs**.



WAIVER PROGRAM POPULATION	WV DHHR	FL AHCA	VA DMAS	ME DHHS	OR OHPCC	NH DHS	NE DHHS	NY DH
YEARS OF SERVICE	22	30	16	15	7	6	2	1
AGED / DISABLED	✓	✓	✓	✓	✓	✓	✓	✓
BEHAVIORAL HEALTH / SUBSTANCE ABUSE	✓		✓	✓	✓	✓		✓
CHILDREN / YOUNG ADULTS	✓			✓		✓		
INTELLECTUAL / DEVELOPMENTAL DISABILITY	✓			✓	✓	✓		✓
MENTAL ILLNESS	✓					✓		✓
TRAUMATIC BRAIN INJURY	✓			✓		✓		✓

WV_140

Figure 64. Atrezzo Usage with Waiver Programs
Atrezzo is used by multiple states to support six different HCBS waiver populations.

Atrezzo includes a Case Management module which includes Incident Management functionality, as well modules for Utilization Management, Assessments, Appeals, Scheduling, and a Provider Portal. We will configure a West Virginia DHHR, BMS specific Incident Management module in accordance with BMS requirements.

Atrezzo is workflow-driven with business rules separate from the application. This results in a significantly shortened implementation period and rapid response to changing agency requirements. Business rules are maintained through an integrated management portal and do not require application development. Atrezzo modifications are easily configurable and can be completed and operational as quickly as 1-2 days.

Table 20 details Atrezzo Integrated Modules.

Module	Description and Function
Utilization Management Modul0e	Designed to support and determine the appropriateness of requested or received services. Key features include: • Integrated criteria such as InterQual® and 3M Grouper • Rules engine that creates automation and efficiency in the review process • Embedded program-specific UM review forms • Request/Review Turnaround Time Tracking • Integrated provider portal for providers to directly provide additional documentation and monitor status and outcome

Module	Description and Function
	• Qbuilder, a proprietary template building tool, used to build client and program specific UM templates and/or forms • Quality Assurance
Assessment Module	Supports the administration of assessments and creation, tracking, and resolution of incidents: • Intake • Screening • Assessments and Reassessments • Enrollment and Re-enrollment • Clinical Eligibility Determination • Offline Assessments supported by our Mobile Assessment Application • Automated assessment scoring for immediate outcomes • Quality Assurance
Provider Portal Module	Technology platform for providers to submit documentation surrounding reviews, requests, and referrals. Key features include: • Electronic provider interface with state-approved algorithms and data entry rules • provider Access 24-hours, 7 days a week • Real-time viewing and printing of determinations • Access to search and view historical data/forms per user role • Prompts to user on program requirements with few steps for completion • State and provider facing data and report cards (such as volume and outcomes) • Quality Assurance
Case Management Module	Supports providers in tracking case plans, incidents, assessments, and outcomes. Key features include: • Member identification and engagement • 100+ embedded physical and behavioral health assessments • Care Plan generation • Tracks problems, goals, and interventions • Tracks status of goals and barriers to completion • Supports communication/notifications • URAC-accredited Plan of Care • Quality Assurance
Scheduling Module	Provides coordination of resources to facilitate on-site provider reviews, interviews, or meetings. • Integrated with Assessments and Case Management module • Can operate independently to support other scheduling needs • Integrated with Microsoft Outlook • Manages staff calendars and sends appointment invitations in ICS format • Provides regional assignments for assessors and case managers – assuring coverage and provision of backup • Documents and confirms resources such as:

Module	Description and Function
	○ Assessors, Case Managers, Beneficiaries, Family/Guardians, providers, Locations, Date, and time • Email reminder notifications (not including PHI) • Quality Assurance

Table 20. Atrezzo Integrated Modules

Atrezzo's five integrated modules promote whole-person care across the individual's continuum of care.

Atrezzo Standard Features

All standard Atrezzo module features are available at no additional costs to DHHR, BMS.

No-cost Differentiating System Capabilities:

Key to Atrezzo is how we differentiate our system capabilities from competitors, including program and client-specific configurable workflows and algorithms. These features are driven by Atrezzo's rules-engine, which is composed of customizable Review/Assessment Forms that streamline the review and assessment process and capture reportable data. Mobile and offline capabilities also enable the work to be conducted anywhere with automated upload when internet connection is accessible. **Table 21 Atrezzo System Capabilities** below describes these capabilities.

Atrezzo Capability	Description
Rules Engine and Workflow	• Workflow-driven with business rules separate from the application. This results in a significantly shortened implementation period and rapid response to changing contract requirements. • Business rules are maintained through an integrated management portal and do not require application development • Review workflows are embedded in Atrezzo for consistency and reliability of the review processes. • Modifications to workflows are easily configurable and can be completed and operational within 24-48 hours of request. • Reviewers enter all interactions and information pertaining to reviews into Atrezzo, which are easily reportable • Pseudocode-based rules, easily built and modified by non-developers - low code or no code configuration used to define all business logic - completely separated from application code • Access to all inbound eligibility, provider, and request data • Rules manage auto-approvals, workflow, eligibility checks
Forms and Data Capture	• Flexible report building with drag and drop build of templated questionnaires – does not require technical expertise to develop • QBuilder questionnaires are usable in the web version and Mobile Review Application • QBuilder allows any type of question to be created – Text, Yes / No, Single Selection, Multiple Selection, or Numeric, Dates and then to quickly build the associated forms using "Drag and Drop" functionality. Used for UM related

Atrezzo Capability	Description
	Reviews, Assessments, checklists, clinical data collection including problems, goals, and interventions
Mobile and Offline Functions	• The Atrezzo Mobile Review Capability provides a platform for reviews to be conducted on site, with or without stable internet connection • Does not require Internet access while conducting on site assessments • Synchronizes data collected when Internet service is available

Table 21. Atrezzo System Capabilities
Key Atrezzo capabilities enable quick and easy configuration changes.

Waiver Processes

Atrezzo is equipped and prepared today to facilitate each stage in the HCBS Continuum of Care. including the following:

Intake – Requests/Referrals can be received via Atrezzo's portal and direct data entry (by a system user) for requests received via fax, email, telephone, or mail. Atrezzo's intake functionality is workflow driven based on configurable rules. As an example, we currently process the WV Traumatic Brain Injury Waiver Medical Necessity Evaluation Request form in Atrezzo. Upon entry of the request, Atrezzo workflow automatically sends the request to a Clinician to initiate the assessment step in the process for applicants seeking TBI Waiver services.

Screening – Once the case is created, Atrezzo's task-based methodology routes the case and screening task to the appropriate screener. The screener will take actions within the system, in accordance with contract requirements, to route the case for additional information, administratively close the request or route to the next phase in the process.

Scheduling – Through our HCBS experience, we have addressed the need to track and report on a complex scheduling workflow. Our Atrezzo scheduler module is linked to staffs' Outlook calendars, so schedulers can view availability as well as select assessors in a regional, county, city, or other catchment area (as defined in configuration). Atrezzo tracks attempts to contact applicants, beneficiaries (or others, as applicable) as well as the outcome of the attempt to schedule (appointment scheduled, not scheduled). Users utilize the scheduler feature to track whether an appointment occurred or not, and why, if it did not occur. This level of detail satisfied WV's current requirements for tracking appointments for Home and Community Based Waivers.

Assessment - Atrezzo can be easily configured to capture any assessment via our "Questionnaire" feature. Questionnaires are fully configurable to capture any question. Our Business Analysts work with Operations or the State to capture questionnaire requirements (such as field validation criteria). Our IT team configures Atrezzo per specification. Any data set (or assessment) not captured elsewhere in our Atrezzo modules can be captured via a questionnaire. Atrezzo supports gathering of assessment information on mobile devices. This allows for in-person assessments to be completed efficiently. Atrezzo is accessible on mobile devices to complete in-person assessments. When internet connection is not available at the time of the assessment, the

assessment is completed on the mobile device and once the mobile device is connected to the internet the Atrezzo system automatically imports the completed assessment into the system.

If a specific assessment cannot be replicated due to copyright restrictions, Atrezzo supports the upload of the completed assessment as an attachment. In this scenario, the completed assessment results are uploaded into Atrezzo to be viewed and utilized to address the beneficiary's needs and services throughout their continuum of care.

Clinical Eligibility Determination – WV programs utilize various contractors to determine medical eligibility for various programs. Atrezzo supports use by BMS and other contractors through role-based access and workflow tasks. Once an assessor completes an assessment and data is either entered or attached within the system, we would route the completed assessment to the contractor responsible for clinical eligibility determination. Based on the program and assessment, we could configure Atrezzo to automatically calculate medical eligibility and determine whether an individual's assessment scores quality for the given program. For example, WV's Nursing Facility program is currently in Atrezzo. Since this program utilizes the Pre-Admission Screening, we have configured the system to calculate the number of deficits the individual exhibits. We can automate clinical eligibility determination or can route completed assessment data to the entity responsible for making the determination.

Enrollment and Re-enrollment – We effectively maintain enrollment information and verify eligibility today for DHHR, BMS providers and members. Through our established data exchange process with the state's systems, member enrollment and eligibility information are stored in our Atrezzo database for real-time and accurate eligibility verification. If the new scope of work requires modification of our current processes for consuming additional data or requires revised workflows for eligibility verification, our Atrezzo platform's flexibility and ease of configuration will allow us to make those changes expeditiously. Atrezzo utilizes a pre-configured case status field to determine where an individual lies within the enrollment process. We define case statuses through configuration and set-up to support the entire eligibility, enrollment, and redetermination process for each new program. Through case status tracking and reporting, we ae able to manage enrollment onto/off a given program. We can track home and community-based waiver slots available or utilized during the fiscal year, calendar year or defined and configured timeline.

Care Planning – The beneficiary's individualized Care Plan is a key component of conducting a comprehensive assessment of the beneficiary's conditions and needs to determine the most appropriate person-centered plan of care for the beneficiary. Atrezzo Care Plan capabilities include developing and monitoring beneficiaries' plan of care. The system's embedded physical, behavioral, and social health assessments and accompanying rules-based workflows help to drive the person-centered Care Plan. Assessments are configured to automatically link assessment results to feed into a consolidated person-centered plan of care. This allows for the beneficiary's Care Team to provide an integrated and well-coordinated approach to develop interventions and support the beneficiary in meeting their physical health, behavioral health and social health goals. This also

prevents duplication of Care Team efforts and ensures that Care Team member's interventions are coordinated, supporting high quality outcomes for the beneficiary.

Service Authorization – We understand the primary objective of the service authorization function is to serve as a utilization management measure allowing payment for only those services that are medically necessary, appropriate, and cost-effective. We currently provide Service Authorizations that follow these guidelines in our DHHR, BMS program today. Service review and authorization resides in Atrezzo's Utilization Management (UM) module. Submitters create a UM case in the Provider Portal where they designate the service, amount, duration, start and end dates. Today, reviewers issue determination (authorization, deny, etc.). The system can be configured to send an email to submitter once a case status has changed, or the system users can also utilize "messaging" feature in Atrezzo to request/track requests for additional information from the submitter. We send authorization files to the DHHR's MMIS system. We do not anticipate any needed changes to this process.

Service Delivery – We monitor Service Delivery across our Waiver programs utilizing Atrezzo. Atrezzo' automated prompts and workflows drive the process. Examples include, determining if services recommended in the care plan have been provided as indicated; beneficiary satisfaction with service delivery; provider service reviews to determine quality and compliance with program requirements.

Billing/Claiming –Atrezzo has the capacity to track provider services, case management hours and units of care. This information can be used to create invoice documentation, as well as create data that can be sent to the claim's payor for payment.

Reassessments – Our Atrezzo workflow is configured to notify users when a reassessment is required. Through our Assessments module, as an example, we can set a system task for 30 days prior to when a beneficiary's reassessment is due. This supports the requirement for reassessment per the state's defined cadence (annually or other, as necessary).

Quality Assurance – Atrezzo's five integrated modules include automated workflows and pre-loaded forms within each module to ensure quality assurance in all processes. Atrezzo's quality assurance rules-based workflows are designed to ensure efficiency, accuracy, and timeliness based on the program-specific services and populations serviced. Integration between these modules promotes whole-person care and quality assurance across the individual's continuum of care.

Standard Reporting Features

Atrezzo's reporting capabilities are highly configurable and adaptable to client-preferred formatting and data. Users can configure reports via drag and drop functionality in Tableau. All data contained in the system is reportable, therefore outcome measure dashboards can be configured as required. Our reporting solution includes the capabilities listed in **Table 22 Atrezzo Reporting Capabilities.**

Reporting Capability	Description
Standard Recurring Reporting	• Standard tabular reporting powered by SQL Server Report Services (SSRS) • Tabular reports • Scheduled or run ad-hoc (available 24/7) • Parameter-driven to provide the needed level of detail • Value: On-time, accurate contractually required reports that provide immediate answers to questions
Advanced Analytics Dashboards	• Powered by Tableau and available via Tableau Server • Range in capability from simple reporting and monitoring to deep-dive drill thru analysis • Built on top of line level detail, meaning that data is available at the necessary level of detail for analysis (easily roll up or drill thru) • Exportable in a variety of standard file formats; can create alerts, export underlying visualization data • Value: Easily monitor performance and operations through data visualizations and get answers to questions by using drill thru, without the need to submit additional ad hoc requests
Drag and Drop Report Creation (Report Authoring)	• Powered by Tableau and available via Tableau Server • Report authoring sits on top of the various client-specific data models • Data grouped by dimensions and measures and organized into concise folders • Users can create calculated fields and parameters • Tabular or visual • Savable to client-specific Tableau server folder and populates with up-to-date data • Value: Easily manipulate existing reports or create new reports to answer questions about performance and operations; reduces the need for additional ad hoc requests

Table 22. Atrezzo Reporting Capabilities
Atrezzo supports a wide range of flexible reporting options.

Configurability

Atrezzo was designed by clinicians, for clinicians to support the care management needs of our 31 Medicaid agency customers – all based on our three decades of state government healthcare experience. Our system is also built to accommodate Medicaid HCBS waivers and is currently being used by nine clients for HCBS Waiver programs, including in West Virginia.

The Atrezzo application is workflow-driven with business rules separate from the application. Business rules are maintained through an integrated management portal and do not require application development. Atrezzo also contains a drag and drag form builder (QBuilder) that allows new form creation without custom coding. These features enable a high degree of configurability - Atrezzo modifications can be completed and operational as quickly as 1-2 days.

WVCHIP PRIOR AUTHORIZATION REQUIREMENTS

WVCHIP PRIOR AUTHORIZATION REQUIREMENTS
Service Plan Description for the WVCHIP program can be found at:
https://chip.wv.gov/SiteCollectjonDocuments/WVCHIP%202022%20SPD%20Finalized.pdf

A1.5. Agency Technical Requirements (WVCHIP)

This section describes the requirements for the development, implementation, and operation of a Utilization Management (UM) program to include:

a. Inpatient Medical/Surgical Services;
b. Organ Transplant Services
c. Hospice Services
d. Durable Medical Equipment, Supplies, and Orthotics and Prosthetics
e. Vision Services
f. Audiology Services
g. Outpatient Physical Therapy, Occupational Therapy and Speech Therapy
h. Physician and Non-Physician Practitioner Services
i. Home Health Services
j. Diagnostic Imaging/Radiology Services
k. Lab/Genetics Services
l. Out-of-Network (OON) Services
m. Cardiac rehabilitation
n. Pulmonary Rehabilitation
o. Chiropractic Services
p. Podiatry Services
q. Case Management
r. Specialty Medications/Physician Administered Drug Services
s. Applied Behavioral Analysis (ABA) Services
t. General Authorization for all programs (Please note: This section is not included in the pricing page)

A1.5.a. Inpatient Medical/Surgical Services

1. The Agency covers inpatient medical/surgical services for all eligible members. As a condition for reimbursement, the Agency requires that all inpatient hospital admissions receive prior authorization.

We have 30 years of experience performing prior authorization of Inpatient Medical/Surgical services. We have been contracted with WV DHHR to provide these services since 2010. Since the start of our current WVCHIP contract with DHHR in 2019, we conducted approximately 477 prior authorization reviews for inpatient hospital admissions.

We understand the critical role of the prior authorization review process and its necessity for ensuring all inpatient hospital admissions are medically necessary and appropriate before costs are realized. To ensure member needs are met with the appropriate level of care, our prior authorization processes are streamlined and in full alignment with State requirements. To accomplish this, our prior authorization of Inpatient Medical/Surgical services is managed in our Atrezzo system using the utilization review process outlined below.

Prior Authorization Process

Atrezzo is configured to determine when an authorization for inpatient hospital admission requires clinical review. Our clinical reviewers receive these requests automatically and in real-time via Atrezzo. The reviewers examine the clinical information based on the appropriate criteria and client-required rules. If the request for services meets medical necessity, the clinical reviewer

documents the approval for inpatient prior authorization and authorizes an initial number of certified days, previously determined in collaboration with BMS, and the provider receives real-time notification via the Provider Portal.

All decisions made by the clinical reviewer to authorize, modify, or deny a given request will be based on medical necessity, as well as program policy criteria. For the WV UM and PA Services program we use InterQual® criteria in addition to contract, State, and CMS required guidelines for authorizations of inpatient and outpatient services and items to ensure the requested services are clinically appropriate and medically necessary.

We bring to WV DHHR our decades of experience, clinical expertise and understanding of UM and PA services across multiple service types and treatment settings to deliver operational excellence in all levels of Utilization Review. We show the standard prior authorization review process in **Figure 65 Prior Authorization Review Process,** displaying the overall process points for key activities and determinations.

Prior Authorization Review Process

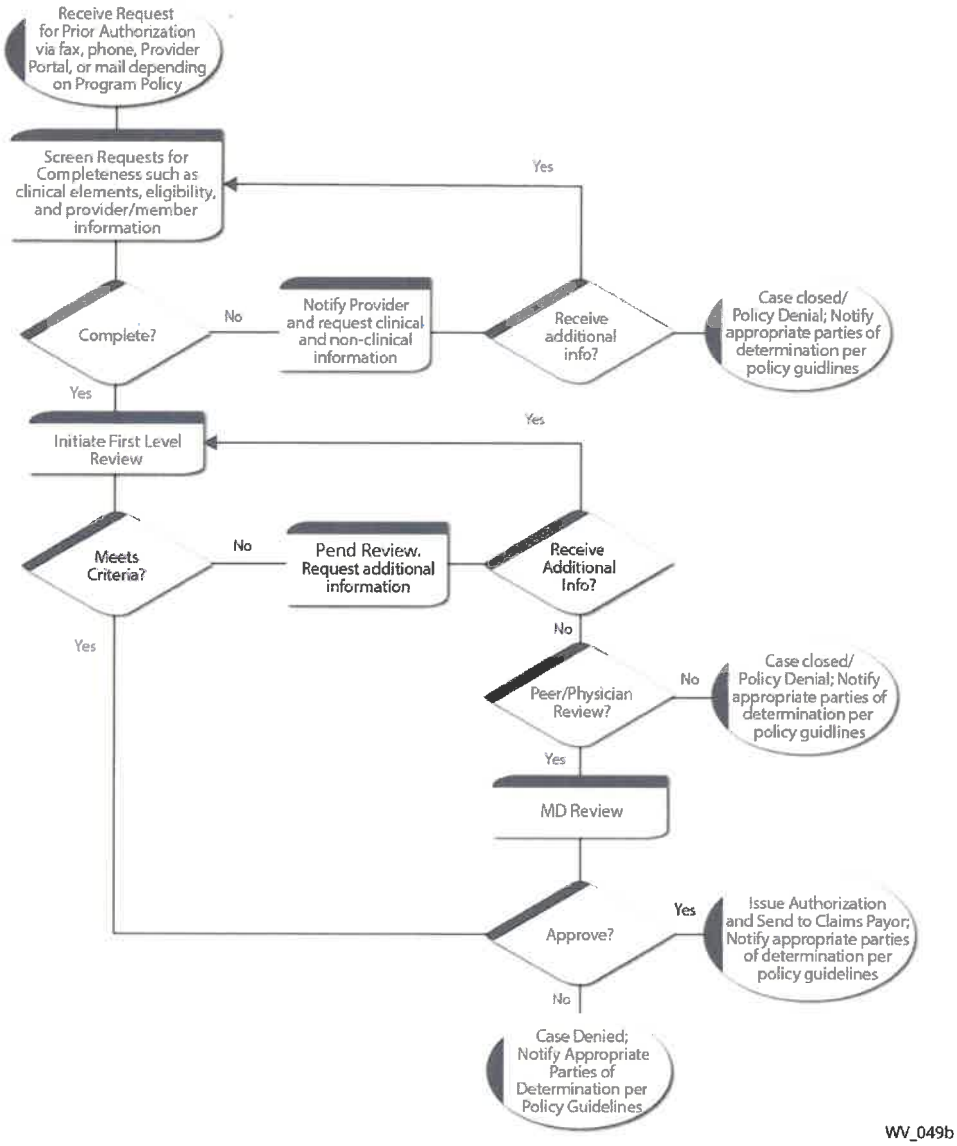


Figure 65. Prior Authorization Review Process

Our PA reviews are straightforward and accommodate client-required criteria.

The prior authorization review process begins with receipt of a request for services. Our clinical reviewer receives the request automatically in real-time via Atrezzo and reviews the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR program

policy. Using these criteria will identify whether the services and items requested are consistent with the provisions of appropriate care. If InterQual® guidelines are not available for a specific service, we have a large library of local evidence-based policies that can be adapted for WV DHHR's consideration.

If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo. The provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the PA request, and a notice is automatically sent to the provider requesting additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to the physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo, and the clinical reviewer finalizes the case. If the case was created by the provider via the Provider Portal, an email notification is automatically sent to the provider.

Receipt of Prior Authorization Requests

Depending on program policy, Kepro offers providers flexibility with convenient options for submitting prior authorization requests via multiple modalities including the Atrezzo portal, telephone, fax, and mail. **Figure 66 Process for Receiving and Processing Prior Authorization Requests** in this section outlines the initial PA request workflow in Atrezzo, whether the request is submitted through the portal or staff enter it into the system.

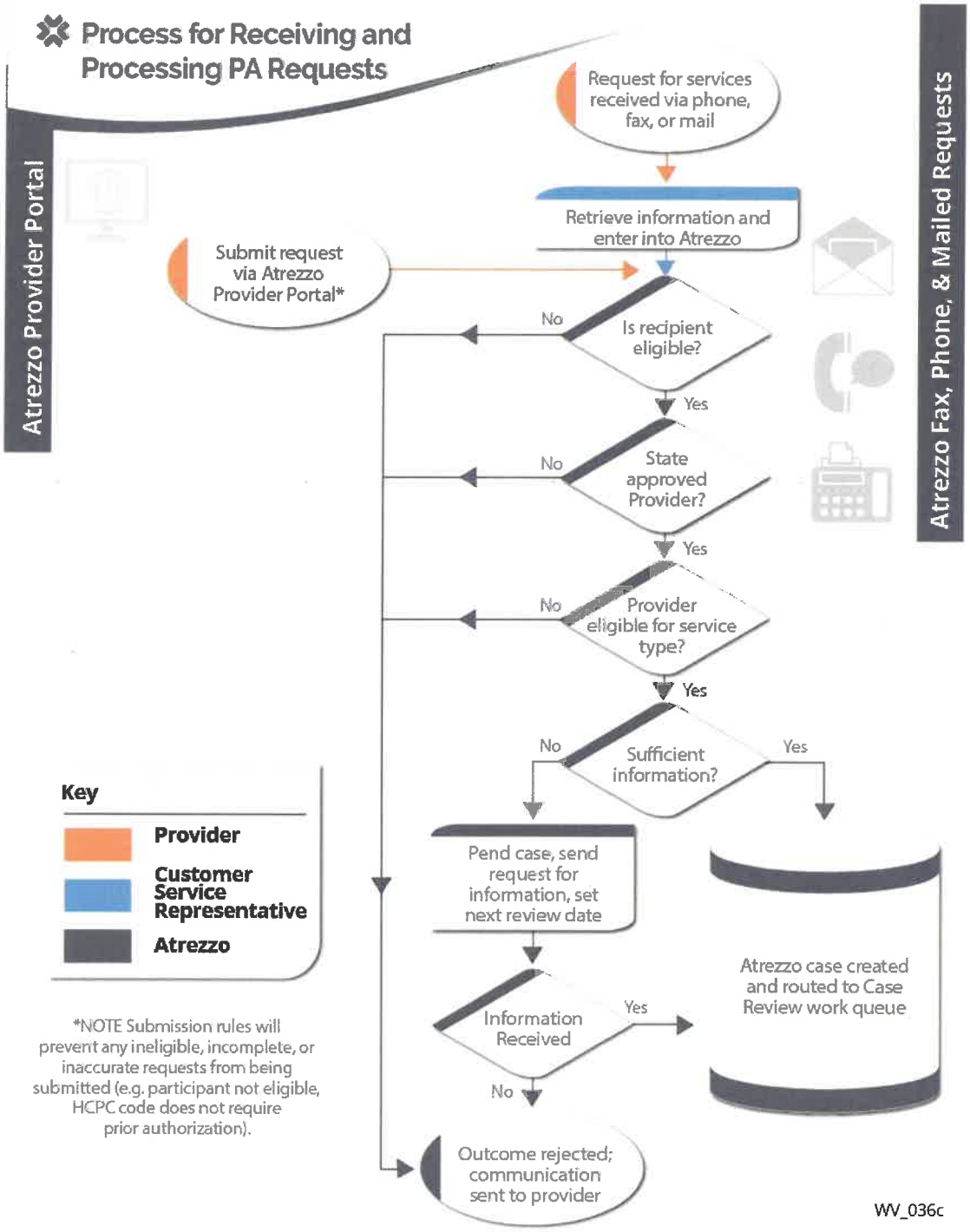


Figure 66. Process for Receiving and Processing Prior Authorization Requests

We will use the above process for receiving and processing of WV DHHR prior authorization requests.

When a PA request is submitted via fax, telephone, or mail our Customer Service Representative (CSR) retrieves the intake information and enters relevant details into Atrezzo. The CSR will record

the date of receipt as the date a mailed, telephonic, or faxed request was received except for requests received after business hours. For requests received after business hours, the date of receipt will be recorded as the next business day. Atrezzo will then automate the remainder of the process, including Medicaid eligibility checks and sending communications to the provider. If the request requires clinical review, the request is automatically routed via Atrezzo workflows to the appropriate clinical review work queue.

We follow the WVCHIP Summary Plan Description relating to policy denials. If it is determined that administrative requirements are not met, the clinical reviewer will document the adverse determination in Atrezzo, and an automated notification is sent to the provider via the Provider Portal. For all adverse determinations, the member receives the denial notification including the fair hearing form. If administrative requirements are met, but the clinical reviewer cannot approve the request due to lack of clinical information, the clinical reviewer will pend the case with notification to the provider via the Provider Portal requesting additional information. If the provider does not fulfill the request for additional information within the allotted timeframe, or, following review of additional information the clinical reviewer cannot approve the case based on medical necessity, the case is routed to a physician reviewer for review.

The physician reviewer will employ medical expertise and best practice when rendering a determination. The physician reviewer documents the determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via USPS.

We complete Concurrent Reviews on inpatient care requests following receipt of all pertinent medical information. Once this review is requested we follow our standard prior authorization process. Prior to termination of the initial number of certified days approved as part of the preadmission process, the facility is required to contact us if the member remains hospitalized, and the provider seeks authorization for additional days.

Concurrent reviews allow for close monitoring of a patient's progress, treatment goals, and objectives established during the inpatient hospitalization stay. It serves to monitor the utilization of services, decreases retrospective denials, and ensures adherence to length of stay. Daily documentation specific to treatment goals and objectives, anticipated length of stay, and discharge planning activities must be completed for each day of hospitalization. Subsequent reviews will be completed as requested, until the member is discharged. Additionally, we have built a step into both the elective and emergency process flows, to reach out to the providing hospital one day before the current end date to send additional documents needed to determine whether a concurrent review is needed. As part of the concurrent review, we will review the discharge plan to determine its adequacy and ensure the member is discharged from the care setting as soon as medically appropriate. This will be completed within 20 business days of receipt of the request.

Retrospective Review

We perform Retrospective Review based on retroactive Medicaid eligibility and admissions occurring on weekends, holidays, or times when the UM review process is unavailable. retrospective reviews must be requested within 12 months of the discharge date. When a retrospective review request is received, an entire review of the information provided during the initial and concurrent review process will be reviewed to validate that all information provided during these reviews were consistent with the medical record documentation and other information provided by the facility that supports the length of stay in an acute hospital. Daily documentation specific to treatment goals and objectives, anticipated LOS and discharge planning activities must be completed for each day of hospitalization.

Our Retrospective Review process follows a similar process to prior authorization review. The retrospective review includes reviewing the member's medical record that corresponds with the date of initial service and subsequent treatment to validate medical necessity throughout the member's length of stay in the inpatient setting. We will check the plan of care for consistency with WV DHHR policy. Daily documentation specific to treatment goals and objectives, anticipated LOS and discharge planning activities must be evident for each day of hospitalization. For inpatient reviews after discharge and prior to billing, the hospital will submit a request for processing. **Figure 67 Retrospective Review Process** illustrates this process.

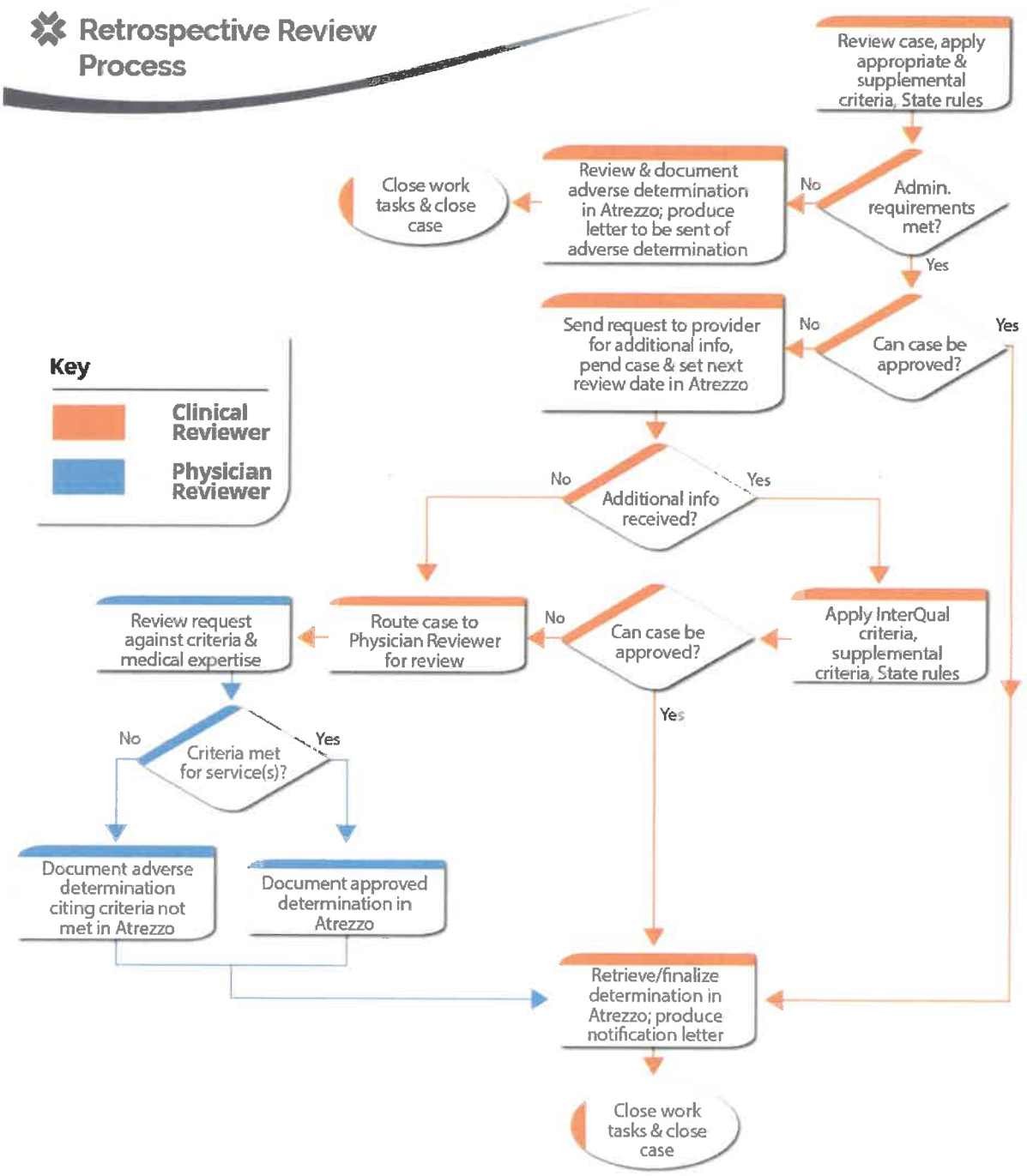


Figure 67. Retrospective Review Process

Our retrospective review process is thorough and can easily accommodate WV DHHR timeframe requirements.

Our clinical reviewer begins the retrospective review by evaluating the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR program rules. Using these criteria will verify whether services and items planned are consistent with the provisions of appropriate care. If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to a physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo, and notification is automatically sent to the provider via the Provider Portal and/or notification is autogenerated via Atrezzo. For all adverse determinations, the member receives the denial notification.

We complete retrospective reviews within 48 hours of the request. We will conduct review of retrospective requests only in compliance with the policy approved by WVCHIP.

If a hospital admission or days were not appropriately pre-authorized, we will deny the admission or days in question. We will not review any medical record for admission which has not been preauthorized prior to the admission and concurrent review completed. This excludes retrospective eligibility cases. If pre-admission review is not documented, the clinical reviewer will consult with the physician reviewer for a denial, as appropriate, the admission or days which required preauthorization but were not preauthorized. The medical record review will also include a review of each emergency admission.

Prior authorization requirements include:

- Applies to all medical inpatient admissions except for those related to maternity services (labor and delivery)
- Services rendered by an eligible provider must be
  - Covered and authorized
  - Rendered by a West Virginia Medicaid enrolled provider
  - Within the scope of the provider's license
  - In accordance with all state and federal requirements

The inpatient facility obtains prior authorization, or the attending physician makes the request on behalf of the facility. The prior authorization covers adjunct services provided by inpatient physicians (such as pathology, Emergency Department, anesthesia, radiology, and laboratory)

unless a specific exception is noted. Inpatient authorizations use Diagnosis-related group (DRG) coding. Per the WVCHIP Summary Plan Description, covered services are inpatient admissions with prior authorization. We currently authorize these services and are prepared to continue our successful management of the program.

A1.5.b. Organ Transplant Services

1. The Agency covers organ transplant services for all eligible members. Organ transplant services are covered when considered safe, effective, and medically necessary and no alternative medical treatment as recognized by the medical community is available. The intended transplant must be performed to manage a disease consistent with recognized standards in the medical community. investigational, research, or experimental procedures are not covered.
2. As a condition for reimbursement, the Agency requires that heart, lung, liver, small bowel, bone marrow, kidney, pancreas, and corneal transplants receive prior authorization. The Agency reserves the right to change the list of covered organ transplants at the discretion of the Agency. Reimbursement for the hospital admission in which the transplant is performed is standard Diagnosis-related group (DRG) reimbursement. Additionally, the hospital will be reimbursed the organ procurement cost at the Center for Organ Recovery & Education (CORE) standard organ procurement cost for each category of organ plus any additional transportation cost associated with the organ acquisition. Donor cost, if not reimbursed by the donor's insurance, may be reimbursed by the Agency Program under the Agency eligible members identification (ID) number.
3. Transplants are not covered when two (2) are performed together, except under the following circumstances:
a. If the primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process.
b. If the damage to the second organ will compromise the outcome of the transplant of the primary organ, multiple organ transplantation may be considered.
4. The Vendor shall determine the medical necessity of transplant applications and requests for extension of benefits for eligible members utilizing the Agency-approved criteria and policies. The Vendor shall ensure determinations transplant applications and requests for extensions of benefits are in accordance with current policies. The Vendor shall have the capability and established procedures to verify the transplant facility is Medicare approved and to determine the existence of other available financial resources.
5. The Vendor shall establish and maintain a procedure for the attending/ordering/referring physician to contact the Vendor's Medical Director to discuss transplant cases that have been denied, modified, or considered for denial. Time frames for notification to the Agency of review outcomes for prior authorization, requests for extensions and retrospective review of transplant services shall be in accordance with current policies.
6. Member selection criteria are based on critical medical need for transplantation and a successful clinical outcome. All other medical and surgical therapies that might be expected to affect short-and long-term survival must have been tried or considered. At a minimum, member selection criteria include the following:
a. Current medical therapy has failed, and the member has failed to respond to appropriate therapeutic management.
b. The member is not in an irreversible terminal state.
c. The transplant is likely to prolong life and restore a range of physical and social function to activities of daily living.

Careful oversight is imperative to the delivery of organ transplant services to ensure their medical necessity and, in turn, reducing the burden on the Medicaid budget. Prior authorization with case management follow-up of these cases assists WVCHIP in containing cost and delivering medically necessary transplants in the appropriate setting, in the most cost-effective manner. Although no organ transplant reviews for WVCHIP were conducted in 2022, the Atrezzo system is configured to

support these reviews and staff are trained on the processes, procedures, expectations, and timelines to complete these reviews.

Prior authorization is required for all transplants, and we use a CM trigger in Atrezzo to flag for transplant patients for review. We currently review requests for prior authorization, which covers the following types of transplants:

- Heart Transplant
- Pancreas/Kidney Transplant
- Bone Marrow Transplant
- Lung Transplant – single and double
- Adult Liver Transplant
- Heart/Lung Transplant
- Pediatric Liver Transplant
- Small Intestine Transplant
- Kidney Transplant
- Cornea

Transplants do not receive coverage when two occur together, except if the:

- Primary organ defect caused damage to a second organ and transplant of the primary organ will eliminate the disease process
- Damage to the second organ will compromise the outcome of the transplant of the primary organ, in this case multiple organ transplantation may be appropriate

Prior Authorization Process - Organ Transplants

The clinical review of organ transplant services occurs within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services**. Our timeframes for notification to the Agency of review outcomes for prior authorization, requests for extensions and retrospective review of transplant services meet current policies.

A case manager will review the request for medical necessity and appropriateness by applying WV Medicaid approved criteria and policies such as InterQual®, the WVCHIP Summary Plan Description, and other approved guidelines. We review medical necessity and appropriateness using InterQual® criteria for those transplants covered by WV Medicaid. If a Medicaid covered transplant does not have an InterQual® criteria set, we use Medicare guidelines or other Medicaid approved guidelines. Due to the documentation requirements, labor intensity, and necessary clinical follow-up, medical case management follows these cases.

Per the WVCHIP Summary Plan Description: Organ Transplants:

- WVCHIP covers certain organ transplants performed in a Medicare-approved transplant facility.

- WVCHIP covers organ transplant services when generally considered safe, effective, and medically necessary and when no alternative medical treatment as recognized by the medical community is available. The intended transplant must be to manage a disease consistent with recognized standards in the medical community. Investigational, research, or experimental procedures are not covered.
- Member selection criteria rely on critical medical need for transplantation and a maximum likelihood of successful clinical outcome. All other possible medical and surgical therapies expected to affect short-and long-term survival must have been tried or considered. At a minimum, member selection criteria include the following:
  - Current medical therapy has failed, and the member has failed to respond to appropriate therapeutic management
  - The member is not in an irreversible terminal state
  - The transplant is likely to prolong life and restore a range of physical and social function to activities of daily living

Additionally, the hospital will receive reimbursement for the organ procurement at the CORE standard organ procurement cost for each category of organ and any additional transportation cost associated with the organ acquisition. The Medicaid program, under the Medicaid-eligible member identifying number may reimburse donor cost, if donor insurance does not cover.

If approved, Atrezzo automatically exports the authorization number to the claims payor via daily file transfer; it is available in the system record and reports tab for referring and servicing providers. Providers who are unable to access the online system and have notified us of their inability to do so receive information by fax or telephone.

All organ transplants are referred to a physician reviewer for determination of approval or denial. Due to the critical nature of organ transplant service, if the initial physician reviewer denies the request, we will expedite the reconsideration by sending the request and all information to a second physician reviewer for a determination. If the second reviewer disagrees with the initial review and approves the request, we will notify all parties of an approval.

We will only deny a request due to lack of medical necessity when two physician reviewers agree to a denial determination. We will attach denial notices to the provider and referring practitioner in Atrezzo - including the policies, criteria not met, and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals. We will communicate the determination and applicable payor limits on requests for an organ transplant to the client or legal representative as well as to the requesting party within 48 hours of receipt of all necessary information.

Peer to Peer Process

Our West Virginia Medical Director, Dr. Paul Kuryla, as well as our physician reviewers, are available to discuss Medical Necessity denial determinations with physicians via Peer-to-Peer

discussion. This process is straightforward, as demonstrated in **Figure 68 Peer-to-Peer Process** and prioritizes support for providers.

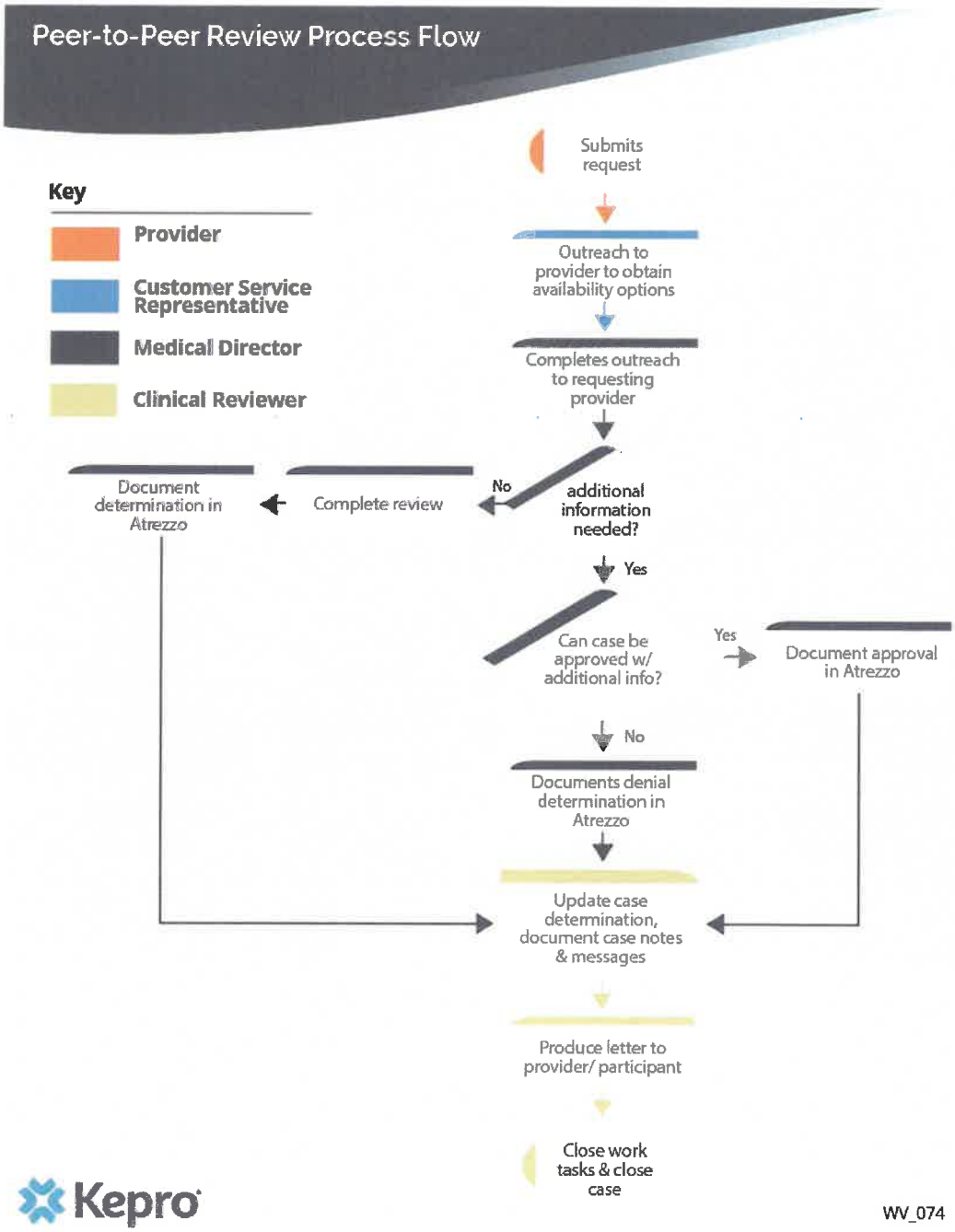


Figure 68. Peer-to-Peer Process
We build support for providers into our process to ensure effective communication.

Per URAC guidelines, upon notification of a denial determination for inpatient services, a Peer-to-Peer discussion is offered to the referring provider. Peer-to-Peer discussions can also be requested for other service types via the Atrezzo Provider Portal as well as through our Call Center. Our clinical reviewer assists in scheduling Peer-to-Peer discussions by first obtaining the requesting provider's full name, office and/or mobile number, and three available dates/times to meet.

The clinical reviewer or Customer Service Representative, if the request was submitted via the call center, then sends the Medical Director or physician reviewer a message or notification via secure portal and/or a secure email marked as "high importance" with:

- The requesting provider's full name and office and/or mobile number.
- The requesting provider's preferred dates and times for the Peer-to-Peer Conversation.
- Patient name and Case ID#
- Example: "Dr. John Doe has requested a Peer-to-Peer with the Medical Director. She is available on Wednesday, 03/28/23 before 3:00pm or Thursday, 03/29/23 between 2:00pm and 4:00pm at 240-555-9999. Member: Initials Only and the Case ID#"

The clinical reviewer then reviews Atrezzo system notes on the Case to confirm that any additional information received prior to the Peer-to-Peer Conversation process is entered into the Case. The reviewer subsequently enters a summary statement in Atrezzo under reviewer notes regarding the requested Peer-to-Peer Conversation, which must include:

- Services being requested
- Guidelines used to review the case
- Reason the case does not meet Medical Necessity requirements per the associated guidelines

The Peer-to-Peer task is generated in Atrezzo and assigned to the identified physician reviewer or Medical Director. Following the meeting review of any additional documentation, the reviewer enters a note in Atrezzo documenting the results of the peer-to-peer conversation. If the denial is upheld, the clinical reviewer does not change the Detail line in Atrezzo showing the denial status on the case but will document the results in the Reviewer Notes section of Atrezzo.

If the result of the peer-to-peer conversation is to reverse the denial, the clinical reviewer updates the Detail line in Atrezzo, reflecting the new decision as Approved and reason as "Peer-to-Peer Conversation." The clinical reviewer also documents the Approval in the Reviewer Notes section in Atrezzo.

Retrospective Review

Our Retrospective Review process follows a similar process to prior authorization review. The retrospective review includes reviewing the member's medical record that corresponds with the date of initial service and subsequent treatment to validate medical necessity throughout the member's length of stay in the inpatient setting. We will ensure the plan of care is consistent with WV DHHR policy. Daily documentation specific to treatment goals and objectives, anticipated LOS

and discharge planning activities must be evident for each day of hospitalization. For inpatient reviews after discharge and prior to billing, the hospital will submit a request for processing. Our Retrospective Review Process is illustrated in **Figure 67. Retrospective Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

Our clinical reviewer begins the retrospective review by evaluating the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR required rules. Using these criteria verifies that services and items planned are consistent with the provisions of appropriate care. If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to a physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo, and notification is automatically sent to the provider via the Provider Portal and/or notification is autogenerated via Atrezzo. For all adverse determinations, the member receives the denial notification.

We complete retrospective reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by WVCHIP.

A1.5.c. Hospice Services

1. The Vendor shall administer prior authorization services for hospice services for eligible members certified as being terminally ill. According to the Patient Protection and Affordable Care Act for Hospice, children under the age of 21 may receive hospice benefits including curative treatment upon the election of the hospice benefit without foregoing any other service to which the child is entitled. Members enrolled in Home and Community-Based (HCBS) Waiver programs cannot receive hospice benefits simultaneously that duplicate HCBS Waiver services. As a condition for reimbursement, the Agency requires that hospice services receive authorization. If the member is receiving any other Agency service, the Waiver service is considered primary. Authorization may occur before or after admission to hospice services. Authorization(s) must be specific to the member, provider agency, service code, units, start and end date. The units, start and end dates in the authorizations may subsequently be modified/edited as necessary.
2. The Vendor shall have established procedures and sufficient capacity to receive review requests, required forms, the member's medical history and physical examinations, additional medical documentation and other forms or documentation required for prior authorization of hospice services.
3. 1he Vendor shall determine the medical necessity of certification and recertification requests for eligible only members, as well as admission and continued stay reviews for dual eligible (Medicare/Medicaid) members electing hospice services to eligible members utilizing the Agency approved criteria and policies. The Vendor shall

also determine medical necessity and approval processes for members receiving hospice services while residing in a nursing facility.

a. Authorization Requests (Medicaid Only Members): The Vendor shall have the capability and established procedures to receive certification reviews for the initiation of a hospice enrollment period for a member with Medicaid only benefits. The Vendor shall ensure determinations for certification requests are completed in accordance with current policies.

b. Admission Reviews (Dual Eligible Members): Dual Eligible Members are defined as members who have both Medicare and Medicaid. The Vendor shall have the capability and established procedures to receive admission reviews for the initiation of a hospice enrollment period for a member with Medicare and Medicaid benefits. The Vendor shall ensure determinations for admission reviews are in accordance with current policies.

c. Recertification Requests (Medicaid Only Members and Dual Eligible Members): The Vendor shall have the capability and established procedures to receive subsequent review requests to determine if continuation of a hospice benefit period is medically necessary. The Vendor shall ensure determinations for recertification requests are completed in accordance with current policies.

4. The Vendor shall have the capability to develop educational trainings and provide technical assistance, at no additional cost to the Agency, regarding policies, available services, service delivery models, and any other information requested by the Agency for members, families, provider agencies, stakeholders and the general community via email, telephone, webinars etc., at no additional cost. To include but not limited to:

a. Plan, advertise and produce statewide trainings and webinars at the request of the Agency.

b. Communicate program announcements to providers, members, and other stakeholders as necessary, at no additional cost to the Agency.

c. Participate in conference calls at the request of the Agency.

d. Offer Continuing Education Units (CEUs) for Nurses, Counselors and Licensed Social Workers that attend attending training sessions.

5. The Vendor will enroll the Medicaid/Medicare Member in Case Management as needed based on length of stay in Hospice program.

6. The Vendor will notify the Agency weekly and the member's Case Manager upon authorization of members who receive services from a waiver program or the personal care program who are also receiving hospice services.

7. The Vendor will collect and report data regarding the utilization and quality of Hospice services as required by the Agency.

We have four years of experience performing hospice reviews for several states, including West Virginia, where we conducted 1 review since the start of the WVCHIP contract in 2019. We conduct medical record reviews of Medicaid members continuously enrolled Long Term Hospice care in West Virginia, Alabama, Minnesota, and South Carolina as well as in Hillsborough County, Florida and additionally for our commercial contracts with National Elevator Industry Benefit Plans, Mississippi State Employees, and the United Mine Workers of America. In West Virginia, we currently reviews and authorizes Hospice requests for Routine Home Care; Continuous Home Care; Inpatient Respite Care, and General Inpatient Care. We apply our extensive experience to the Hospice review processes, policies, and procedures. We understand the specific requirements of WV DHHR's hospice benefit. Our Atrezzo system is equipped to incorporate any additional supporting guidance in the review, such as the health plan's own benefit rules/structure, internally developed criteria, and/or specialty society criteria.

Hospice Clinical Review

We perform clinical review of hospice services requests, pursuant to the criteria established in the West Virginia Medicaid Manual Chapter 509 and Local Medical Policies (LMPs). For a hospice records review, our clinical reviewer first verifies that all applicable policies, and program and administrative requirements, are met and then evaluates the clinical information submitted by the provider along with any supporting documentation. Upon submission, clinical reviewers verify that the member is in fact eligible for the benefit, that all data elements are completed on the form and are signed by the physician. The clinical reviewer compares the information to the applicable first level review clinical decision support tools, such as InterQual®, which also indicates appropriate length of stay and triggers for continued stay based on the member's medical status.

Prior to seeking authorization for hospice services within the community, the member will have active Medicaid eligibility and be included in Gainwell eligibility file in Atrezzo. A Medicaid eligible enrolled hospice provider accepts the referral from the member's physician who has completed the Hospice Election Form (HEF1) and the Certification of Terminal Illness (CTI).

Prior to seeking authorization for hospice services within the nursing home, the member must have active Medicaid coverage and the claims payor and WVCHIP will have been notified via the Notification of Contribution of Cost of Care (DFA-NH-3). A Medicaid eligible enrolled hospice provider accepts the referral from the member's physician and care team. The physician and care team complete the HEF1 and the CTI.

The clinical review process for hospice is outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.** Our clinical review process for hospice is broken down into ten key steps. First, verification of member Medicaid eligibility, coverage and service eligibility takes place, which is executed through the standard verification processes described throughout this proposal. Verification of provider Medicaid status also takes place during this stage of the process, where prior authorization requests are only accepted from providers enrolled in the WV Medicaid program. If the requestor is not a participating Medicaid provider, we will contact the provider within one working day and inform them we cannot process the request before establishing their participation status in the program. Verification of other payor sources, coverage status of the service, and service limitations also take part during this first step.

The second step of the process is to determine if the request is complete. If the request does not have all the required information, we will suspend the request and place it in a pending status. Following verification of covered service status and completeness, a clinical reviewer evaluates the request to determine if the service is medically necessary and appropriate as the third step. Documentation reviewed for medical necessity includes certification of terminal illness (CTI), hospice election form (HEF1), and the Palliative Performance Score (PPS). If the request is approved by the clinical reviewer, the fourth step of our process dictates that the system will export the authorization number to the claims payor in a daily file.

After referral from the nurse level for physician review, we will complete admission decisions requiring physician review within 24 hours as step five. If it is approved by the physician reviewer, our team would then follow the same process described in step four. Alternatively, step six of our process details that if the request is denied after the physician review determination, we will attach denial notices to the provider, referring practitioner, and servicing provider in Atrezzo and accessible via the Provider Portal. This notification includes the policies and criteria that were not met, and we will send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals. **Figure 69** outlines our **Reconsideration Process**.

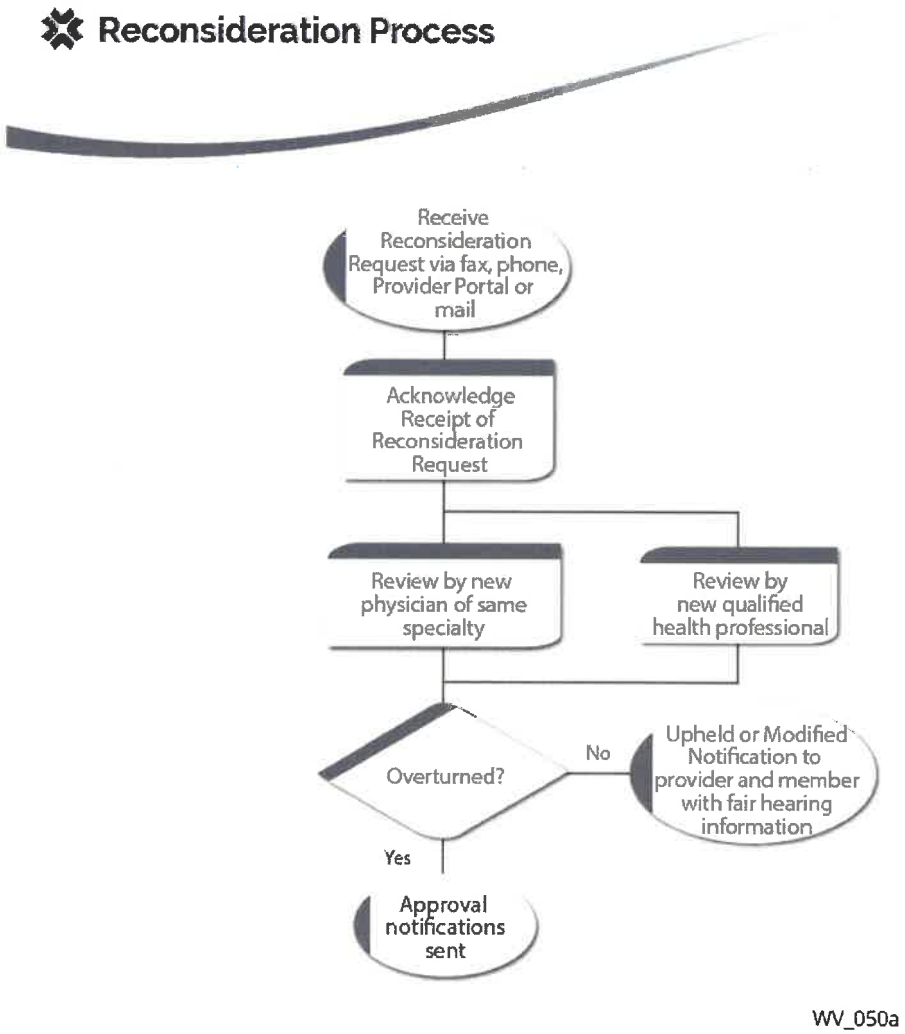
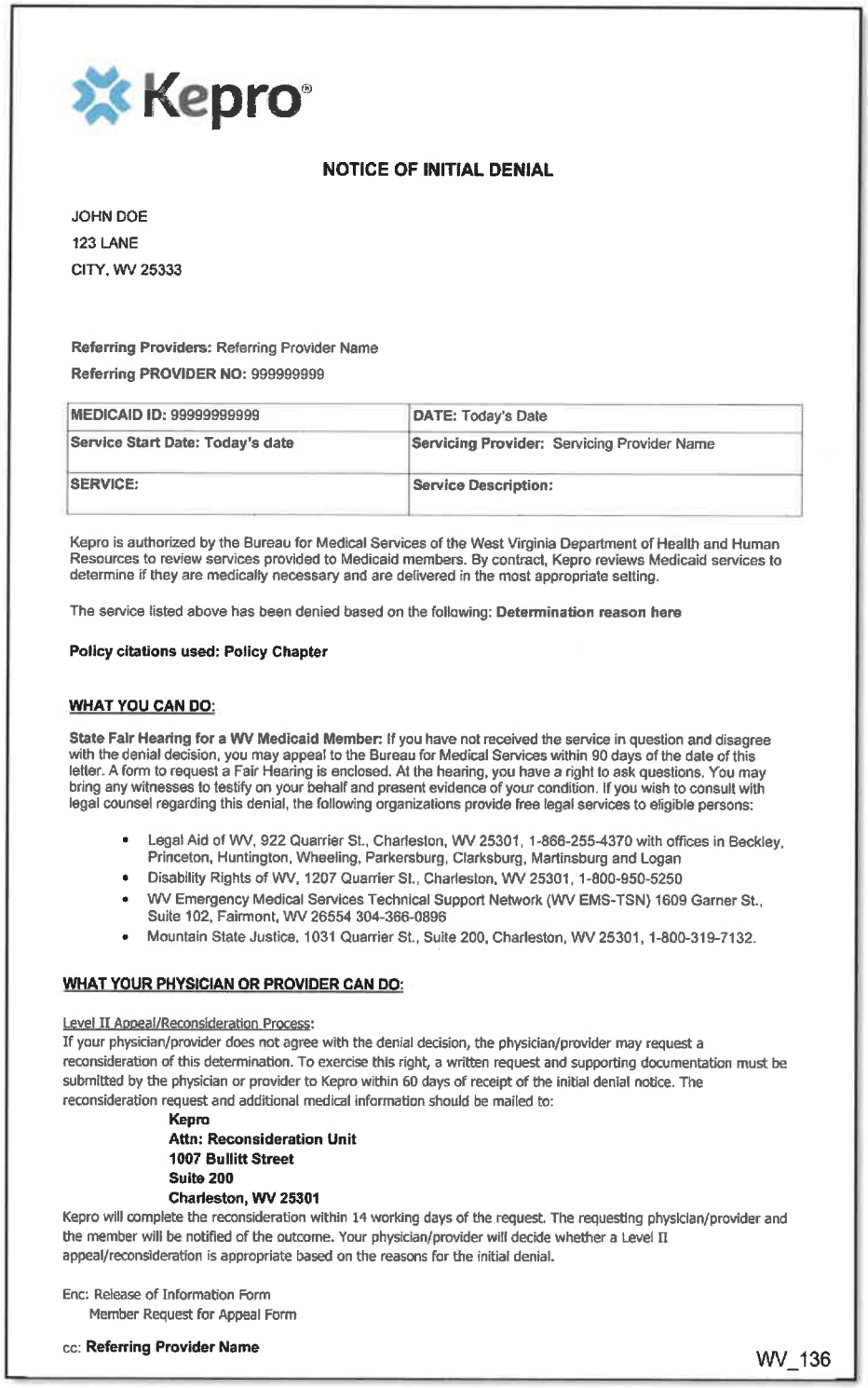


Figure 69. Reconsideration Process
Our reconsideration process efficiently accommodates WV DHHR timeframe requirements.

Providers may request reconsideration of an initial denial within 60 days of the denial notification, and our response to reconsideration requests documents that we will review reconsideration

requests within 7 calendar days for expedited requests and 14 calendar days for non-urgent requests. We send reconsideration determination notices to the provider and referring practitioner. Additionally, if the physician reviewer reverses the initial decision, we will send the approval decision to the MMIS, and members may request an appeal of a denial of services not yet provided. We will also prepare documentation necessary to process the member's appeal.

We will perform clinical determinations within five business days of receipt. The availability of qualified clinical reviewers is the most critical aspect of ensuring timeliness. All records reviews will be conducted by licensed clinical staff with a scope of practice that is relevant to the clinical areas addressed. Our clinical staff use InterQual® Medical Necessity Review Criteria and/or WV DHHR-required Medical Necessity Review Criteria when conducting utilization reviews. **Figure 70 Sample West Virginia Member Denial Letter** shows a sample member communication.



Kepro®

NOTICE OF INITIAL DENIAL

JOHN DOE
123 LANE
CITY, WV 25333

Referring Providers: Referring Provider Name
Referring PROVIDER NO: 999999999

MEDICAID ID: 99999999999	**DATE:** Today's Date
Service Start Date: Today's date	**Servicing Provider:** Servicing Provider Name
SERVICE:	**Service Description:**

Kepro is authorized by the Bureau for Medical Services of the West Virginia Department of Health and Human Resources to review services provided to Medicaid members. By contract, Kepro reviews Medicaid services to determine if they are medically necessary and are delivered in the most appropriate setting.

The service listed above has been denied based on the following: **Determination reason here**

Policy citations used: Policy Chapter

WHAT YOU CAN DO:

State Fair Hearing for a WV Medicaid Member: If you have not received the service in question and disagree with the denial decision, you may appeal to the Bureau for Medical Services within 90 days of the date of this letter. A form to request a Fair Hearing is enclosed. At the hearing, you have a right to ask questions. You may bring any witnesses to testify on your behalf and present evidence of your condition. If you wish to consult with legal counsel regarding this denial, the following organizations provide free legal services to eligible persons:

- Legal Aid of WV, 922 Quarrier St., Charleston, WV 25301, 1-866-255-4370 with offices in Beckley, Princeton, Huntington, Wheeling, Parkersburg, Clarksburg, Martinsburg and Logan
- Disability Rights of WV, 1207 Quarrier St., Charleston, WV 25301, 1-800-950-5250
- WV Emergency Medical Services Technical Support Network (WV EMS-TSN) 1609 Garner St., Suite 102, Fairmont, WV 26554 304-366-0896
- Mountain State Justice, 1031 Quarrier St., Suite 200, Charleston, WV 25301, 1-800-319-7132.

WHAT YOUR PHYSICIAN OR PROVIDER CAN DO:

Level II Appeal/Reconsideration Process:
If your physician/provider does not agree with the denial decision, the physician/provider may request a reconsideration of this determination. To exercise this right, a written request and supporting documentation must be submitted by the physician or provider to Kepro within 60 days of receipt of the initial denial notice. The reconsideration request and additional medical information should be mailed to:

Kepro
Attn: Reconsideration Unit
1007 Bullitt Street
Suite 200
Charleston, WV 25301

Kepro will complete the reconsideration within 14 working days of the request. The requesting physician/provider and the member will be notified of the outcome. Your physician/provider will decide whether a Level II appeal/reconsideration is appropriate based on the reasons for the initial denial.

Enc: Release of Information Form
Member Request for Appeal Form

cc: **Referring Provider Name**

WV_136

Figure 70. Sample West Virginia Member Denial Letter

Our automated communications include all relevant stakeholders to streamline all notification processes.

Atrezzo automation enables timely and efficient review of hospice records. Atrezzo has a core functionality of providing status updates, alerts, and status tracking capabilities to relevant users. Atrezzo delivers the capability to automatically create notifications and alerts, make those notifications and alerts visible to all relevant personnel, and track those notifications and alerts as the review moves through the Atrezzo workflow. Alerts can be added either through automated rules or manually, and the status – either "Pending," "Active Review" or "Completed" - are visible to all users. These status indications help Atrezzo manage and keep WV DHHR informed as to the current volumes and turnaround times for review completion ensuring Kepro is meeting or exceeding your requirements for timeliness.

Hospice Level of Care reviews

We will follow a standard prospective clinical review process for Hospice Level of Care (LOC) reviews, however prior to closing the case, the clinical reviewer will schedule the case for reassessment. **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services** outlines the process to be used for Hospice LOC reviews with the exception that the clinical reviewer will create a task in Atrezzo for 90/60 calendar days before current end date to remind the provider to send documents for reassessment.

We will perform a reassessment or extension of LOC cases after initial approval every 90 or 60 calendar days (additional 60 calendar days if hospice care is appropriately outlined and in accordance with WVCHIP policies. Additionally, our process can accommodate reassessment of hospice benefit periods lasting two, 90-day periods or an additional 60-day period that lasts until revocation or termination for other reasons such as ineligibility or death.

Training and Technical Assistance

Additionally, we will develop educational trainings to Hospice providers regarding policy, available services, service delivery models, and any other topics requested by WVCHIP. We will provide CEUs for RNs, counselors and Licensed Social Workers developed in conjunction with the WVCHIP. We use RNs to assist in developing topic specific CEUs, which are also in compliance with Board of Nursing and Social Work education requirements.

We provide technical assistance as requested by individual providers or to all Hospice providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will participate in and conduct training for members and other stakeholders as requested by the Agency. We will participate in conference calls at the request of the Agency.

A1.5.d. Durable Medical Equipment, Prosthetics, Orthotics and Supplies

1. The Agency covers medical equipment, prosthetics, orthotics, and supplies (DMEPOS) for all eligible members. As a condition for reimbursement, the Agency requires that DMEPOS identified in the Agency Policy.

We have 30 years of experience performing prior authorization for DMEPOS across nine states, including West Virginia, Alabama, Colorado, South Carolina, Virginia, North Dakota, Illinois, Florida, and Pennsylvania. In 2022, we conducted nearly 23,000 DMEPOS reviews for the state of West Virginia. Our breadth of experience leaves our teams uniquely qualified to apply best practices learned in those programs within WV DHHR's UM and PA program, enabling WV DHHR to reap the advantages of tried and tested processes.

BMS' policy to provide the most cost-effective equipment that meets the members' need coupled with InterQual screening criteria for medical necessity is successful for cost containment in the current UM contract. There are Local Medical policies approved for some services based on the requirements of Chapter 506. Our clinical reviewers will continue to work with BMS in the new contract to refine DMEPOS criteria and ensure that this program continues to be both cost effective and efficient.

We will also continue to work with BMS to identify areas for additional cost savings. We take care to consistently add value to our clients' programs in this and other ways. In West Virginia We have worked closely with BMS and providers to educate them on a variety of cost saving measures regarding DME requests. Education topics have included:

- High cost DMEPOS equipment
- Enrolling members in our Care Management system to follow and track their services
- Obtaining Certificates of Medical Necessity
- Prescriptions
- Explanation of Benefits
- Cost calculation and invoice forms
- Verifying DME credential in Gainwell and Atrezzo systems

We have also provided extensive training for providers in submitting prior authorization requests and medical reviews. Trainings conducted focused on every aspect of the submittal process, including the documentation needed for submission and review and using our systems effectively.

Our highly flexible system and its configurable rules engine further allow us to customize criteria to WV DHHR needs. During the prior authorization review of services, our system can use InterQual® criteria, federal regulations, and any State policies. Kepro uses InterQual® Criteria as the baseline of our review. If InterQual® criteria are not available for a specific item or services, We have a large library of local medical policies that can be adapted to specific contracts. Our customizable platform guarantees continual alignment with potential WV DHHR updates to applicable policies.

We will perform prior authorization of designated DMEPOS to determine if the service is medically necessary and clinically appropriate as outlined in Chapter 506. We can attach prior authorization check lists to the Provider Portal, which uses an alert system to ensure all required information is submitted with each DME request. We will use the process outlined in **Figure 71 DMEPOS Prior Authorization Process** to perform prior authorizations of DMEPOS.

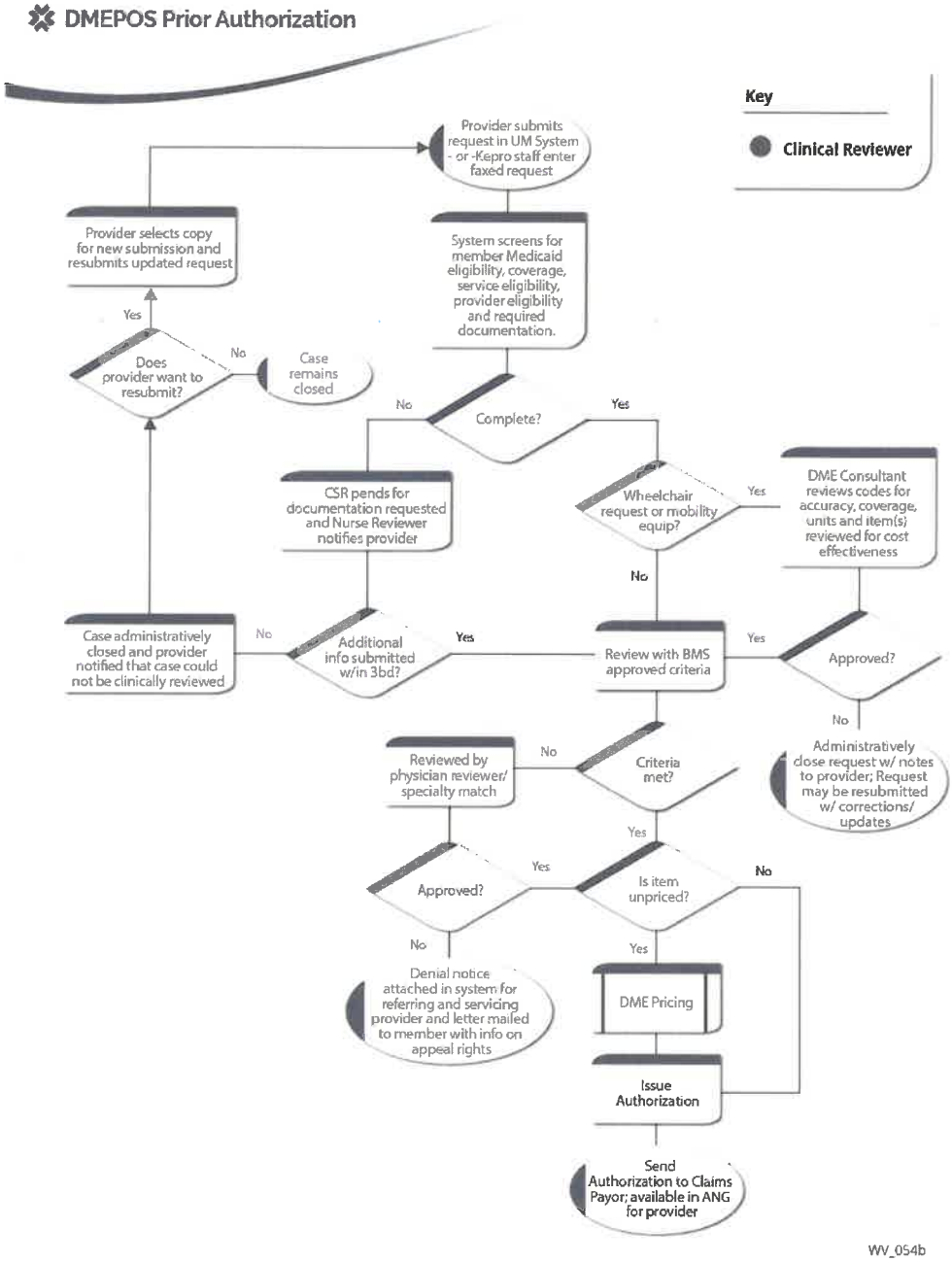


Figure 71. DMEPOS Prior Authorization Process

Our DMEPOS processes are built on decades of clinical experience performing these services.

The prior authorization process begins upon receipt of the prior authorization request for DMEPOS. First, Atrezzo verifies of the following:

- Member Medicaid eligibility, coverage, service eligibility
- Provider Medicaid status. We will only accept prior authorization requests from providers enrolled in the WV Medicaid program. We will use the provider file received from the Bureau's MMIS vendor to verify the requestor as a Medicaid participating provider. If the requestor is not a participating Medicaid provider, we will contact the provider within one working day and inform them that we cannot process the request before establishing their participation status in the program. (Please see Section A1.1.t Out-of-Network Services, for more details on this process.) Additionally, enrolled providers must register with Kepro to gain access to the Provider Portal.
- Other payor sources. Our review staff will use the MMIS system, as well as information gathered during the review process to establish whether an alternative payor may be responsible for the services requested. If we can establish an alternative payor, we will notify the provider through messaging on the request.
- The service requested is a covered service. Atrezzo has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, the system configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. Our staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see Section A1.1.aa Expanded EPSDT Services and Criteria Development for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.
- Service limitations: our team verifies that the request is within any service limitations attached to the coverage at the time of the request.

Upon eligibility verification, our clinical reviewer receives the request automatically and in real-time via Atrezzo and reviews the clinical information based on the appropriate criteria and client-required rules. Our systems ensure that vital aspects of the DME review process are efficient and accurate. An example is Atrezzo's ability to check for duplication of services, which may include:

- Either the same service or equipment is provided by more than one provider during the same time period
- A specific DME that is only authorized periodically. For example, electric wheelchairs may be authorized for members only every five years. Reviewers check the system for claims to determine whether this same equipment was authorized and delivered to the member within the designated timeframe. If there is evidence of prior authorizations, reviewers contact

providers to determine the need for this repeat request. Replacement or repairs will be processed in accordance with WV DHHR policy and regulations.

- Our reviewers have considerable experience in evaluating repair compared to replacement and renting compared to purchase of DMEs. Repairs are not authorized if the cost of the repair equals or exceeds the purchase price of the item. However, they also consider the cost associated with renting a replacement item during the estimated period of repair when making a determination. They also determine the cost of renting equipment for the estimated required period of time compared to the cost of purchasing the same equipment.

When a clinical reviewer pulls a DMEPOS case from queue, they will first determine if the request is complete. If a request is incomplete (i.e., does not have all the required information), we will suspend the request and place it in a pending status documentation requested. The provider receives a message in the system and contacted within one business day to obtain the necessary additional information and/or correct errors. If we do not receive additional information within three business days, we close the request administratively. The provider may resubmit the request by selecting copy for new submission and updating the request or by resubmitting the request by fax with the additional information. If the clinical reviewer is still unable to approve the request after receipt of additional information, we refer the review to a physician with all available information.

If administrative requirements are met, but the clinical reviewer cannot approve the request due to lack of clinical information, the clinical reviewer pends the request with automatic notification to the provider via the Provider Portal requesting additional information. If the provider does not fulfill the request for additional information within the allotted timeframe, or, following review of additional information the clinical reviewer cannot approve the case based on medical necessity, the case is routed to a physician reviewer for review. The physician reviewer documents the determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via mail.

After administrative requirements are verified, the clinical reviewer will determine if the service is medically necessary and appropriate. Currently, we use InterQual® DME criteria as the Bureau for Medical Services previously approved. There are local medical policies for some items and supplies. Additionally, if the request is for a wheelchair or other mobility equipment, a DME Consultant reviews the request for accuracy, coverage, units, appropriate coding and verifies that the item is the most cost effective for the member's needs.

If approved by the clinical reviewer, Atrezzo exports the authorization number to the claims payor in a daily file. It is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability by fax or telephone. If the item does not have a price, we do not release the authorization until the provider attaches an unaltered cost invoice to the record and enters the

cost into the system for exporting in the prior authorization file. Cases awaiting pricing are in a status hold for pricing for 30 days. The system prompts the provider at multiple points to send the invoice. Vendors cannot place equipment without authorization.

After referral from the nurse level for physician review, we will complete admission decisions requiring physician review within 24 hours. If approved by the physician reviewer, Atrezzo exports the authorization number to the claims payor in a daily file. It is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability to do so by fax or telephone.

If denied after physician review determination, we will attach denial notices to the provider, referring practitioner and servicing provider in Atrezzo. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

DMEPOS Pricing

During the prior authorization process, if an item requested does not have an associated cost, our team calculates pricing for the DME using the process outlined in **Figure 72 DMEPOS Pricing.**

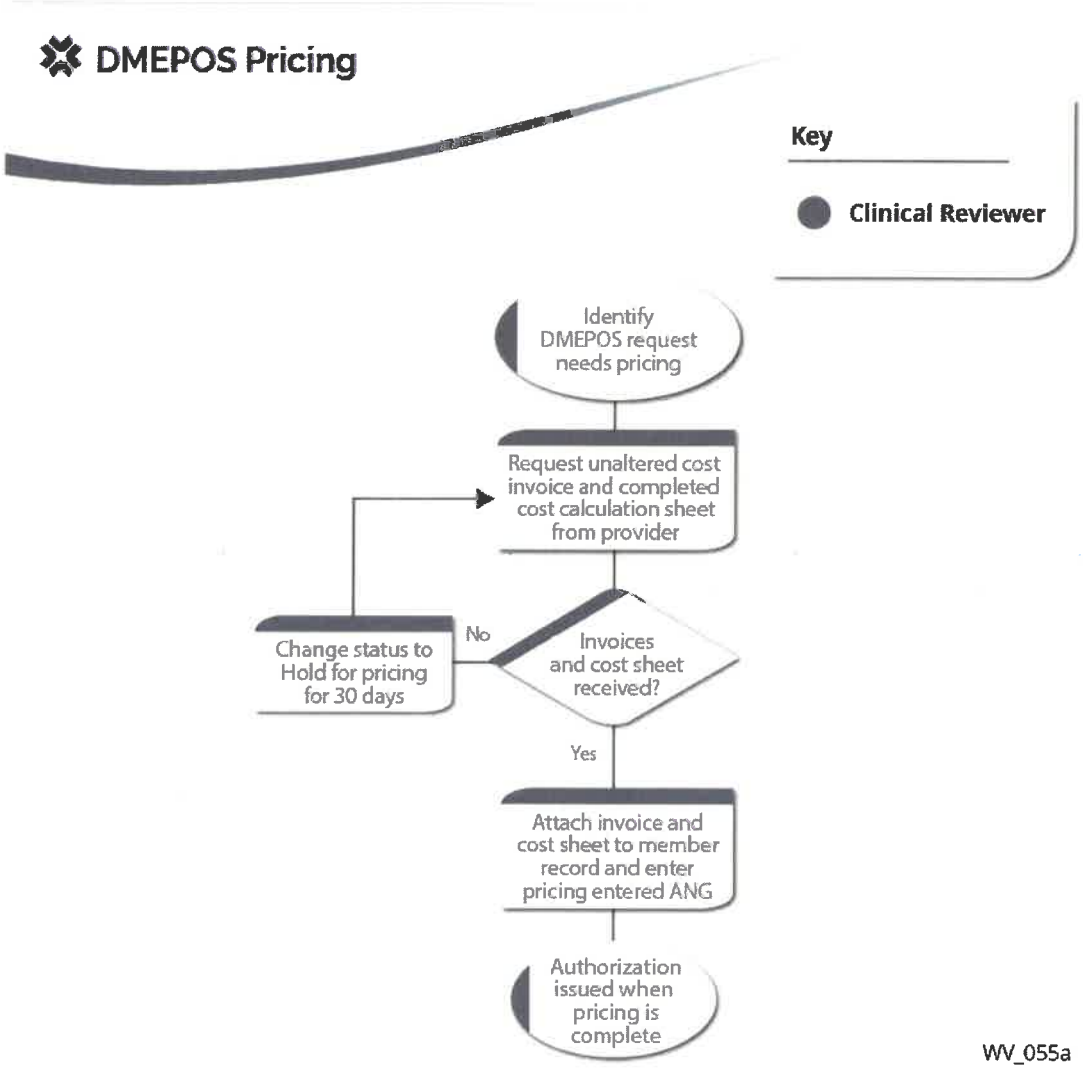


Figure 72. DMEPOS Pricing

Our clinical reviewers ensure authorizations are issued on completed requests within 30 days of request receipt.

When it is identified that DMEPOS pricing is required, our clinical reviewer will request an unaltered cost invoice and completed cost calculation sheet from the provider. Upon receipt, the clinical reviewer will attach the invoice and cost sheet to the member record and enter the pricing into Atrezzo. After the pricing is completed, an authorization number is issued. If the required documentation is not received from the provider after 30 days, the clinical reviewer will send a second request for the required documentation to complete pricing.

providers may request reconsideration of an initial denial within 60 days of the denial notification. The request must include any additional information they want reviewed by the physician. We then forward the initial review information, reconsideration request, and additional information to another board-certified MD/DO with specialty match for a final determination.

Response to reconsideration requests: we will review reconsideration requests within two business days of the request and will send reconsideration determination notices to the provider and referring practitioner via the system at the reconsideration request level. The member or member's representative will receive notice of the reconsideration and the outcome, via USPS. If the initial denial is upheld the member letter includes information on the information on the right to fair hearing, with instructions on how to proceed.

Reconsiderations resulting in reversals: If we reverse the initial decision, we will send the approval decision to the MMIS. The process for reconsideration is in the workflow in **Figure 69 Reconsideration Process in Section A1.5.c Hospice Services**.

Obtaining an appeal: Members may request an appeal of a denial of services not yet provided. we will prepare documentation necessary to process the member's appeal.

A1.5.e. Vision Services

1. The Agency covers vision care services for the examination, diagnosis, treatment, and management of ocular and adnexal pathology. This includes diagnostic testing, treatment of eye disease or infection, specialist consultations and referral, comprehensive ophthalmologic evaluations, and eye surgery (but not cosmetic surgery). Visual examinations to determine the need for eyeglasses are covered for members under 21 only. Full vision care benefits are available for members under 21 years of age. Limited vision care benefits are available for members 21 years and older. There is no coverage for cosmetic purposes.

Under our current UM and PA Services contract, we complete prior authorization services for several outpatient procedures involving vision related conditions. For example, blepharoplasties, repairs for entropion and ectropion disorders, and lagophthalmos corrections. InterQual® has criteria for a number of these surgical procedures and we use them to review these requests. However, some procedures do not have specific criteria. In these instances, we use the WVCHIP specifications, and a board-certified ophthalmologist reviews the request. We understands the coverage differences for vision care benefits between members 20 and under and those 21 and over.

Since 2019 we received seven Vision Services review requests. The clinical review of vision services process will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

Following verification of covered service status and completeness, the clinical reviewer evaluates the request to determine if the service to be provided is medically necessary and appropriate, and

if the service should be approved or referred to physician review. Currently we use InterQual® Criteria sets (InterQual Adult & Pediatric, InterQual Procedures & Acute) as previously approved by the WVCHIP. Services for which there are no InterQual criteria available go directly to physician review. We will research clinically sound criteria for these services and submit them for WVCHIP approval in the next contract cycle.

If approved by the clinical reviewer, Atrezzo exports the authorization number to the claims payor in a daily file. It is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified Kepro of their inability by fax or telephone.

If Physician Review is required, we will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, Atrezzo exports the authorization number to the claims payor in a daily file as described above.

If a prior authorization request is denied after a physician review determination, we will attach denial notices to the provider, referring practitioner and servicing provider in Atrezzo. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

A1.5.f. Audiology Services

1. The Agency covers medically necessary audiology services to members under 21 years of age. Services provided on or after the 21st birthday are not eligible for reimbursement. Audiology covered services include mandatory newborn hearing screens, one (1) initial evaluation per calendar year to determine hearing capability, two (2) re-evaluations per calendar year, diagnostic audiology testing, Cochlear implants, hearing aids and batteries. Replacement of Cochlear implants, hearing aids and/or accessories require prior authorization.

We conduct prior authorization reviews of speech, language, and audiology services to include hearing aids, speech generating devices and cochlear implants and will continue to provide this service subject to WVCHIP. We have designed the Atrezzo portal to clearly assist both speech and audiology providers by reflecting the current audiology services requiring prior authorization as outlined in the WVCHIP Summary Plan Description. Included in the review process for this area are consultants: licensed speech therapists and audiologists who conduct reviews to ensure compliance with WVCHIP policy for these services.

Prior authorization requests may be entered directly into the submission portal by the provider. If a prior authorization request is submitted via fax, telephone, or mail our Customer Service Representative (CSR) retrieves the intake information and enters relevant details into Atrezzo. The CSR will record the date of receipt as the date a mailed, telephonic, or faxed request was received by Kepro, except for requests received after business hours. For requests received after business hours, the date of receipt will be recorded as the next business day. Atrezzo will then automate the remainder of the eligibility process, including Medicaid eligibility checks and sending

communications to the provider automatically. If the request requires clinical review, the request is automatically routed via Atrezzo workflows to the appropriate clinical review work queue.

Atrezzo also assists our staff in provider enrollment verification. We receive a provider enrollment file from the fiscal agent, which contains data for active and credentialed, or enrolled, providers with WV Medicaid and WVCHIP. The enrollment file allows our staff to quickly and efficiently verify that a provider is appropriately enrolled.

In 2022, we conducted a total of six audiology reviews. The clinical review of audiology services process will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient/Medical Surgical Services.**

When determining if the service requested is a covered service, Atrezzo has validation rules, which only allow providers to request covered services requiring prior authorization. Additionally, Atrezzo configuration includes policy restrictions on age, service limits, lifetime benefits and diagnostic restrictions. Our staff can key requests for policy exceptions or non-covered services at the request of the Bureau (also see **EPSDT in Section A1.1.aa** for a description of this program, which allows for prior authorization of non-covered services under EPSDT requirements). We confirm that the service conforms to current Medicaid program coverage policy and benefit limitations and highlight any exceptions as pend reasons for the reviewer to evaluate. If the provider requested the service by fax (and it is not EPSDT) and we determine they are a non-covered benefit, we will advise the requestor, not enter the request, and discontinue the review.

We verify that the request is within any service limitations attached to the coverage at the time of the request.

If a request is incomplete, as in it does not have all the required information, we will suspend the request and place it in a pending status documentation requested. The provider receives a message via the Provider Portal within one business day to obtain the necessary additional information and/or correct errors. If we do not receive additional information within three business days, we close the request administratively. The provider may resubmit the request by selecting copy for new submission and updating the request or by resubmitting the request by fax with the additional information. If the clinical reviewer is still unable to approve the request after receipt of additional information, we refer the review to a physician with all available information.

Following verification of covered service status and completeness, a clinical reviewer evaluates the request to determine if the service requested is medically necessary and appropriate, and if the service should be approved or referred to physician review. We use WVCHIP criteria with consultant review; Speech Generating Device (SGD) InterQual Criteria; InterQual Hearing Aid criteria (with local edits); Cochlear implants WVCHIP criteria and InterQual criteria. We will research additional clinically sound criteria for these services and submit them for WVCHIP approval in the next contract cycle.

If the audiology consultant reviewer approves the request, Atrezzo exports the authorization number to the claims payor in a daily file; it is available in the system record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified our team of their inability by fax or telephone.

After referral from the audiology consultant level for physician review, we will complete admission decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payor in a daily file. It is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability to do so by fax or telephone.

If the request is denied after physician review determination, we will attach denial notices to the provider, referring practitioner and servicing provider in the Provider Portal. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

A1.5.g. Outpatient Physical, Occupational, and Speech Therapy

1. The Agency covers outpatient physical, occupational, and speech therapy services for all eligible members.

We began providing Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy for WV DHHR in 2019. Since that time, we have worked with the state to streamline our approach and maximize efficiency in our processes and program offerings to ensure we have sufficient resources to address contract deliverables and WV DHHR needs. Our commitment to successfully delivering contract requirements is further underscored by our consistently timeliness. We provide a monthly report card of service activities and remained timely for this service level agreement 95% of the time in 2022.

High volumes are a particular focus. Since 2019 we conducted over 1,200 Outpatient Physical Therapy, Occupational Therapy, and Speech Therapy reviews for West Virginia. We were able to accomplish this volume of work because of our commitment to streamlining and continual improvement. In 2022, Kepro migrated Outpatient Physical Therapy and Occupational Therapy initial assessments to our innovative technology solution, Atrezzo, which now adjudicates these assessments.

Occupational and Physical Therapy now have a combined limit of 20 visits per calendar year. A prior authorization is required for the initial visits but does not require clinical review. Atrezzo captures these visits as initial visits, and we administratively approve them on the date of receipt by our team. Visits beyond 20 in a calendar year require clinical review. We capture these visits as established, and subject them to nurse review and physician review, if necessary, to determine

medical necessity. We can modify the threshold for the number of initial visits allowed to accommodate any changes in the WVCHIP Summary Plan Description of Occupational/Physical Therapy once current policy remediation efforts are complete.

The prior authorization of physical, occupational, and speech process will take place within Atrezzo using the prior authorization process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

Prior authorization requests entered by the provider via the portal are automatically uploaded to Atrezzo. When a prior authorization request is submitted via fax, telephone, or mail our Customer Service Representative (CSR) retrieves the intake information and enters relevant details into Atrezzo. The CSR will record the date of receipt as the date a mailed, telephonic, or faxed request was received by Kepro, except for requests received after business hours. Atrezzo will then automate the remainder of the eligibility process, including Medicaid eligibility checks and sending communications to the provider automatically. If the request requires clinical review, the request is automatically routed via Atrezzo workflows to the appropriate clinical review work queue.

For each prior authorization request, the clinical reviewer pulls the case from the clinical review queue and determines first if the request is complete. If a request is incomplete, we will suspend the request and place it in a pending status documentation requested. The provider receives a message in the system and contacted within one business day to obtain the necessary additional information and/or correct errors. If we do not receive additional information within three business days, we close the request administratively. The provider may resubmit the request by selecting copy for new submission and updating the request or by resubmitting the request by fax with the additional information. If the clinical reviewer is still unable to approve the request after receipt of additional information, we refer the review to a physician with all available information.

Physical and Occupational Therapy

Occupational and Physical Therapy now have a combined limit of 20 visits per calendar year. A prior authorization is required for the initial visits but does not require clinical review. Atrezzo captures these visits as initial visits, and we administratively approve them on the date of receipt by our team. Visits beyond 20 in a calendar year require clinical review. We capture these visits as established, and subject them to RN review and physician review, if necessary, to determine medical necessity. We can modify the threshold for the number of initial visits allowed to accommodate any changes in the WVCHIP Summary Plan Description of Occupational/Physical Therapy once current policy remediation efforts are complete.

When we receive an initial Physical or Occupational Therapy PA request, we automatically review the request. This information is also available in the system record and reports tab for the referring and servicing provider.

If the request is an established request, the clinical reviewer determines if the service is medically necessary and appropriate. Following verification of covered service status and completeness, the

clinical reviewer evaluates the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. For Physical and Occupational Therapy reviews, we utilize InterQual Criteria sets (InterQual Adult & Pediatric PT/OT), WVCHIP criteria and policy to determine medical necessity as approved by WVCHIP.

If the PA request is approved by the clinical reviewer after clinical review, Atrezzo exports the authorization number to the claims payor in a daily file as described above.

We will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payor in a daily file. It is also available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified Kepro of their inability to do so by fax or telephone.

If denied after physician review determination, the clinical reviewer will attach denial notices to the provider, referring practitioner and servicing provider in Atrezzo. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

Speech and Language Services

We authorize speech and language services in conformance with the WVCHIP Summary Plan Description. Speech therapy services require prior authorization from the initial service and are no longer subject to limits in conjunction with Occupational and Physical Therapy. Licensed speech therapists conduct reviews of Speech Therapy requests to ensure compliance with WVCHIP policy for these services.

When a Speech and Language PA request is received, the clinical reviewer will first determine if the service is medically necessary and appropriate. Following verification of covered service status and completeness, the clinical reviewer evaluates the request to determine if the service to be provided is medically necessary and appropriate, and if the service should be approved or referred to physician review. Currently we use WVCHIP criteria with consultant review and WVCHIP policy for the review of these services.

If approved by the speech and language therapy consultant reviewer, Atrezzo exports the authorization number to the claims payor in a daily file, and the approval is also available in the Atrezzo record and reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability by fax or telephone.

After referral from the Consultant Level for speech and language therapy for physician review, we will complete decisions requiring physician review within 24 hours. If approved by the physician reviewer, the system, exports the authorization number to the claims payor in a daily file. It is also

available in the record and the reports tab for the referring and servicing provider. We inform providers who are unable to access the online system and have notified us of their inability to do so by fax or telephone.

If denied after physician review determination, we will attach denial notices to the provider, referring practitioner and servicing provider in Atrezzo. This notification includes the policies and criteria that were not met and information about the reconsideration process. We send the denial letter to the member or member's representative via USPS. The member denial letter contains information on the member's appeal rights and timelines for appeals.

A1.5.h. Physician and Non-Physician Practitioner Services

1. The Agency requires Prior Authorization for all hospital admissions, and specific surgeries performed in defined places of service, to be authorized in accordance with current policies. No surgical procedure may be covered on an inpatient basis if the procedure can be performed appropriately and safely in a physician's office or other outpatient setting. If the surgery is authorized by the UM, separate prior authorization numbers for the surgeon and the outpatient facility are assigned. In addition, specific practitioner services and all unlisted codes for procedures/services require Prior Authorization.

As part of Kepro's commitment to providing quality assurance in utilization management, ensuring medical necessity is essential to our daily work with clients and providers. As such, we incorporate WV DHHR's priorities, including requiring prior authorization for all hospital admissions and elective surgeries as outlined in the RFP above, into our UM processes to ensure an integrated and seamless implementation of the State's policies and procedures. Our processes are essential to effectively managing high volumes. Since 2019 we conducted close to 1,025 Physician and Non-Physician Practitioner Service reviews for West Virginia.

We currently conduct prior authorization of elective outpatient surgery cases under our existing contract with WVCHIP. We understand that this review helps to ensure medical necessity for elective surgery performed for WVCHIP members.

The prior authorization of physician and non-physician services will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

A1.5.i. Home Health Services

1. The Vendor shall have established procedures and sufficient capacity to receive requests, physician's orders, plans of care, assessments, and other forms or documentation required for the Home Health provider to register for the initial 60 visits.
2. The Vendor shall have the capability and established procedures for determining the medical necessity of requested authorization requests for Home Health services that exceed the initial 60 visits. Authorization(s) must be specific to the member, provider agency, service code, units, start and end date. The units, start and end dates in the authorizations may subsequently be modified/edited as necessary.
a. Authorization Reviews: The Vendor shall have the capability and established procedures to ensure determinations for authorization reviews are completed in accordance with current policies.

b. Continued Stay Reviews: The Vendor shall have the capability and established procedures to ensure determinations for continued stay reviews are completed in accordance with current policies.
c. Retrospective Reviews: The Vendor shall have the capability and established procedures to ensure determinations for retrospective reviews are completed in accordance with current policies.
3. The Vendor shall have the capability to develop educational trainings and provide technical assistance, at no additional cost to the Agency, about policies, available services, and any other information requested by the Agency for members, families, provider agencies, stakeholders and the general community via email, telephone, webinars etc. at no additional cost to include but not limited to:
a. Plan, advertise and produce statewide trainings and webinars at the request of the Agency.
b. Communicate program announcements to providers, members, and other stakeholders as necessary, at no additional cost to the Agency.
c. Participate in conference calls at the request of the Agency.
d. Offer Continuing Education Units (CEUs) to nurses, counselors and Licensed Social Workers attending training sessions.
4. The Vendor will enroll the Agency Member in Case Management to monitor and assist when the needs required if necessary.
5. The Vendor will notify the Agency weekly and the members' Case Managers upon issuing authorization(s) for members who receive services from a waiver program or the personal care program who are also receiving home health services.
6. The Vendor will collect and report data regarding the utilization and quality of Home Health services as required by the Agency.

We understand the importance of a complete and thorough review, as we have 17 years of experience performing Home Health services. Since 2019 we conducted eight Home Health reviews for West Virginia. As part of the review process, clinical reviewers will review each request to ensure the beneficiary does not have existing services with another provider, that all required clinical documentation has been submitted and is completed in its entirety. The clinical reviewer will also take note of any previous visits authorized due to the service limits set forth by WV DHHR. If a request is submitted for authorization that will exceed the 60-visit annual limit, the clinical reviewer will ensure that the request is medically necessary and work with the Agency for final approval of the services.

Our understanding of the unique needs of WV DHHR's Home Health program is based on our review of WVCHIP Summary Plan Description. These requirements are incorporated into our systems and prior authorization processes to ensure compliance with WV DHHR regulations. We ensure that services provided fall within the scope of practice of home health providers and that services are covered under the home health benefit. Our reviewers are practiced in raising concerns, should there be any indication that the plan of care includes services that are outside of that scope.

Online Training

Kepro holds regular Home Health refresher trainings on initial requests. As Kepro provides these trainings online, our individuals statewide can receive instruction.

We understand that Home Health services are intended to be short term in duration, and that an important goal of these services is to educate members and their families on self-care principles. As such, our personnel will ensure that the home health plan of care will address educational

needs and increase the member and their families' health literacy. We will ensure that, for established requests that are clinically reviewed, covered home health services are prescribed and supervised by a physician, Advanced Practice Registered Nurse (APRN), or a Physician Assistant, as stated in the applicable regulation. Services provided will follow a written plan of care to help the member to receive medically necessary and reasonable care. Additionally, we enroll the Member in Case Management to monitor and assist when the needs required if necessary.

In performing this work, we and our clinical reviewers have gained invaluable best practices that we bring to WV DHHR vulnerable population:

- **Monitor for duplication of services**. clinical reviewers check past authorizations (or claims if available) to determine if requested services are currently being provided by another provider.
- **Importance of knowing benefit limits.** We know that members initially will be permitted up to 60 visits per year, depending on medical necessity, for any combination of skilled nursing, speech/language, occupational and physical therapy(ies). We understand the importance of tracking the initial visits and their role in DHHR's efforts pertaining to Electronic Visit Verifications (EVV). We will continue to further track established Home Health requests along with reviewing for medical necessity. All initial and established requests for HH services will be entered into the Atrezzo system to assist with EVV. We also recognize benefit changes between coverage types. Home Health Alternative Benefit members have a 100-visit cap, while traditional members for Home Health Occupational, Physical and Speech Therapy member benefits do not have a cap for established requests; Alternative Benefit plan members have a 30-visit maximum. It is our responsibility to ensure adequate services to provide quality of care yet conserve visits for future needs. clinical reviewers evaluate the plan of care and requested visits, including the number of visits, and compare against designated medical necessity review criteria and potentially consult with our physician reviewers before authorizing the number of visits. Receipt of requests beginning with in initial visits, and including established patients, in a calendar year supports the need to determine whether the member is making progress. If the individual has not made progress, they must again consult with our medical director and – in some cases - the treating provider/ordering physician to discuss the best course of treatment.

Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services outlines the process that will be used to make a prior authorization determination.

The prior authorization process begins upon receipt of the prior authorization request for Home Health services. The clinical reviewer receives the request automatically and in real-time via Atrezzo and reviews the clinical information based on the appropriate criteria and client-required rules. If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo and automated notification is sent to the provider in real-time via the Provider Portal. If it is determined that administrative requirements are not met, the clinical reviewer will document the adverse determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal

and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via mail.

If administrative requirements are met, but the clinical reviewer cannot approve the request due to lack of clinical information, the clinical reviewer pends the request with automatic notification to the provider via the Provider Portal requesting additional information. If the provider does not fulfill the request for additional information within the allotted timeframe, or, following review of additional information the clinical reviewer cannot approve the case based on medical necessity, the case is routed to a physician reviewer for review. The physician reviewer documents the determination in Atrezzo, and automated notification is sent to the provider via the Provider Portal and/or by autogenerated letter via fax or mail. For all adverse determinations, the member receives the denial notification via mail.

Continued Stay Review

To ensure beneficiaries move through the continuum of care appropriately based on medical need criteria, Continued Stay Reviews are provided throughout all levels of care. We have provided Continued Stay Review Management for decades. Our extensive experience in Continued Stay Review Management includes contracts in Maine, West Virginia, South Carolina, Minnesota, and Florida. As such, we can provide Continued Stay Review to support WV DHHR as required. We will conduct Continued Stay Reviews within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

Reviews of medical record information are conducted by a nurse to determine if the need for continued stay and to provide notice and/or reconsideration for denied participants. This review ensures quality assurance and multidisciplinary team requirements pursuant to state requirements.

Using an algorithm based on approved criteria, we assess the medical necessity and appropriateness of the recipient's continued stay. Where the medical record documentation does not substantiate the need for continued stay, the attending physician and/or direct care staff is contacted and requested to supply additional documentation to justify the continued stay.

Retrospective Review

Our Retrospective Review process follows a similar process to prior authorization review. The retrospective review includes reviewing the member's medical record that corresponds with the date of initial service and subsequent treatment to validate medical necessity throughout the member's length of stay in the inpatient setting. We will ensure the plan of care is consistent with WV DHHR policy. Daily documentation specific to treatment goals and objectives, anticipated LOS and discharge planning activities must be evident for each day of hospitalization. For inpatient reviews after discharge and prior to billing, the hospital will submit a request for processing. Our Retrospective Review Process is illustrated in **Figure 67 Retrospective Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

Our clinical reviewer begins the retrospective review by reviewing the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR required rules. Using these criteria will ensure that services and items planned are consistent with the provisions of appropriate care. If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to a physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo, and notification is automatically sent to the provider via the Provider Portal and/or notification is autogenerated via Atrezzo. For all adverse determinations, the member receives the denial notification.

We complete retrospective reviews within 48 hours. We will conduct review of retrospective requests only in compliance with the policy approved by the WVCHIP.

Training and Technical Assistance

Additionally, we will develop educational trainings to Home Health providers regarding policy, available services, service delivery models, and any other topics requested by the WVCHIP. We will provide CEUs for RNs, counselors and Licensed Social Workers developed in conjunction with the WVCHIP. We use RNs to assist in developing topic specific CEUs, which are also in compliance with Board of Nursing and Social Work education requirements.

We provide technical assistance as requested by individual providers or to all Home Health providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will participate in and conduct training for members and other stakeholders as requested by the Agency. We will participate in conference calls at the request of the Agency.

A1.5.j. Diagnostic Imaging/Radiology Services

1. The Vendor shall develop, implement, and maintain a UM program, which includes prior authorization for all non-emergency advanced imaging studies provided in outpatient settings (including but not limited to Independent Diagnostic Testing Facilities (IDTF), hospital outpatient, and private physician offices. These include, but are not limited to:
a. Computerized Tomography (CT) scans.
b. Magnetic Resonance Images (MRI).
c. Magnetic Resonance Angiograms (MRA).
d. Positron Emission Tomography (PET) scans.
e. Nuclear Cardiology.
f. Radiopharmaceutical's.
g. Any other identified imaging service or over utilized and/or high-cost Diagnostic Imaging/Radiology services.
2. The Agency reserves the right to modify the list, through either addition or deletion, of imaging study procedures subject to prior authorization over the term of the contract.
3. In performing medical necessity determinations, the Vendor shall use nationally recognized, research based, standardized, clinical criteria in reviewing each prior authorization and eligibility review request. If not nationally accredited, researched based criteria exist, the Vendor shall develop criteria based on current research available. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all Diagnostic Imaging/Radiology and imaging services reviewed under the contract.
a. The Vendor shall maintain the capability to update the review criteria for Diagnostic Imaging/Radiology services reviewed under the resulting contract. The Vendor shall make recommendations to the Agency annually or as needed, regarding what, if any, changes should be made to the criteria that is currently being used or will be used for the following the calendar year. The recommendations shall be included in the Vendor's annual report and communicated to the Agency.
b. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria annually.
c. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the resulting contract.
d. The Vendor is responsible for any cost associated with the purchase of any review criteria.
4. In performing medical policy coverage recommendations, the Vendor shall use nationally accredited, research-based standards of care in determining recommendations. If not nationally accredited, research based, standards of care exist; the Vendor shall develop recommendations based on current research available. Policy recommendations shall take into consideration, the WV State Plan, any applicable federal regulations, and comparisons of other State Agency policies.

We will continue our work, which began in 2019 under the current WVCHIP contract, providing prior authorization of elective outpatient, high-cost imaging studies to ensure that these services are medically necessary and the most cost-effective service for the member.

Since we conducted close to 800 Diagnostic Imaging and Radiology Service reviews for West Virginia, covering services such as computerized topographies (CT), positron emission tomography (PET), magnetic resonance imaging (MRI) and angiography (MRA), as a method to control costs in the West Virginia Medicaid program. We understand that these tests do not require prior authorization when provided in an emergency room, to avoid delaying emergency treatment for

members. We will also include any other identified imaging service or over utilized and/or high-cost Diagnostic Imaging/Radiology services, as requested by WVCHIP.

When InterQual criteria are not available Kepro provides recommendations to WVCHIP based on research of clinically sound and research-based criteria that have been endorsed by our Medical Director and physicians in the specialty of the criteria under review. It is possible to edit these criteria to create local medical policies (LMPs) that conform to WVCHIP specific policies. WVCHIP may also develop Local Medical Policies for existing criteria, based on updated policy or clinical practices changes. WVCHIP receives recommendations for approval, and once approves, we implement the policies. We update providers regarding criteria changes and if the criteria are not proprietary, they are available to providers unless otherwise specified by WVCHIP. Publishers do not release proprietary criteria, such as InterQual; however, Kepro can provide "SmartSheets" for many review areas that at WVCHIP's request.

We will continue to update the review criteria annually, and alert WVCHIP to any changes in the criteria. Any recommended changes in criteria will be included in the annual report provided to the Agency. Since InterQual criteria is utilized in several review areas it is not within the purview of Kepro or WVCHIP to make major modifications to the proprietary criteria set - however, recommendations will be made to the Agency for any additions or edits that may need to be approved to conform to BMS policies. For all other policies, we will present recommended changes to the Agency for consideration. The Bureau may reject current or recommended criteria and specify use of different criteria. We will provide the Agency with access to a complete set of materials associated with the criteria annually. We are responsible for the purchase of InterQual review materials, and any other criteria adopted that are not public domain.

The prior authorization of diagnostic imaging and radiology services is conducted using InterQual®, LMPs, and WVCHIP policy. PA of diagnostic imaging and radiology will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

provider Education and Stakeholder Engagement

We have, and will continue to, develop educational trainings for imaging stakeholders on topics requested by WVCHIP. We provide technical assistance as requested by individual providers or to all Imaging providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcements of the training to providers. We will provide the following services to WVCHIP to ensure appropriate utilization management of imaging services:

- Participate in conference calls at the request of the Agency.
- Develop a reference manual for providers.
- Maintain updated imaging/radiology information, instructions, updates, code lists, bulletins, links to other information and sites, and announcements of new information on the website.

- Hold initial orientations to Atrezzo with key stakeholders, as requested by the Agency.
- Provide support to the Agency related to stakeholder inquires, including but not limited to members, providers, facilities, legislators, and/or other government offices or officials.
- Provide a toll-free line for providers and members for inquiries regarding service coverage, prior authorization status or to answer questions regarding issues or problems with a prior authorization request.
- Make recommendations or develop forms upon request of the Agency.
- Represent the Agency regarding UM and/or Agency policies, guidelines and/or other criteria at meetings, conferences, or educational seminars, as needed.
- We will also coordinate with Gainwell, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. We will also monitor over- and under- utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

A1.5.k. Lab/Genetics Services

1. The Vendor shall develop, implement, and maintain a UM program, which includes prior authorization for any laboratory/molecular diagnostic tests and/or pathology services:
a. BRCA testing
b. Oncotype DX
c. Genetic testing
d. Molecular diagnostic and Pathology tests
e. Drug Screening
f. Any other identified laboratory service or over utilized and/or high- cost lab services
2. The Agency reserves the right to modify the list, through either addition or deletion of laboratory procedures subject to prior authorization over the term of the contract.
3. Vendor shall develop, implement, and maintain a Molecular Diagnostic Services Program and propose coverage determinations and/or prior authorizations in addition to the following:
a. Accept claim and/or any documentation from lab or ordering physician needed to complete determination and/or prior authorization process.
b. Develop a method to determine test specific correct coding and pricing (when no price is available in the Medicare Clinical Laboratory Fee Schedule) that Vendor can submit to Fiscal Agent for adjudication.
c. Coordinate with and submit information needed to Fiscal Agent to ensure adjudication.
d. Generate appropriate policies to support decisions.
e. Update master file with new policies for quarterly release.
f. When making determinations and pricing decisions take into consideration the WV State Plan, any applicable federal regulations and policy comparisons of other State Agencies. The Agency shall have prior approval of the proposed plan and policy.
g. Scope of Molecular Diagnostic Services may include, but is not limited to:
h. Tier 1- 81200-81383 CPT code range
i. Tier 2- 81400-81479 CPT code range
j. Micro dissection- 88380-88381
k. HCPCS: Molecular pathology procedure; physician interpretation and report- G0452
l. Not otherwise classified (NOC)- 81479, 84999, 85999, 86849, 87999, 88199,88299,88399,89398
4. The Agency reserves the right to modify the list, through either addition or deletion, over the term of the contract.

In the last several years, we have seen an increased demand for the development and implementation of a more robust UM system to authorize high-cost laboratory services, particularly laboratory/molecular diagnostic tests and/or pathology services to aid in the treatment of diagnosed conditions.

Since, under our current contract with WV DHHR, we conducted 13 Lab/Genetics services reviews. The prior authorization of lab/genetics services is conducted using InterQual®, LMPs, and WVCHIP policy. Prior authorization of lab/genetics services will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

Through thorough review and research, we developed, and will continue to develop, criteria for Genetic/Molecular Diagnostic services in conjunction with and for WVCHIP in these review areas as new codes are implemented by WVCHIP. Over the last several years CPT and/or HCPCS coding systems expanded to incorporate numerous genetic testing and drug screening codes. Our team assists the Bureau by:

- Researching codes and making coverage recommendations (e.g., genetic testing codes added in 2015)
- Researching and recommending criteria (e.g., Cystic Fibrosis criteria)
- Developing criteria when criteria is not available (Drug Screening/G Codes)
- provider education, webinars, and training (Drug Screening/G codes and BRAC)

The increased number and types of laboratory services covered by WVCHIP that require prior authorization include:

- Cystic Fibrosis, Toxicology laboratories, Vectra (Rheumatoid Arthritis Disease Activity)
- Drug metabolism (pharmacogenics) sequence analysis
- Targeted genomic sequence analysis panel
- Targeted genomic sequence analysis panel solid organ or hematolymphoid neoplasm
- Infectious agent antigen
- Infectious agent DNA or RNA
- infectious agent detection by DNA or RNA
- Cytogenic analysis for chromosomal abnormalities
- Cytogenomic analysis for constitutional chromosomal abnormalities
- Exome
- Inherited bone marrow failure syndromes
- Oncology Breast, MRNA
- Oncology (uveal melanoma)
- Thiopurine (TPMT)

We will continue to assist the Agency when InterQual® criteria are not available by providing recommendations to the WVCHIP based on research of clinically sound and research-based criteria

endorsed by our Medical Director and physicians in the specialty of the criteria under review. These criteria can also be edited to create local medical policies (LMPs) that conform to WVCHIP specific policies. Local Medical policies may also be developed for existing criteria sets, as policy is updated or clinical practices changes. Recommendations are sent to the WVCHIP for approval, and once approved, are implemented. Providers are updated regarding criteria changes and if the criteria are not proprietary, they are available to providers unless otherwise specified by WVCHIP. Proprietary criteria, such as InterQual, may not be disclosed to providers; however, InterQual has developed SmartSheets in many review areas that can be made available to providers upon request.

We will update the review criteria annually, and alert WVCHIP to any recommended changes in the criteria, considering the WV State Plan, any applicable federal regulations and policy comparisons to other state agencies. Any recommended changes in criteria will be included in the annual report provided to the Agency. Since InterQual criteria is utilized in several review areas it is not within the purview of Kepro or WVCHIP to make major modifications to the proprietary criteria set- however, recommendations will be made to the Agency for any additions or edits that may need to be approved to conform to WVCHIP policies. For all other policies, recommended changes will be presented to the Agency for consideration. The Bureau may reject current or recommended criteria and specify different criteria to be used. We will provide the Agency with access to a complete set of materials associated with the criteria annually. Kepro assumes responsibility for the cost of InterQual review materials and any other criteria set adopted that is not public domain.

Further, we developed a Molecular Diagnostic Services Program to:

- Make coverage recommendations related to new testing codes as well as codes that move from investigational/experimental to standard medical practice
- Assist WVCHIP with coding and pricing for services where pricing is not available in the Medicare Clinical Laboratory Fee Schedule, taking into account the WV State Plan, any applicable federal regulations and policy comparisons to other state agencies
- Request agency approval of the criteria for: 1) Tier 1 81200-81383 CPT code range; 2) Tier 2- 81400-81479 CPT code range; 3) Micro-dissection 88380-88381; 4) HCPCS- G0452; 5) Not Otherwise Classified Codes (NOC)- 81479, 84999, 85999, 86849, 87999, 88199, 88299, 88399, 89398, and; 6) other laboratory/codes as requested by the Agency

Stakeholder Engagement and Education

We will develop training for laboratory/genetic testing stakeholders on topics requested by WVCHIP. Technical assistance is provided as requested by individual providers or to all Laboratory/Genetics service providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will provide the following services to WVCHIP to ensure appropriate utilization management of laboratory/genetic testing services:

- Participate in conference calls at the request of the Agency.
- Develop a reference manual for providers.
- Maintain updated imaging/radiology information, instructions, updates, code lists, bulletins, links to other information and sites, and announcements of new information on the website.
- Hold initial orientations to Atrezzo with key stakeholders, as requested by the Agency.
- Provide support to the Agency related to stakeholder inquires, including but not limited to members, providers, facilities, legislators, and/or other government offices or officials.
- Provide a toll-free line for providers and members for inquiries regarding service coverage, prior authorization status or to answer questions regarding issues or problems with a prior authorization request.
- Make recommendations or develop forms upon request of the Agency.
- Represent the Agency regarding UM and/or Agency policies, guidelines and/or other criteria at meetings, conferences, or educational seminars, as needed.

We will also coordinate with Gainwell, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. We will also monitor over- and under-utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

A1.5.l. Out-of-Network (OON) Services

1. The Vendor shall develop, implement, and maintain a UM program, which includes prior authorization for any Out of Network services according to the Agency policies: Out of Network services are only approved when it meets medical necessity for the member to be treated by an out-of-network, non-enrolled provider, because there is no In-Network provider available or appropriate that can meet the member's need. Any non-emergent service that is done Out of Network (OON) requires prior authorization obtained by an In-Network attending/ordering/referring provider as per the Agency's policies. Any OON provider wanting to provide services for Agency members must enroll with the Agency.
2. Vendor shall have the ability to fulfill the OON process, to include but not limited to the following:
a. Confirm attending/ordering/referring provider is in-network and member's eligibility. If the member is enrolled in an MCO the attending/ordering/referring provider is notified and directed to the MCO. If the member is ineligible for Medicaid or WVCHIP benefits and/or has Third Party Liability (TPL) the request is closed, and the provider and member are notified of the reason.
b. Determine enrollment status of provider and/or facility being referred to. If in-network the usual prior authorization process is implemented.
c. Determine if service requested is a covered service.
d. Determine if service requested requires an OON prior authorization per the Agency's policies.
e. Determine if service can be appropriately provided In-network. Notify attending/ordering/referring provider of In-Network provider's that are available.
f. Determine if medical necessity is met for the OON service. If medical necessity is not met a denial letter is sent to the member and all providers stating the reason for denial, and the member's notification of appeal rights, and if applicable, the procedures, for the attending/ordering/referring provider's ability to request a peer-to- peer review and/or reconsideration. If medical necessity is met, enrollment tracking begins, the Fiscal Agent is notified of approval by Vendor and the Fiscal Agent sends enrollment letter. Vendor holds the prior authorization (unless urgent) until enrollment of the provider is completed and directs the OON provider to the Fiscal Agent for enrollment. (Fiscal Agent provider Enrollment Policy and Procedure E- 104). Fiscal Agent/Vendor coordinates

enrollment and prior authorization efforts. Fiscal Agent communicates via tracking the enrollment of the OON provider to the Vendor within a specified timeframe.

We understand that services must be provided by in-network providers whenever practicable. Since 2019, We have conducted out-of-network provider reviews to ensure that when out-of-network providers are needed, the circumstances are valid and medically necessary as defined in this section and by WVCHIP policy. For example, in instances when services may not be available from in-network providers or extraordinary circumstances exist. Under the current contract cycle, our team has reviewed 40 cases for West Virginia to ensure out-of-network provider usage was in full compliance with WVCHIP regulations. **Figure 73 Out-of-Network Provider Process** outlines our process for out-of-network provider review.

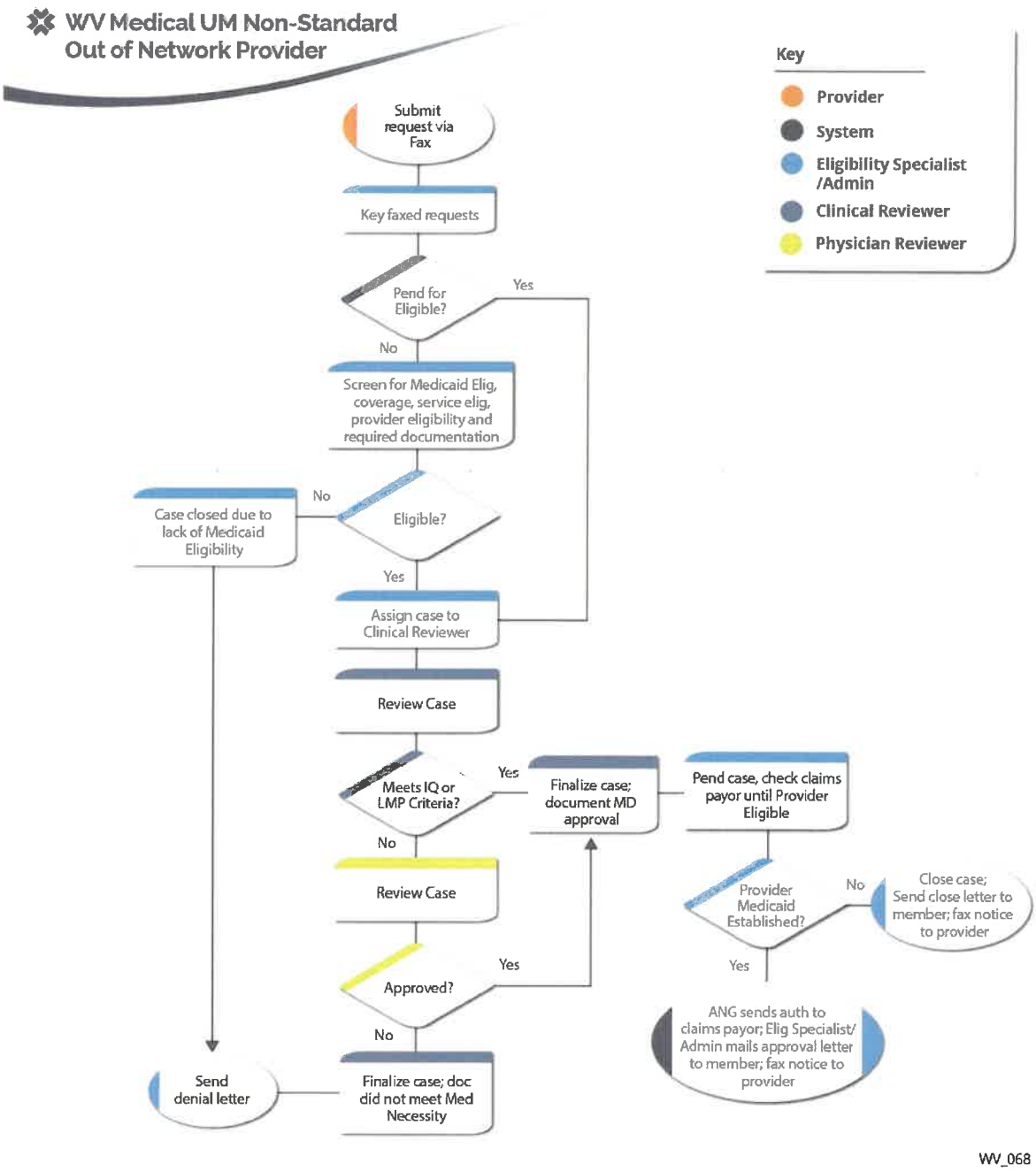


Figure 73. Out-of-Network Provider Process

A well-established process for out-of-network provider review is critical to ensuring medically necessary actions.

The out-of-network provider review process begins when a provider listed in a prior authorization request for medical/behavioral health is not enrolled in the network. We will review in-network options for a viable provider and will contact the Options for in-network providers for that service

are explored and the WV Medicaid enrolled referring physician and requested out-of-network provider are contacted. If we determine an in-network provider is available to provide the service, the initial request is closed, and the referring physician and member are made aware of available in-network providers who are enrolled to provide the service. If no in-network provider is identified, and the review determines that the out-of-network provider is appropriate and medically necessary, an authorization is granted. However, the information cannot be exported to the MMIS system until the out-of-network provider is enrolled.

Next, call tracking is initiated with Gainwell enrollment, the provider is referred for enrollment via letter and telephonic notification, and the request is placed in a status "Hold for provider Enrollment." Once the provider is enrolled, the authorization is exported to Gainwell. If the provider fails to enroll, the referring physician and member are notified. In the event the provider is denied enrollment, the referring physician and the member are informed, and the authorization may either be assigned to another designated out-of-network provider or closed. If a different out-of-network provider is selected, the process begins again until the authorization can be assigned.

We will prior authorize necessary services provided by out-of-network providers. providers will be informed of the enrollment process and any prior authorizations will be time limited. Referrals to out-of-network must come from a West Virginia Medicaid practitioner and the request must be supported with sufficient documentation to determine that the prior authorization is medically necessary and that the service cannot be obtained through an in-network provider.

We currently provide out-of-network services for WVCHIP on a case-by-case basis, and we understand the value of consistent monitoring of these providers for both the management of the fiscal requirements of the Medicaid Program and the best interests of the Medicaid members. We understand the WVCHIP requirement that out-of-network prior authorization periods and enrollment time must coincide. We are familiar with program requirements including the requirement that services, which can be provided by an in-state or border provider, should not be authorized out-of-network, unless deemed as a medical emergency. Additionally, a WV Medicaid enrolled practitioner must request the services. We are also aware the specified providers have been designated as in-network providers when services they provide are not available in-state or from border providers.

Currently, border facilities are not considered out-of-network and are enrolled as border or in-state providers. The out-of-network process does not apply to any out-of-state provider designated as in-network. We have worked diligently with the WVCHIP to develop and document a more streamlined approach to handling out-of-network services, which includes:

- Improving the Bureau's ability to control addition of providers
- Ensuring that each request is treated consistently
- Ensuring that members can access out-of-network services in a timely fashion Ensuring that out-of-network providers can be paid in a timely manner for authorized services rendered to WV Medicaid members

Stakeholder Engagement and Education

We will develop educational training and webinars for stakeholders on referring and providing out-of-network services as requested by the WVCHIP. Technical assistance is provided as requested by providers or to all providers when changes in out-of-network policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will provide the following services to the WVCHIP to ensure appropriate utilization management of imaging services:

- Participation in conference calls at the request of the Agency
- Development of a reference manual for providers
- Maintenance of updated imaging/radiology information, instructions, updates, code lists, bulletins, links to other information and sites, and announcements of new information on the website
- Providing initial orientations to the system with key stakeholders, as requested by the Agency
- Supporting the Agency related to stakeholder inquires, including but not limited to members, providers, facilities, legislators, and/or other government offices or officials
- Providing a toll-free line for providers and members for inquiries regarding service coverage, prior authorization status or to answer questions regarding issues or problems with a prior authorization request
- Recommending or developing forms upon request of the Agency
- Representing the Agency regarding UM and/or Agency policies, guidelines and/or other criteria at meetings, conferences, or educational seminars, as needed

We will also coordinate with Gainwell, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. Additionally, we will monitor over- and under-utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

A1.5.m. Cardiac Rehabilitation

1. Cardiac rehabilitation is a comprehensive outpatient program of medical evaluation, prescribed exercise, cardiac risk factor modification, and education and counseling that is designed to restore members with heart disease to active and productive lives. The central component of cardiac rehabilitation is a prescribed regimen of physical exercises intended to improve functional work capacity and to improve the member's well-being. Members who use tobacco must be referred to the tobacco cessation program. The cardiac program consists of a series of supervised exercise sessions with continuous electrocardiograph monitoring. Cardiac rehabilitation can be performed in a specialized, freestanding physician directed clinic or an outpatient hospital department.
2. Cardiac rehabilitation programs are regulated exercise programs which are effective in the physiological and psychological rehabilitation of many members with cardiac conditions. These services are considered medically necessary for selected members when they are individually prescribed by a physician.

Since 2019, under our current contract with WV DHHR, we conducted 0 Cardiac Rehabilitation reviews. We will continue to provide prior authorization services for Cardiac Rehabilitation. This program consists of a series of supervised exercise sessions with continuous electrocardiograph

monitoring. Cardiac rehabilitation can be performed in a freestanding physician directed clinic or in an outpatient hospital department. The goals of cardiac rehabilitation are:

- To increase exercise tolerance
- To reduce symptoms of chest pain and shortness of breath
- To improve blood cholesterol levels
- To improve psychosocial well-being
- To reduce mortality

The prior authorization of cardiac rehabilitation services is conducted using InterQual®, local medical policies, and WVCHIP policy. Prior authorization of cardiac rehabilitation services will take place within Atrezzo using the utilization review process outlined in 3.

A1.5.n. Pulmonary Rehabilitation

1. Pulmonary Rehabilitation (PR) is an individually tailored multidisciplinary approach to the rehabilitation of members who have pulmonary disease. PR offers members a chance to reduce hospitalizations, increase their knowledge about pulmonary disease and its management, the ability to control and alleviate the symptoms of pulmonary disease, and the ability to carry out activities of daily living with less shortness of breath. Pulmonary rehabilitation programs include exercise training, psychosocial support, and education, which are intended to improve the member's functioning and quality of life.

Based on current WVCHIP regulations, Pulmonary Rehabilitation is not a covered program. If WVCHIP offers Pulmonary Rehabilitation as a covered service, we would be happy to follow our prior authorization methodology to provide these services. We would work with the state to define and document any unique requirements related to this service and implement in accordance with WVCHIP.

A1.5.o. Chiropractic Services

1. The Agency covers chiropractic services for eligible members. Vendor is to review all chiropractic service requests for services requiring prior authorization regardless of place of service. As a condition for reimbursement, the Agency currently requires prior authorization for more than 20 visits.

We have served as the prior authorization agent for WVCHIP for Chiropractic services since 2019. Since contract start, we conducted over 160 Chiropractic services reviews. We propose to continue to provide this service subject to WVCHIP approval. We understand that prior authorization is required for Chiropractic care beyond the initial 12 services in a calendar year. WV Medicaid coverage of chiropractic services includes the following:

- Coverage is limited to manual manipulation (by use of hands) for subluxation of the spine and certain diagnostic radiological examinations related to chiropractic services.
- Chiropractors may use manual devices in performing manual manipulation of the spine, but no additional payment is available for use of device by Medicaid and Medicaid will not reimburse extra charges for the device itself.

- WV Medicaid limits its coverage of Chiropractic Services to treatment by means of manual manipulation to correct a subluxation of the spine, demonstrated by an x-ray.
- WV Medicaid waives the X-ray requirement for initially covered services for pregnant women and children. Services requested above the initial 12 visits for children require an X-ray.
- Taking the X-ray must occur no more than 3 months prior to the initiation date of the course of treatment. In certain cases of an acute exacerbation of a chronic subluxation, we will accept an x-ray no older than a year.
- X-ray equipment must be certified radiology equipment that complies with all applicable State and federal requirements.
- Medicaid reimburses chiropractors for the professional and technical components of covered diagnostic radiology services (CPT 72010-CPT 72120) if the chiropractor performs both parts of the procedure.
- Medicaid will provide reimbursement for only one interpretation of an x-ray and will not pay for a second confirmatory x-ray.

The prior authorization of chiropractic services is conducted using InterQual®, local medical policies, and WVCHIP policy. Prior authorization of chiropractic services will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services**.

We will develop educational trainings for providers regarding WVCHIP chiropractic policy, available services, service delivery models, and any other topics requested by WVCHIP. Technical assistance is provided as requested by individual providers or to all chiropractic providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will participate in and conduct training for members and other stakeholders as requested by the Agency. We will participate in conference calls at the request of the Agency.

A1.5.p. Podiatry Services

1. The Agency covers podiatry services for eligible members. Vendor is to review all podiatry procedure/service requests requiring prior authorization.

We understand that podiatry services encompass foot and ankle procedures that are provided by a WV-licensed podiatrist. Our purview includes reviews for surgical foot and ankle procedures that require prior authorization, such as bunionectomies, tarsal-tunnel release, calcaneal spur removal, removal of nail beds (matrixectomy), and hammer toe corrections. A podiatrist or a board-certified MD/DO will continue to conduct required physician-level reviews.

The prior authorization of podiatry services, of which there were 2 since 2019, is conducted using InterQual®, local medical policies, and WVCHIP. Prior authorization of podiatry services will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services**.

We will develop educational trainings for providers regarding WVCHIP policy, available services, service delivery models, and any other topics requested by WVCHIP. Technical assistance is provided as requested by individual providers or to all podiatric providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers. We will participate in and conduct training for members and other stakeholders as requested by the Agency as well as participate in conference calls at the request of the Agency.

A1.5.q. Case Management

1. Some members will automatically be assigned to case management. Those include, and are not limited to organ transplant patients, private duty nursing services members, high risk pregnancies, and members who have had bariatric surgery. Others may be identified based on claims history reflecting inordinately high costs or intensity of services and/or other populations as defined by the Agency or recommended by the Vendor.
2. The Vendor must evaluate referrals from case management to determine the feasibility of achieving significant improvements in member outcomes from coordination of services or fiscal advantages to managing the member services required. Vendor is to coordinate member services upon referral from the Agency as needed. As a condition for reimbursement, the Agency requires that all case management services receive prior authorization.
3. If any members transition from Fee-For-Service to a Managed Care Organization, the Vendor will prepare and send the Case Management Summary to the Managed Care Organization, in which the member is enrolled.

Medical Case Management encompasses coordinating and monitoring healthcare services for members identified by WVCHIP or who receive authorization for a service(s) specifically identified as requiring case management during the authorization period or for some designated period following authorization of the service. The primary goal is to monitor progress during or following delivery of intensive or high-cost services. We will notify the member and the referring physician requesting prior authorization of the service(s) that trigger medical case management concerning provision of the service. Our electronic submission portal provides alerts for members enrolled in case management, a feature that promotes continuity of care across review areas.

Certain categories of review receive automatic assignment to case management, including organ transplant services, private duty nursing services, high-risk pregnancies, and bariatric surgery patients. We recognize that WVCHIP may add additional review areas for case management, depending upon claims data review indicating utilization of high-cost services, and high utilization patterns. Our team is more than capable of providing these services, as we have managed over 30 cases in 2022.

We recognize the benefits of medical case management its application to additional review areas; we welcome the opportunity to discuss this with WVCHIP. Through our existing scope of work, We have enrolled members receiving adult dental, out of network, and Pulmonary Rehabilitation service, to name a few. Case management staff from the preauthorization unit, hospitals, physician's offices, and WVCHIP may refer patients for case management. Members or their legal representatives may also request case management services. In addition to those services mandated for medical case management services by the Agency, we propose case management follow-up as noted in other service areas of this proposal and described above, i.e., Hospice, and

Home Health services. This process describes the relationship of medical case management to the initial prior authorization and the reassessment process.

Notifications related to participation in the medical case management services program include:

- **Notification/Confirmation to Member of Engagement** into the medical case management services program. Whether we engage the member/legal representative via telephone or not, we will send a notification letter to the member/legal representative within two business days after the confirming the member status is suitable for the program. The letter will inform members that their current and future providers will also receive notification.
- **Notification/Confirmation to provider(s) of Member's Engagement** into the medical case management services program. We will send a notification letter to all treating provider(s) within two business days after the approving the member's case for the program. The letter will also notify members and legal representatives. Any providers treating the member under medical case management services will receive the notification letter within two business days of the member's first date of treatment with the provider.
- **Notification/Confirmation of Member's Declination/Discharge** of the medical case management services program. We send a notification letter to the member/legal representative and all treating providers within two business days after receipt of the member's written or verbal notification of the declination or discharge.

We will continue to provide case management support for members receiving medical case management services until one of the following conditions exists:

- The member is stable, has reached maximum potential, and no longer requires case management services
- The member is admitted to long term care
- The member does not respond to inquiries or to follow treatment plans
- The member is no longer Medicaid eligible

Cost savings is an important part of any medical case management program. Each referral will be evaluated to determine the feasibility of achieving cost savings while achieving significant improvements in member outcomes. Cost savings related to recommendation and/or approval of less costly care options, efficacious and less costly equipment or other cost savings will be reported to the WVCHIP. We will apply the WVCHIP approved medical necessity criteria for prior authorization of the specific services that trigger medical case management and will deliver medical case management services within nationally accepted standards for case management that are compliant with applicable federal regulations and WVCHIP policies.

We will develop educational trainings for providers regarding medical case management, available services, service delivery models, and any other topics requested by the WVCHIP. Technical assistance is provided as requested by individual providers or to all providers when changes in policy or updates in the system occur. We will plan, advertise, and conduct statewide training and webinars as requested by the Agency and communicate announcement of the training to providers.

We will participate in and conduct training for members and other stakeholders as requested by the Agency. We will participate in conference calls at the request of the Agency.

Kepro will also coordinate with Gainwell, the state's fiscal agent, to ensure adequate and timely claims processing related to services requiring prior authorization. We will also monitor over- and under- utilization of services and produce reports to identify these trends and make recommendations for improving utilization patterns.

A1.5.r. Specialty Medications/Physician Administered Drug Services

1. The Vendor must provide authorizations for specialty medications/physician administered drugs.
2. The Vendor must apply evidence-based clinical guidelines to drive utilization for the clinically appropriate and safe use of high-cost specialty medications to ensure the value of therapy is optimized at the lowest possible cost.
3. The Vendor must capture the necessary clinical information to enable meaningful analysis and reporting to the Agency in a mutually agreed upon format.
4. The Vendor must agree to provide authorization reviews for specialty medications at the request of the Agency.
5. The Vendor must make recommendations on any and what changes to make to review criteria to the Agency six (6) months after implementation and annually thereafter.
6. The Agency will provide a list of specialty drugs that the Vendor must provide authorizations within thirty (30) calendar day of contract award. This list may be updated annually, or throughout the year as medications are introduced in the market.
7. Specialty medications are physician-administered drugs, billed as medical claims that can fall into any one of more of the following categories:
   a. Prescribed for a member with a complex or chronic medical condition, including medical, behavioral, or developmental condition that may have no known cure, is progressive, and/or is debilitating or fatal if left untreated or under-treated;
   b. Treats rare diseases;
   c. Requires additional patient education, adherence, and support beyond traditional dispensing activities;
   d. In an oral, injectable, inhalable, or infusible drug product;
   e. Has a high monthly, annual, or per treatment episode cost.

Kepro's history with covering high dollar, specialty medications began in 2019. At that time, three drugs were required to be prior authorized. Our work with WVCHIP has grown to a total of 18 specialty medications through 2022. We conducted over 50 special medication/physician administered drug service reviews for West Virginia since contract start.

We understand the importance of clinically sound, safe use practices related to high-dollar medications to reach optimal therapeutic value at the lowest possible cost. As such, our team works closely with WVCHIP on development and revisions of medical necessity criteria stemming from evidence based clinical guidelines. We look forward to continuing our partnership with WVCHIP regarding the 18 current specialty medications and any additional requested by the bureau and will provide a current listing of specialty drugs within 30 days of award. We also understand and will comply with the requirement to submit potential medication additions to WVCHIP for consideration six months following implementation.

The prior authorization of specialty medications/physician administered drug services is conducted using InterQual®, local medical policies, and WVCHIP policy. Prior authorization of specialty medications/physician administered drug services will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

A1.5.s. Applied Behavioral Analysis (ABA) Services

1. The Vendor must provide authorizations for Applied Behavioral Analysis services in accordance with Agency policy.

We authorize ABA services for WVCHIP within the behavioral health program and through EPSDT services. All requirements are followed for WVCHIP members including:

- Members must be between the ages of 18 months through age 20 with a primary diagnosis of autism spectrum disorder (ASD) prior to their eighth birthday.
- Referred for necessary diagnostic and treatment services identified during an EPSDT encounter with a health professional practicing with scope and practice.

We will verify provider participation requirements with WVCHIP and certification by the Behavior Analyst Certification Board, ensure diagnostic requirements and timelines are met, and both an annual physician order and functional assessment of adaptive skills is present.

All ABA services require prior authorization and clinically reviewed for medical necessity according to evidence-based guidelines, and WVCHIP policy. Requests for continuation of services are reviewed also for progress achievement and effectiveness of treatment provided.

The prior authorization of Applied Behavioral Analysis (ABA) services is conducted using InterQual® and WVCHIP policy. Prior authorization of Applied Behavioral Analysis (ABA) services will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

A1.5.t. General Authorization for All Programs

1. The Vendor shall be responsible for printing/copying and delivery of outreach and program administration materials at no additional cost.
2. The Vendor shall attend and participate in Agency Fair Hearings as requested by the Agency at no additional cost.
3. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive and review requests for documentation, including itemized and unaltered invoices for manually priced procedures, and request additional information as needed to complete timely reviews and issue completed prior authorizations. All prior authorizations shall adhere to State Code §33-25A-8s, which can be found at: http://www.wvlegislature.gov/wvcode/ChapterEntire.cfm?chap=33&art=25A&section=8S, and Agency policies.
4. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review forms and request additional medical documentation required for prior authorization and eligibility review of inpatient medical/surgical services to eligible members utilizing the Agency approved criteria and policies.

5. The Vendor shall have a form which is placed in an easily identifiable and accessible place on the health maintenance organization's webpage and contain a comprehensive list of all procedures, services, drugs, devices, treatment, durable medical equipment, and anything else for which the health maintenance organization requires a prior authorization. This list shall also delineate those items which are bundled together as part of the episode of care. The standard for including any matter on this list shall be science-based using a nationally recognized standard. This list is required to be updated at least quarterly to ensure that the list remains current.
6. The Vendor shall determine the medical necessity for urgent/emergent and non-emergency inpatient admission prior authorizations, continued stays, and retrospective reviews for inpatient medical/surgical services to eligible members utilizing the Agency approved criteria and policies.
7. Urgent/Emergent Admission Reviews: Urgent/emergent admissions are defined as admissions to an inpatient hospital setting resulting from the sudden onset of a medical condition or injury requiring acute care and manifesting itself by acute symptoms of sufficient severity that the absence of immediate inpatient hospital care could result in:
a. Permanently placing the member's health in jeopardy.
b. Serious impairment to bodily function; or
c. Serious and permanent dysfunction of any bodily organ or part, or other serious medical consequence.
8. The Vendor shall have the capability and established procedures to receive urgent/emergent admission reviews post-admission for admissions that are not planned or elective and conduct prior authorizations when the member has not been discharged. The Vendor shall ensure determinations for urgent/emergent admission reviews are completed in accordance with current policies.
a. Non-Emergency Admission Reviews: Non-emergency admissions are admissions for planned or elective admissions and the member has not been hospitalized. The Vendor shall have the capability and established procedures to receive non-emergency admission review requests and conduct prior authorizations prior to the planned date of admission. The Vendor shall ensure determinations for non-emergency admission reviews are completed in accordance with current policies.
b. Weekend and Holiday Admission Reviews: Weekend admissions are those admissions where the member was admitted on a Friday, Saturday, or Sunday. Holiday admissions are defined as those admissions where a member is admitted on a state-observed holiday. The Vendor shall have the capability and established procedures to receive weekend and holiday admission review requests and conduct prior authorizations post-admission when the member has not been discharged. The Vendor shall ensure determinations for weekend and holiday admission reviews are completed in accordance with current policies.
c. Continued Stay Reviews: Continued stay reviews are subsequent reviews performed to determine if continuation of services is medically necessary and appropriate. The Vendor shall have the capability and established procedures to receive continued stay review requests for additional inpatient days of care for admissions previously certified and conduct prior authorizations on or before the next review point (i.e., the last certified day). The Vendor shall have the capability and established procedures to provide all hospital providers with a daily listing of members whose certification expires within 48 hours.
d. The Vendor shall ensure determinations for continued stay reviews are completed in accordance with current policies.
e. Retrospective Reviews: The Agency provides retrospective eligibility for a member that was not eligible for benefits at the time of hospitalization. Retrospective reviews cover those admissions where the member was admitted and discharged; certification was not obtained while the member was hospitalized. The Vendor shall have the capability and established procedures to receive retrospective review requests and conduct eligibility reviews. The Vendor shall ensure determinations for retrospective reviews are completed in accordance with current policies
9. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, and other forms or documentation, including itemized invoices for manually priced procedures required for prior authorization and eligibility review.
10. The Vendor shall determine the medical necessity of precertification and retrospective reviews to eligible members utilizing the Agency approved criteria and policies.

a. Authorization Reviews: The Vendor shall ensure determinations for authorization reviews are completed in accordance with current policies.
b. Retrospective Reviews: The Vendor shall ensure determinations for retrospective reviews are completed in accordance with current policies.
11. The Vendor shall have the capability to develop provider educational trainings and provide technical assistance, at no additional cost to the Agency, regarding policies and available services to members and providers. It shall include, but not be limited to:
a. Participation in conference calls with providers and development and implementation of statewide trainings and webinars at the request of the Agency.
b. Develop a reference manual for members and providers. The manual will provide guidelines on policies, as well as procedures to obtain prior authorization, seek clarification on policies, and procedures to file complaints.
c. Develop and maintain a website with updated information, instructions, updates, code lists, bulletins, links to other needed information and/or websites, and any announcements or new information that needs made available to providers.
d. Develop and implement outreach programs to train members and providers on policies and authorizations.
e. Provide a member and provider support line and tracking for inquiries regarding coverage of services, prior authorization status, and answer any questions regarding issues or problems with prior authorization requests.
f. Provide support via phone, letter, email, or fax to the Agency with any issues/inquiries that arise that are referred from providers, facilities, legislature, members, and/or any other government offices or officials.
g. Make recommendations and develop program forms upon request and need of the Agency.
h. Communicate to and educate providers on any program announcements, policies or payment changes to providers and members, as necessary, at no additional cost to the Agency.
i. Represent the Agency regarding UM policies, and/or criteria at meetings, conferences, and educational seminars, as needed per the Agency.
12. Vendor shall coordinate with Fiscal Agent to ensure adequate and timely claims processing. Vendor shall have capability to exchange necessary data with Fiscal Agent to allow adjudication of claims for prior authorized services to providers.
13. Vendor shall create reliable process for monitoring potential over- and under-utilization of services and produce performance reports to identify both providers and members with utilization patterns that fall outside the norms that, if warranted this can lead to, but not be limited to:
a. Further analysis
b. provider education
c. Development of interventions, which can include outbound telephone calls to educate members regarding appropriate use of services, importance of preventive care and/or a referral to case management.
14. In performing medical necessity determinations, the Vendor shall use nationally recognized, research based, standardized, clinical criteria in reviewing each prior authorization and eligibility review request. If not nationally accredited, researched based criteria exist, the Vendor shall develop criteria based on current research available. The Agency shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all services reviewed. The Vendor shall maintain the capability to update the review criteria for services reviewed under the resulting contract. The Vendor shall make recommendations to the Agency annually or as needed, regarding what, if any, changes should be made to the criteria that is currently being used or will be used for the following the calendar year. The recommendations shall be included in the Vendor's annual report and communicated to the Agency.
a. The Vendor shall provide the Agency with access to a complete set of materials associated with the criteria annually.

b. Any modifications to the criteria or policies must be prior approved by the Agency. Based on the best interest of the State and the review outcome, the Agency reserves the right to specify the use of different criteria/guideline products during the resulting contract.
c. The Vendor is responsible for any cost associated with the purchase of any review criteria.
15. The Methodology section of the Technical Proposal must provide detailed information on the Vendor's process for determining medical necessity, including: 1) a description of the recommended review criteria for each service; 2) a description of the review instrument(s) for each service; and 3) a description of the Vendor's capability to develop an automated rules- driven certification system.
16. Specific codes or services may be subject to change due to changes in national codes, changes in federal or state regulations, or changes in state Agency policies.
17. Each of the broad general service areas listed below have a number of different components which will be subject to medical necessity review, authorization, and reporting. The Bureau utilizes MCO services for a part of its population. For those services which are MCO covered, and for members who are assigned to an MCO, the utilization review prior approval requirements are the responsibility of the MCO, (subject to the coverage, rules, and authorization procedures specific to the MCO) not to be subject to review by the potential Vendor bidding on this RFP.
18. The Methodology section of the Technical Proposal must provide information on the Vendor's experience that clearly demonstrates how the Vendor will meet stated requirements and describe in detail the Vendor's experience administering similar UM programs for acute and ancillary services for commercial and/or government health care programs.
19. In performing medical policy coverage recommendations, the Vendor shall use nationally accredited, research based, standards of care in determining recommendations. If not nationally accredited, research-based, standards of care exist; the Vendor shall develop recommendations based on current research available. Policy recommendations shall take into consideration, the WV State Plan, any applicable federal regulations and should make comparisons of other State Agency policies. The Agency shall have prior approval of the proposed policies.
20. The Vendor shall have policies and established procedures to verify eligibility prior to authorization of any services.
21. The Vendor and State shall discuss policy changes during Agency and Vendor meetings.

Along with our expertise conducting utilization management and prior authorization reviews, we bring to WV DHHR our clinical reviewers who are well-trained in URAC, InterQual® clinical guidelines, and Person-centered review processes. All reviews are conducted with a primary focus on optimizing the services available for each individual's needs to facilitate achieving the best health status and outcome. Our methodology is built into our rules-driven, automated system via Atrezzo; by incorporating InterQual® and other WV-preferred review criteria directly within our automated system, configured for each review type, we ensure consistent and thorough application of our criteria across all reviews.

Our expert clinical reviewers ensure medical necessity and compliance with WV DHHR's policies with a keen focus on quality and clinically appropriate services and treatment setting with each review. Our clinical reviewers ensure the authorization reviews are person-centered, clinically appropriate, and reflect an optimal level of quality services rendered. Ultimately, our authorization reviews determine if beneficiaries are receiving the appropriate care and services or if they may be better served in a lower level of care or with alternative services to meet their individual needs. The end result of the Kepro advantage is that the individual is provided the best option of service to achieve their best health status and outcome. WV DHHR can be confident that it is maximizing

its taxpayer investment in the best holistic care approach available for each member based on that member's unique circumstances.

The volumes we have handled company-wide for reviews, appeals, and hearings for the last five years are shown in **Table 23 Kepro Review and Appeals Experience** below, which represents our experience and expertise.

Type	2018	2019	2020	2021	2022
Medicare Discharge Appeals	88,733	74,164	67,075	99,482	148,995
Reconsideration Appeals	10,000	10,000	10,160	10,160	24,803
Medical Review Appeals	13,400	9,764	10,327	16,448	21,615
Total Appeals	**112,133**	**93,928**	**87,562**	**126,090**	**195,413**
Prior Authorization Reviews	1,884,615	2,860,060	2,874,498	3,112,778	3,302,709
Prior Authorization Reviews (Pharmacy)	2,406,556	4,876,987	4,347,143	4,031,080	4,132,547
Compliance Reviews	8,273	2,034	0	89	0
Quality of Care	86,149	175,948	118,525	108,627	79,470
Reconsiderations	116	31	111	128	10,562
Standard of Care	3,369	3,566	3,485	3,982	4,399
Witness Hearings	5,206	4,673	3,575	4,501	4,245
Specialty Reviews	13,721	448	174	448	466
Total Reviews	**4,408,005**	**7,923,747**	**7,347,511**	**7,261,633**	**7,534,398**
Total Reviews + Appeals	**4,520,138**	**8,017,675**	**7,435,073**	**7,387,723**	**7,729,811**

Table 23. Kepro Review and Appeals Experience
We have a wealth of experience with a range of review types and appeals.

Receipt of Prior Authorization Requests

Depending on program policy, Kepro offers the highest flexibility by offering providers the convenience of submitting prior authorization requests via multiple modalities including the Atrezzo portal, telephone, fax, and mail. **Figure 66 Process for Receiving and Processing Prior Authorization Requests located in Section A5.1.a Inpatient/Medical Surgical Services** outlines the initial prior authorization (PA) request workflow in Atrezzo, whether the request is submitted through the portal or entered manually into the system.

When a prior authorization request is submitted via fax, telephone, or mail our Customer Service Representative (CSR) retrieves the intake information and enters relevant details into Atrezzo. The CSR will record the date of receipt as the date the request was received by Kepro, except for requests received after business hours. For requests received after business hours, the date of receipt will be recorded as the next business day. Atrezzo will then automate the remainder of the process, including Medicaid eligibility checks and sending communications to the provider automatically. If the request requires clinical review, the request is automatically routed via Atrezzo workflows to the appropriate clinical review work queue. **Table 24 Medicaid Client Prior Authorization Requests by Method** breaks down the method of prior authorization submission requests for a large Medicaid client in 2021.

Did You Know?

In 2021, the Atrezzo provider Portal received more than 1.14 million total service lines/ procedures.

Submission Method	2021 Percentage
EDI	0.03%
Fax	4.42%
Mail	0.01%
Phone	4.64%
Provider Portal	90.90%

Table 24. Medicaid Client Prior Authorization Requests by Method
We have worked with providers to get most PA requests submitted online.

Atrezzo Provider Portal Submission Process

We apply the following step-by-step process for prior authorization requests received via the Atrezzo provider portal, telephone, fax, or mail. We supply a master code list that indicates all allowable codes for providers to obtain prior authorization, which is available on the website and includes the code, units, and benefits.

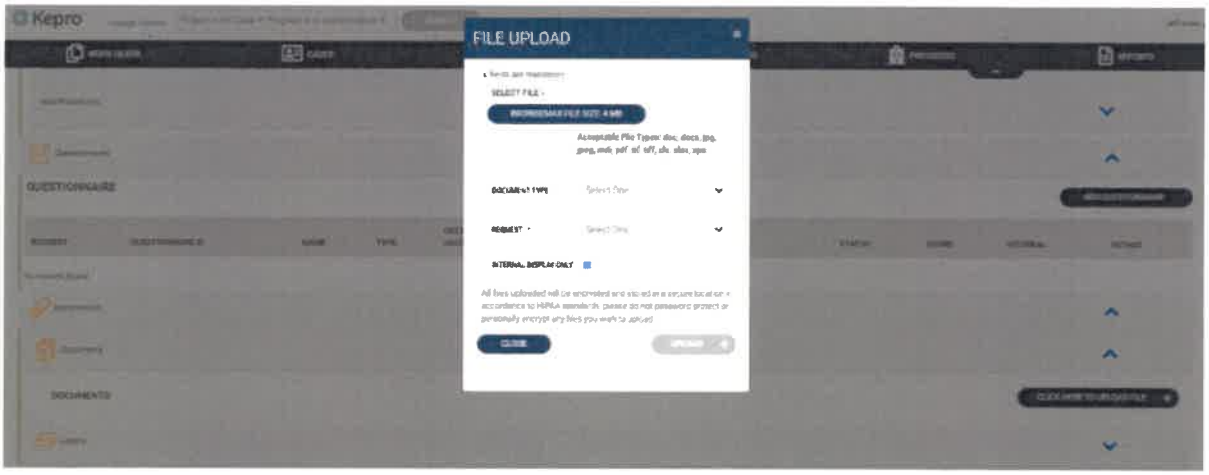
We understand that final prior authorization processes are subject to WV DHHR approval.

Step 1: Prior Authorization Request and File Upload

Prior authorization requests can be submitted via the Atrezzo Provider Portal or by fax, mail or telephone call to our CSRs and directly entered into Atrezzo. Requests submitted directly to the Provider Portal are immediately queued for review or immediately approved using auto approval logic if criteria are met. When prior authorization requests are received by telephone, fax, or mail instead of our Provider Portal, CSRs will input the requests into Atrezzo upon receipt. Atrezzo is optimized to prevent duplicative data entries, therefore any requests entered via portal or telephone, mail or fax are entered into one Atrezzo module.

All prior authorization requests and supporting documentation are housed in our Atrezzo system—from start to finish our clinical staff and providers can view all information and documentation for a specific request through a single, web-based system. When a request for a prior authorization is received either by phone, mail or fax, our CSRs immediately create a case in Atrezzo. providers can add/upload supporting documentation, either by uploading documentation directly into Atrezzo, or by sending to us via mail or fax and CSRs upload the information into the system. We pend a case when the authorization requires clinical review and supporting documentation, and we request the additional information from the provider. To ensure providers submit the required additional information in a timely manner, we utilize notifications and alerts ensuring submissions are reviewed within the review types required timeframe.

As shown in **Figure 74 File Upload Screen**, uploading files into Atrezzo is a simple, efficient process for providers.



WV_037a

Figure 74. File Upload Screen
From this view, relevant documentation can be uploaded into the Provider Portal.

Maintaining Documentation in an Electronic Record Format – All documentation is housed within Atrezzo, regardless of how it arrives. Providers and Kepro staff upload files to a case and can enter clinical documentation and other notes directly into the case even if it is submitted via electronic data interchange. providers can also call, mail, or fax in information. Fax images are housed in Atrezzo, along with any uploaded documents. Staff-enter information provided by phone or mail is scanned and uploaded. Users with Atrezzo client access, which includes physician consultants and WV DHHR staff, can view documentation online from within the case.

Our secure Provider Portal facilitates communications between medical providers and our clinical review staff. Our design of the Atrezzo system is based on years of interaction with the various provider communities. We continuously look for ways to make the system more efficient and easier

to use for providers, and their staff. Owning this system allows us to implement enhancements that providers and WV DHHR are requesting in a cost-effective and timely manner.

Process for Marrying Prior Authorization with Supporting Documentation – All documentation related to a specific case is available in one place for ease of review, as shown in **Figure 75 Documentation Screen.**

Figure 75. Documentation Screen
Documentation is centralized in this screen to ensure ease of access to case information.

Step 2: Case Creation

Once a provider submits a request for services either through the Provider Portal, or via telephone, mail or fax, our Customer Service Representatives use the Create Case screens to create a case workflow and initiate a first level review. **Figure 76 Case Creation screen** shows an example.

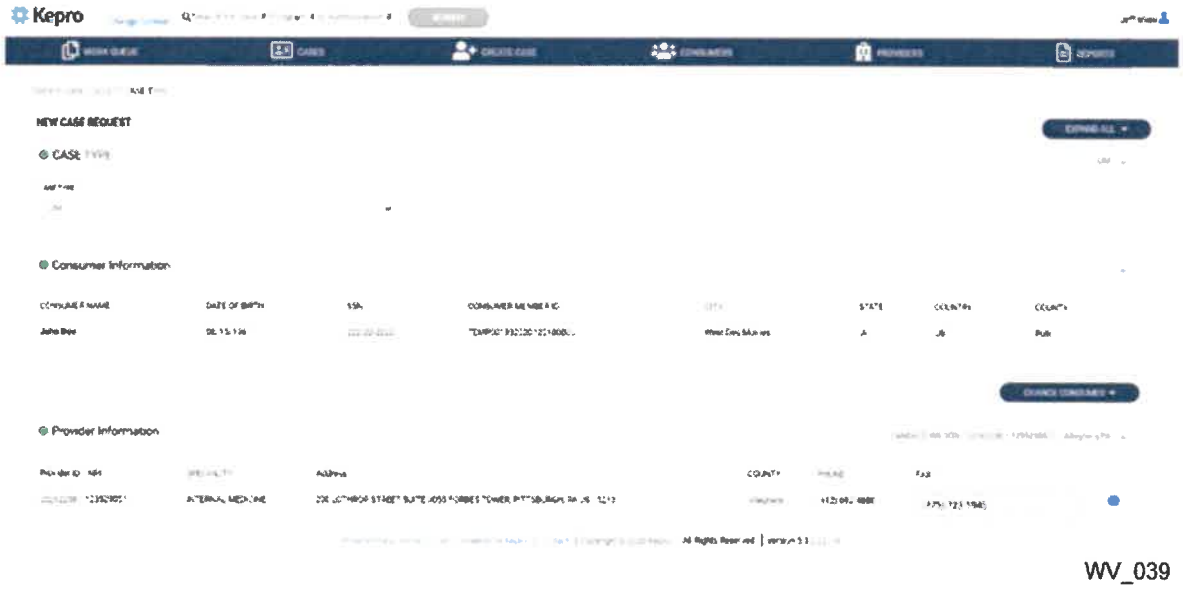


Figure 76. Case Creation Screen
A clinical reviewer creates a case in Atrezzo to initiate a first level review.

From here the system captures all relevant information for a case (e.g., physician/facility information, clinical information such as service details, diagnosis codes and procedure codes). From this interface (shown in **Figure 77 Case Information Screen**) both clinical reviewers and providers can see all the relevant information captured for each case.

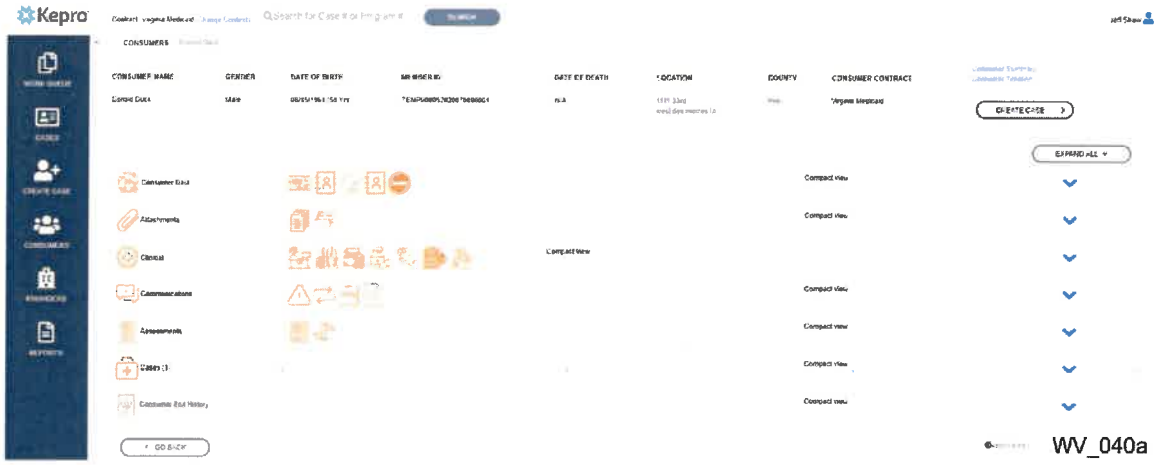


Figure 77. Case Information Screen

Atrezzo allows both clinical reviewers and providers to see all information relevant to the case.

Figure 78 Clinical Information Expanded View provides an expanded view of the clinical information area. From here reviewers can look at service details, diagnosis codes, and procedures specific to each case.

Figure 78. Clinical Information Expanded View

Clinical reviewers can expand desired service details, diagnosis codes, and procedures specific to the case.

Figure 79 Service Details Screen provides a view of the service details for a case.

WV 042

Figure 79. Service Details Screen

Within Atrezzo, the clinical reviewer can drill down to specific service level details of a case.

Figure 80 Document Screen provides an expanded view of documents, which falls under the Attachments area, where all relevant documentation is uploaded for review.

WV_043

Figure 80. Document Screen

Atrezzo allows for easy upload of clinical documentation for review.

Figure 81 Interactions Screen shows a breakdown of the interactions portion of the Communications area, which also includes notes and alerts.

WV_044

Figure 81. Interactions Screen

Atrezzo's Interactions Screen enables efficient communication of pertinent case information to relevant parties.

Step 3: Ensure Documentation is Complete and Request Additional Information as Needed

Once we receive the supporting documentation from a provider, a clinical reviewer evaluates the documentation and determine if it is complete or if more information is needed. If the documentation does not include all the required documents, we will contact the provider requesting additional information in the manner and timeframes required by WV DHHR. The clinical reviewer will call, fax, or email the provider, indicating the information needed and the timeframe the provider must return the information.

We will request the provider send the missing information within approved timeframes via the Atrezzo Provider Portal, fax, or mail. The use of the Atrezzo Provider Portal is an important feature of our system that improves record submission by making it possible to upload materials 24/7 and immediately confirm acceptance of the upload. Our call center is also available to assist providers during office hours, and we will scan the records into the system if we receive them in hardcopy format. Our administrative process validates that the records are complete and ready to review. If needed information is still missing, we will notify the providers and request them to submit just the specific materials. If providers do not submit the requested documentation in response to the first and second requests, we will close the case and indicate "Reject – Insufficient Information."

Additionally, provider training will focus on educating providers to the required components in submitting complete medical records. Ensuring providers are well educated in key processes and procedures, including the submission of complete documentation, is key to our ongoing, successful partnership with our state program providers.

Step 4: Review

Once all the needed documentation is gathered each review is conducted by a qualified Kepro reviewer. When performing clinical review all reviewers first ensure all applicable program and administrative requirements and policies are met. The reviewer then evaluates clinical information submitted and any supporting documentation. The reviewer evaluates the information using applicable first level review clinical decision support tools, such as InterQual® criteria or other WV DHHR preferred criteria; these criteria indicate appropriate length of stay, medical necessity, and triggers for continued stay based on the member's medical status. Regardless of service type requested, we will adhere to the policies and procedures set forth in federal and state policies such as the Code of Federal Regulation (CFR) and specific state requirements.

Upon review of all medical documentation received for each review, if all required criteria are not met such as whether the services were rendered at an appropriate level of care or if quality of care concerns have been identified, the reviewing clinician will refer the case to the Medical Director or Physician Consultant within a matching specialty for a second level review.

Clinical Criteria Review Screens – Figure 82 InterQual® Interface Screen shows our clinical review: InterQual® Interface screen. Using this screen, reviewers can view the InterQual® review conducted on a request, the Criteria Subset chosen, Status, Review Date, Modified By, and Date.

Figure 82. InterQual® Interface Screen
This screen displays the Healthcare InterQual® review conducted on a PA request.

The screen shown in **Figure 83 InterQual® Criteria Recommendations Screens** enables users to view what clinical information was documented as well as the results of the InterQual® review.

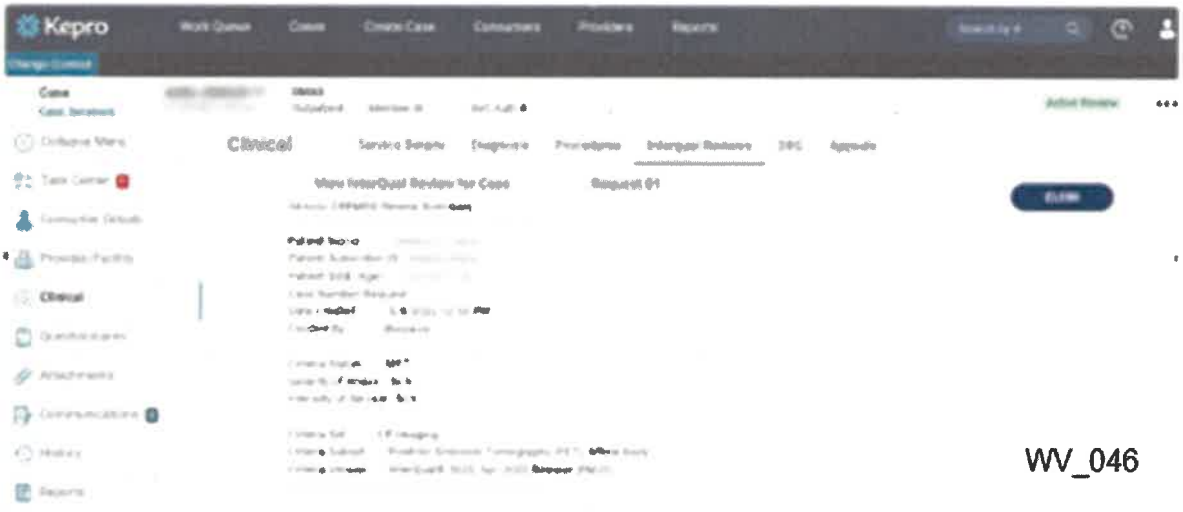


Figure 83. InterQual® Criteria Recommendations Screens
Shows the results of the Healthcare InterQual® review.

Figure 84 Sample Outcome Screen is an example for a clinical review. This screen enables users to view the completed review (e.g., Approved, Denied, Pended, Void), along with dates of service, units, price, and frequency.

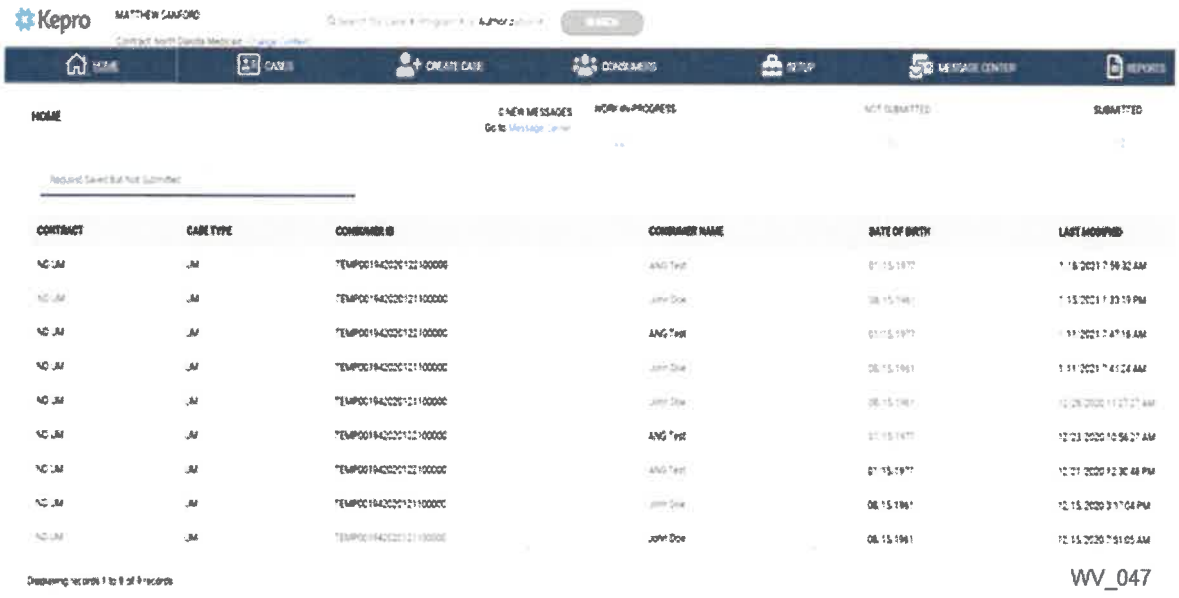


Figure 84. Sample Outcome Screen

Users can view the review outcome as well as dates of service, units, price, and frequency.

From start to finish Atrezzo captures all relevant case information, interactions, and supporting documentation, making it a one-stop resource for both clinical reviewers and providers alike.

Step 5: Determination and Notification

Once the determination has been made regarding an approval, denial or partial denial, communication is automatically sent to the State's MMIS through data file transfer. We will generate applicable notification letters to providers and members per contract and policy guidelines.

Approvals – Approval notifications are delivered in real-time to providers when the Provider Portal is used for prior authorization request submissions. Notification will contain a unique identifier to the case and clearly outline the dates and services/treatment approved. Confirmation of authorization will include the approval notes, the admission or onset of care, the number of days or units of service, next anticipated review time (end date of authorization), total number of days or services approved.

Denials – Following the entry of the denial decision into Atrezzo, the communication is automatically sent to the submitting provider via portal notification. In addition, a notification letter is mailed to the member within 24 hours of the determination. Denials will include all necessary service authorization request information for the member and provider to take next steps toward an appeal or submission of additional information to support the request.

Atrezzo Provider Portal

Access to a provider portal through Atrezzo has further streamlined the daily workload for providers and reviewers in utilization management. Our portal allows providers to submit requests 24-hours, 7 days a week, attach documentation, complete review specific forms, communicate electronically with staff (including the clinical reviewers), and manage and track requests for authorization. In 2021 alone, our portal reported over 27,000 enrolled providers and over 87,000 provider users, as well as handled over 50,000 provider portal submissions each month. For our West Virginia contract, 1,810 providers are enrolled for portal use, and we host a total of 5,154 individual West Virginia-specific provider users. These features also further support our data-driven approach to reporting. Our Provider Portal has proven to be a differentiator - helping to drive a 95% customer satisfaction rate measured by annual provider Surveys.

Providers say: Portal

Our providers consistently give us excellent feedback on their experience using our provider portal:

"I like to use Kepro because it (the portal) is fast, and the response time is also fast. The people are courteous and willing to help you solve problems."

"Thankful that Kepro service authorization process is consistent and reliable."

A key component of Atrezzo's Provider Portal is the improved collaboration between WV DHHR Operations staff, provider relations staff and operations staff, resulting in a high level of provider satisfaction and acceptance of the portal process. The shift away from fax to portal benefits our Medicaid clients and provider communities by eliminating the delay and uncertainty inherent in a fax-based system. Atrezzo is configuration-based, allowing for rapid implementations and updates to the WV UM and PA program without the need for extensive IT support or software development.

Authorization requests are also accepted from providers via fax or mail per WV DHHR guidelines. When Kepro staff receive and enter a provider's submission into Atrezzo, the same rules engine and embedded workflows are employed, affirming WV DHHR requirements and timeliness standards.

The following key features of the Atrezzo Provider Portal ensure a streamlined authorization process, leading to ease of use for providers:

- ✓ **Robust Rules Engine** – Requires only necessary fields be completed based on the requirements of the UM/PA request, minimizing the information required to request authorization.
- ✓ **Embedded workflows** – Streamline the authorization submission process for providers and ultimately ease administrative burden.
- ✓ **Automated Notifications** – Providers receive real-time notifications such as insufficient information or incomplete submission and authorization and denial decisions and notifications.
- ✓ **Real-time Communication with Kepro clinical reviewers** – Providers can communicate directly with clinical reviewers via the Portal, removing the need to contact the Call Center for questions or status inquiries.

Atrezzo's Workflow and Task Driven Activities

Atrezzo's internal algorithms and rule-based workflow functionality supports the life cycle of all types of authorization requests beginning from the provider's submission of request and continuing through provider validation, member eligibility, clinical review, service type validation, determination, notification, and completion of the case.

Atrezzo's workflow functionality for authorization requests includes the following six core components:

1. **Submission Validation.** Submission validation rules confirm that the request requirements are met, member and provider eligibility, benefits validation, service type requirements, and other client-specific data elements related to the submission of the request.
2. **Rules-Driven Authorization.** After passing the Submission Validation ruleset, each service request is evaluated to see if it meets the criteria for Rules-Driven Approval. If the criteria are met, then the service line is marked as approved. If the criteria are not met, no action is taken. If all services requested are marked as Approved by the Rules Driven Authorization ruleset, the Case is closed and is not pushed to a clinician's queue for review.
3. **Request Routing.** Requests not completely approved by the Rules-Driven Authorization are evaluated based on the type of request and routed to the corresponding clinician or administrative staff, depending on the requirements.
4. **Clinician Review.** The workflow supports clinicians conducting an initial review for medical necessity. If the clinician does not find the request to contain information to support medically necessity, the workflow triggers a referral to a physician for a peer-to-peer review. If all services have a decision (approve or deny), then the ruleset marks the services to be extracted and sent to the claim's payor in the next scheduled extract.
5. **Authorization Rules.** Authorization Rules recheck the request to confirm that the rules required for submission are followed by validating, at the time of approval or denial, that the business rules are still being followed.
6. **Notifications.** Notification of determination is auto generated to provider(s) based on configured rules specific to the client.

Atrezzo's Task Driven activities are managed through custom workflow configuration, moving the task automatically through the process from receipt of request to decision and completion. Each workflow step is tracked with a date/timestamp. The end-to-end authorization request, review process through decision and notification is facilitated by workflow queues that allow for pooled resources to work the items based on the rules established for that team. When a request is submitted there are business rules that route the request to the appropriate queues. These rules can be specific to attributes such as review type, and urgency. If the queue or team requires an additional level of assignment the system has algorithms to assign to specific team participants in a round robin, random or custom rule approach. Custom rules can include things like capacity limits, risk level or complexity.

Through workflow and task-driven functionality, Atrezzo monitors and alerts Reviewers of authorization turnaround times (TAT). Authorization Dashboards are used by Kepro UM staff and can be used by WV DHHR as well. The Dashboard includes several visual indicators to alert users of turnaround times and priority. Elements that are critical are indicated by color (typically red for past due). Each request type has a configurable turnaround time that is measured starting upon initial submission. There are scenarios where the time is suspended such as when the request is pended back to the submitter for additional information. The dashboard allows for sorting by remaining time as well as other parameters.

Atrezzo's task driven timeliness tracking includes:

- Timeliness tracking of an authorization begins immediately upon submission
- Timeliness tracking automatically starts and stops the clock when pended or returned
- Dashboard reflects visual color indicators for requests that are approaching due date/time and past due date/time

We have the capability to exchange necessary data with the Fiscal Agent to allow adjudication of claims for prior authorized services to providers. Our extract files include authorization data that is exported to the fiscal agent to load into their system for claims processing and payment.

Auto Approvals

Atrezzo supports auto-approvals by utilizing rule-based algorithms for Authorization requests submitted through the Portal or when entered manually. We use ICD-10, HCPCS, demographic information, provider specialties and other information as necessary to create client specific rules for auto approvals. Atrezzo employs a series of checks and balances when reviewing authorization requests such as providing warnings if services requested have been previously authorized, or if a provider is not approved to provide services or if information is not sufficient to complete the request. Upon submission of the authorization request the configured auto-approval workflow will drive the approval of the request. Atrezzo, whether entered by a CSR or via the Provider Portal by the provider, provides real-time auto-approval notification.

Our auto-approval algorithms are developed by our highly experienced staff of clinicians with support from our Data Scientists. They are reviewed by panels of physicians yearly to determine accuracy and reflect national clinical guidelines. During the Implementation Phase we will collaborate with WV DHHR to configure your preferred auto-approvals by service type as well as share our extensive library of auto-approval service types that can be adopted or modified.

EPSDT Screening

Atrezzo allows clinical reviewers to easily verify if service was identified during the performance of an Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) screening. Atrezzo is configured so that all codes are accepted for members under 21. Atrezzo will check for allowed codes. If a request for a code is not typically allowed, and the member is under 21, Atrezzo will not stop the

prior authorization request from being submitted. If the prior authorization request for a member under 21 is for an allowed code, the request will be routed to the respective service type queue in Atrezzo. If the request for a member under 21 includes a code that is not on the allowed codes list, it will be routed to the EPSDT queue.

General Authorization Process

All decisions made by the clinical reviewer to authorize, modify, or deny a given request will be based on medical necessity, as well as program policy criteria. For the WV UM and PA program we use InterQual® criteria in addition to contract, State, and CMS required guidelines for authorizations of inpatient and outpatient services and items to ensure the services requested are clinically appropriate and medically necessary.

We bring to WV DHHR our decades of experience, clinical expertise and understanding of UM and PA services across multiple service types and treatment settings to deliver operational excellence in all levels of Utilization Review. We show the standard prior authorization review process in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services**.

The Authorization Review process begins upon receipt of request for services. The clinical reviewer receives the request automatically in real-time via Atrezzo and reviews the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR program policy. Using these criteria will ensure that services and items planned are consistent with the provisions of appropriate care. If InterQual® guidelines are not available for a specific service, We have a large library of local evidence-based policies that can be adapted for WV DHHR's consideration.

If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo. The provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to the physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo, and the clinical reviewer finalizes the case. If the case was created by the provider via the Provider Portal, an email notification is automatically sent to the provider.

We have the experience necessary to coordinate all the logistical pieces involved in medical necessity determinations and whether a covered benefit or service is medically necessary. Our

expertise is in coordinating these pieces in a manner that ensures uniformity, accuracy, and timeliness for all review types, review mechanisms, or geographic locations.

Our UM and PA program provides review of medical necessity and appropriateness of care through application of standardized screening criteria to ensure services are authorized only when medical necessity is met, and services are a covered benefit; this ensures that WV DHHR only pays for the appropriate clinical care which decreases claims associated with inappropriate inpatient and outpatient services. Our primary program goal is to ensure members receive the best quality care they are eligible to receive in the most appropriate setting while focusing on a whole person-centered care and services.

Medical necessity reviews follow our prior authorization process and are conducted in the best interest of the member and medical appropriateness. These reviews are provided for medical reasons rather than primarily for the convenience of the individual, their caregiver, the health care provider, or for cosmetic reasons.

Our properly credentialed, licensed, and qualified clinicians will combine our high standards of quality and expertise with administrative rules of WV DHHR when making medical necessity determinations using InterQual®, a nationally recognized Clinical Determination tool. We have extensive experience reviewing prior authorization requests from providers for services outlined in this RFP. Clinical reviewers will perform the initial review of the case to evaluate the proposed services based on an individualized assessment of the member's medical needs, ensuring medical necessity and appropriateness of the setting as outlined above. Clinical reviewers do so by comparing the information contained in the request, including ICD-10, HCPCS, service type and member demographics such as age, against the appropriate InterQual® Criteria and other applicable West Virginia Medicaid rules to ensure requested services are reasonable and are required to identify, diagnose, treat, correct, cure, palliate, or prevent a disease, illness, injury, disability, or unhealthy practice. They must also fall in line with the terms of the service, amount, scope, and duration based on evidence-based medicine.

The clinical reviewer, using InterQual®, indicates whether the condition of the member meets the severity of illness and intensity of service requirements for the level of care and the type/number of services requested to arrive at a review determination. As part of the review, the clinical reviewer will assess whether the requested service is provided in the most appropriate location, with regard to generally-accepted standards of good medical practice, where the service may, for practical purposes, be safely and effectively provided.

Kepro reviews demographic information and all relevant clinical information submitted by the provider that would justify the need for inpatient services. Examples of justification include:

- Clinical information of chief complaint
- Previous treatment to substantiate the need for hospitalization and level of service for the requested admission/procedure

- History of present illness
- Vital signs/Blood Pressure
- Results of physical exam
- Diagnostic testing results including lab and radiology results
- Diagnoses
- Treatment plan and level of care
- Physician's plan of care including medications information including dose/route/frequency, all treatment modalities, monitoring and diagnostic tests, discharge plan

The clinical reviewer's approval of the requested services is based on medically necessary care and the member's benefit plan. Depending on the review type, the clinical reviewer approves the case when the following are present:

- Services are a covered benefit
- Appropriate severity of illness clinical factors
- Appropriate treatment elements in services provided or planned
- Appropriate treatment setting (e.g., can the member be better served in a lower level of care)
- Medical necessity as determined by InterQual and/or any other clinical guidelines used by WV DHHR.

Severity of illness includes measuring objective clinical indicators of illness through presenting signs and symptoms as well as abnormal findings in the clinical picture of the member. Intensity of services includes evaluation of diagnostic, monitoring, and therapeutic services that can be administered only at a specific level of care and the treatment plan implemented for the member. Severity of illness and intensity of services rules, per InterQual® guidelines, are consistently applied to all clinical reviews and determinations.

The clinical reviewer communicates the approval determination to the provider through the provider portal and/or via fax or autogenerated letter.

If clinical reviewer does not believe that the request meets medical necessity based on InterQual® guidelines, the request and accompanying documentation are sent to a physician reviewer. The physician reviewer makes a determination based on acceptable, current evidenced based practice, and, if required (per URAC, for all inpatient services) or requested, a Peer-to-Peer discussion with the requesting provider to better understand why the provider is requesting the services. The physician reviewer's determination is then communicated to the provider verbally and through the Provider Portal and/or via fax or autogenerated letter. For all adverse determinations, the member receives the denial notification via certified mail.

We are knowledgeable and consistent with our application of medical necessity for EPSDT services. We also understand the sensitivities of EPSDT services sought for under-aged beneficiaries, stakeholder groups, and the communities we serve. As an example, to better serve our Colorado HCPF client following the transition from a previous UM Program vendor, we learned that EPSDT

services previously sought through the incumbent vendor were often inconsistent with the application of medical necessity, creating disruption for the beneficiaries and HCPF. We developed an intensive EPSDT training plan for mandatory participation by our clinical reviewers and physician reviewers to ensure each Clinician was individually trained upon hire and received annual continuing education and training on EPSDT guidelines. We also established templated verbiage surrounding EPSDT that physician reviewers use in their determination. This templated language is used to document and confirm that they applied EPSDT criteria to the decision.

We will conduct all urgent and emergent reviews within the required timeframes. The medical record review will also include a review of each urgent/emergent admission to determine if the admission was a non-emergency admission. If the clinical information presented does not meet InterQual® guidelines and the clinical reviewer determines the hospital designated emergency admission is non-emergent, the case will be referred to a physician reviewer. If the physician reviewer concurs with the clinical reviewer decision, the clinical reviewer will deny admission for lack of medical necessity. The clinical reviewer will also validate that concurrent review has been completed as required. Failure to meet these requirements for pre-authorization or concurrent review will result in denial of the admission or days in question by the clinical reviewer.

Requests for weekend and holiday admissions, in addition to retrospective requests, will receive eligibility verification and clinical review by the date of receipt. Behavioral Health admission requests must be accompanied by the MCM-1 form, which certifies this level of care is the most appropriate. This WV form is utilized to meet the independent evaluation requirement in 42 CFR.

To help beneficiaries move through the continuum of care appropriately based on medical need criteria, Continued Stay Reviews are provided throughout all levels of care. We have provided Continued Stay Review Management for decades. Our extensive Continued Stay Review Management experience includes contracts in Maine, West Virginia, South Carolina, Minnesota, and Florida. As such, we can provide Continued Stay Review to support WV DHHR as required. We will conduct Continued Stay Reviews within Atrezzo using the utilization review process outlined previously outlined above in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient/Medical Surgical Services**.

A nurse conducts reviews of medical record information to determine if the need for continued stay and to provide notice and/or reconsideration for denied participants. Additionally, this review ensures quality assurance and multidisciplinary team requirements pursuant to state requirements.

Using an algorithm based on approved criteria we assure the medical necessity and appropriateness of the recipient's continued stay. Where the medical record documentation does not substantiate the need for continued stay, the attending physician and/or direct care staff is contacted and requested to supply additional documentation in the recipient's record to justify the continued stay.

Our Retrospective Review process follows a similar process to prior authorization review. The retrospective review includes reviewing the member's medical record that corresponds with the date of initial service and subsequent treatment to validate medical necessity throughout the member's length of stay in the inpatient setting. We will ensure the plan of care is consistent with WV DHHR policy. Daily documentation specific to treatment goals and objectives, anticipated LOS and discharge planning activities must be evident for each day of hospitalization. For inpatient reviews after discharge and prior to billing, the hospital will submit a request for processing. Our Retrospective Review Process is illustrated in **Figure 67 Retrospective Review Process located in Section A1.5.a Inpatient Medical/Surgical Services.**

Our clinical reviewer begins the retrospective review by reviewing the clinical information based on nationally recognized InterQual® clinical guidelines and WV DHHR required rules. Using these criteria will ensure that services and items planned are consistent with the provisions of appropriate care. If the request for services meets medical necessity and is a covered service under the member's benefit plan, the clinical reviewer documents the approval in Atrezzo, and the provider receives real-time notification via the Provider Portal.

If clinical information is not sufficient, the clinical reviewer pends the request and automatic notification is sent to the provider for additional clinical information. If the additional information is received timely and meets criteria, the request for authorization is approved. The clinical reviewer documents the approval in Atrezzo, and the provider receives automatic real-time notification of the approval via the Provider Portal.

If additional information received does not meet criteria or additional information is not received, the request is forwarded to a physician reviewer to review all available documentation against criteria and medical expertise. The physician reviewer documents the approval or denial decision in Atrezzo, and notification is automatically sent to the provider via the Provider Portal and/or notification is autogenerated via Atrezzo and can be viewed as well as downloaded from the Provider Portal. For all adverse determinations, the member receives the denial notification.

Over-and Under-Utilization of Services

Kepro maintains a reliable process for monitoring potential over- and under-utilization of services and produce performance reports to identify both providers and members with utilization patterns that fall outside the norms. Our Health Intelligence (HI) team stands ready to provide WV DHHR with insightful review of Medicaid covered services and FFS claims to identify over- and under-utilization of services and other data and trends to mee the goals of the organization. Our HI team, working in collaboration with our Executive Director and Project Managers, gathers and analyzes data to include both pertinent and comprehensive findings as well as presents recommendations to WV DHHR. We bring our expertise to WV DHHR, including collaborating with outside agencies for review of value-based payment models and bringing multiple managed care, fee-for-service, and agencies together to meet the goals of the organization.

We monitor provider utilization patterns primarily through our monthly reporting. It is our practice to review and discuss reporting and concerns with WV DHHR regarding any potential concerning trends. We will exercise our longstanding, tenured relationship with BMS and WV providers to continually focus on quality and appropriate utilization of cases to ensure the most appropriate services are identified. Any concerning practices regarding over or under-utilization will be discussed with BMS and further explored.

In addition to provider monitoring, member services receive ongoing evaluation to ensure appropriate WV Medicaid benefits are appropriately distributed. Our case management process allows us to identify repetitive services or high-cost services that may be repetitive. We also locally review UM reports and provider monitoring so that if issues arise, we can discuss provider performance with the Bureau.

Kepro conducts monthly Participant Satisfaction surveys within our West Virginia contract that routinely top 98%. Our October 2021 score showed 98.1% satisfaction. Kepro received an average score of 99% throughout 2021.

Stakeholder Engagement

Our overarching approach to stakeholder engagement is standardized across Utilization Management and Waiver programs and has ensured Kepro maintains a pulse on stakeholder needs. Our approach has been honed over years of experience with hundreds of clients and uses continuous improvement and identification of best practices as its foundation for education, training, and outreach.

With each client, we begin by identifying the relevant stakeholders. Kepro believes that stakeholders impacted by this program will include not only WV DHHR staff, but also related agencies and providers. Additionally, we estimate some level of secondary communication to State government, members, and the public. We also anticipate variations in operational impacts to users based on not only different technology environments in the various offices, but also different office types (eligibility, service delivery, claims). Finally, we recognize that the dynamics between WV DHHR and its district offices will add an additional layer of organizational complexity. Our stakeholder analysis approach will ensure that these differential impacts to various stakeholders and end-users are duly identified, analyzed, and addressed through custom change enablement actions.

We will implement our collaborative engagement strategy by working with WV DHHR stakeholders to define initial requirements, review and resolve issues, and refine and update requirements as the contract dictates. Kepro's Stakeholder Engagement Model, including our Stakeholder Advisory Council, serves as a feedback loop to improve the quality and ultimately the outcomes of the program where we promote transparency and avenues for ongoing input into our program from key stakeholders.

Consistent and open collaboration with WV DHHR is essential to successful implementation of the WV DHHR UM and waiver program. We prioritize continuous two-way communication from the start to ensure stakeholders are empowered with the information and resources they need to fully participate in UM implementation activities and to meet program requirements.

Kepro also embraces partnerships with community stakeholders as the most effective means of improving the quality of services that ultimately benefits Medicaid members. We will work in close collaboration with WV DHHR to identify key stakeholders such as human service providers, families, and advocates to ensure that together, we lay the foundation for strong working relationships and ongoing program buy-in. We will provide the following necessary components to successfully engage stakeholders in the delivery of WV DHHR UM and waiver services in West Virginia to achieve person-centered excellence. Our communication, outreach, and training plan include the following six components:

1. **Gain Insights about Challenges:** We will conduct stakeholder listening sessions to understand the current needs of WV DHHR stakeholders, discuss communication strategies, and learn about any concerns related to the program. We use stakeholder advisory councils and workgroups for insight into implementation and ongoing processes.
2. **Implement a Formal Stakeholder Engagement Plan:** We will implement a formal stakeholder engagement plan during implementation, building on and learning from the listening sessions, existing WV DHHR efforts and best practices. Using our proven experience and successes, we will draft the plan and submit to WV DHHR for approval. We will verify key stakeholders and develop training/meeting agendas and materials for all key groups. We will work with WV DHHR to encourage stakeholders to attend trainings/meetings where they will learn about program requirements and strategies to fully participate in UM activities. We believe that transparency in our process garners stronger relationships and cooperation amongst stakeholders. Accordingly, we strive to make the process accessible and efficient for all involved.

Ensure Initial and Ongoing Communication with providers: We prioritize communication with providers every step of the way to provide program updates and support. Communications and educational materials will be routinely customized to meet WV DHHR needs, including purchased educational brochures and internally created documents. These types of targeted educational materials include content based on WV DHHR input and trends we have identified as an educational need. Educational materials, to include the WV DHHR logo and content requested or approved by WV DHHR, are updated at least quarterly. We create a customized newsletter using a consistent level of quality and success within the program. In addition to our healthcare expertise, training is a foundation to Kepro's approach to providing successful programs. During the implementation, we will review and obtain approval from the WV DHHR for all planned communication. Once approved, we will engage with key stakeholders to explain the program, our role, and any changes occurring within the program. Our communication strategies to engage and foster collaborative relationships with stakeholders include:

- Targeted educational materials based on stakeholder feedback and best practices.
- Communication through email, website postings, virtual and in-person meetings and presentations, Town Halls, phone-based and in person technical assistance, newsletters (see **Figure 85 Newsletter Example**) and "hot topic" alerts (see **Figure 86 Example of "Hot Topics" Provider Notification**).

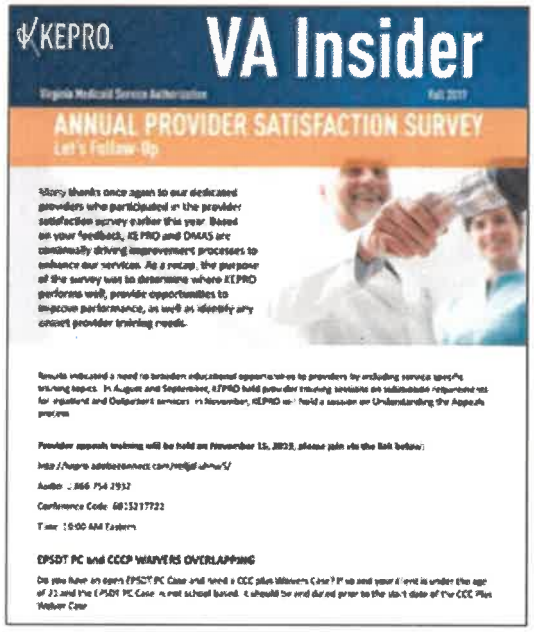


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Figure 85. Newsletter Example

Customized newsletter targets providers, emphasizes continued engagement and promotes training and resources.

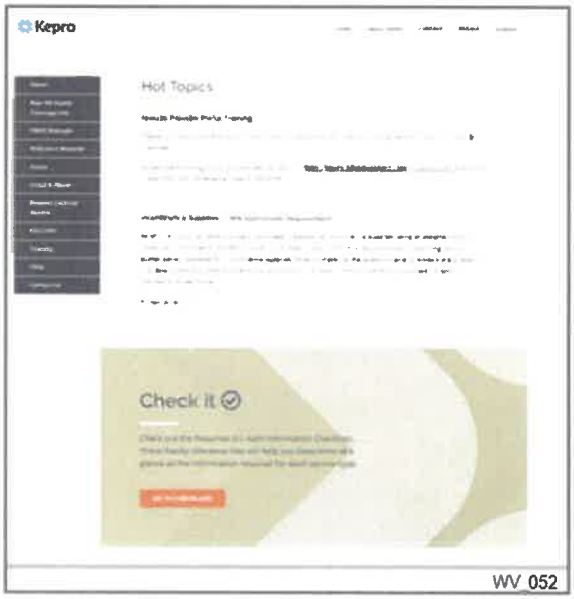

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Figure 86. Example of "Hot Topics" Provider Notification

"Hot Topics" alerts within Provider Portal identify upcoming changes that may impact authorizations and reviews.

3. **Implement Stakeholder Trainings:** One of the most important components to the implementation of the program will be education and buy-in from WV DHHR and the stakeholders that we jointly identify as integral to the program's success. Each review type has a dedicated web training for Atrezzo submissions according to review areas. These trainings are recorded and available on our website for providers to access at any time. We will collaborate with the WV DHHR to finalize our short and long-term Training Plans for all facilities impacted. Once approved by the Agency, we will address the training needs of our internal team, WV DHHR staff, and provider staff to ensure successful implementation and ongoing operations. Initial and ongoing specific training topics will include but are not limited to 1) How to submit requests; 2) Requests for additional information; 3) Best practices in submitting records; 4) Transmission of determinations; 5) Peer-to-Peer reviews; 6) Discharge planning Coordination; 7) Appeals processes; 8) Medical Necessity Criteria. Our stakeholder engagement strategy will be governed by the following core principles.

Did You Know?

Between Fiscal Years 2016 and 2022, Kepro developed and facilitated over 500 provider trainings reaching over 10,000 participants.

   - **Responsive.** We engage with key stakeholders early and often to identify issues, and act upon the feedback received.
   - **Inclusive.** We foster dialogue and collaboration with stakeholders representing various specialties, settings and services, and tailor our operations to meet their unique needs and address any concerns.
   - **Transparent.** Transparency in our process garners stronger relationships and cooperation. We make information readily available to stakeholders to promote meaningful collaboration.
   - **Proactive.** Using data insights on UM and waiver practices to provide suggestions on rules or policies.
   - **State-Informed.** We will work with WV DHHR on all materials and communications.

4. **Establish a Community Stakeholder Advisory Council:** As part of our commitment to West Virginia and the ongoing success of the WV DHHR's program, we will work with WV DHHR to identify the appropriate stakeholders and members of the stakeholder council. Once identified, we will meet with and recruit key community stakeholder organizations to join our Community Stakeholder Advisory Council. We will design the Council to provide actionable feedback to Kepro and its local leadership about the direction and challenges of the program. This Council will be facilitated by our Vice President for Public Affairs, Michael Wolf. Mr. Wolf brings 18 years' experience in the healthcare industry with specific focus healthcare communications and policy development. This includes 5 years

Exceeding Standards

Our Stakeholder Engagement Model leverages our current successful outreach models with Nebraska Department of Health and Human Services, Maryland Developmental Disabilities Council, among other organizations.

of experience in outreach and engagement of multiple stakeholder groups while serving as the Secretary of Health in the Commonwealth of Pennsylvania, including facilitating the Pennsylvania State Health Improvement Plan and implementation of CMS State Innovation Model funding. His primary responsibility will be to engage key community stakeholders in creating the Community Stakeholder Advisory Council.

5. **Administer Annual Stakeholder Surveys:** Annual Stakeholder Surveys are conduced which include questions around provider and WV DHHR satisfaction, ease of reaching a Kepro staff member, Kepro staff helpfulness and knowledge, timely processing of requests, effectiveness of web-based and in-person trainings provided, and overall satisfaction with Kepro services. Results of these surveys are thoroughly addressed with WV DHHR and incorporated into our team's training efforts to ensure subsequent improvement the following reporting period. A similar survey process is performed with current state contracts in West Virginia, Colorado, Florida, Virginia, and South Carolina and has found it to be vital for quality improvement. In West Virginia, we received recent provider Satisfaction scores of 90% and 92%.

Agency Fair Hearing Participation

We have provided appeals and fair hearings support across several of our clients for more than three decades. Our current appeals management policies and processes can be customized to address any necessary support of the appeals process for WV DHHR's needs. This support includes research, administrative support, written statements, and documentation, as well as providing Our experienced appeals staff and subject matter experts for testimony where appropriate to defend WV DHHR decisions. The volumes we have handled for peer reviews, appeals, and expert testimony for the last five years are shown in **Table 23 Kepro Review and Appeals Experience** which details our experience with peer reviews, appeals, and expert testimony.

Our deep knowledge in this arena has taught us how important it is for all providers and residents to know their rights to an appeal, evidentiary hearing, and fair hearing and for the process to serve them. To ensure we prioritize our clients, Kepro adapts our customizable appeals and fair hearing process to accommodate contract-specific requirements ensuring determinations comply with due process and support WV DHHR needs. We will provide Kepro's experienced appeals staff and subject-matter experts for testimony when asked to support WV DHHR Fair Hearing process and provide the documentation necessary to defend WV DHHR decisions. We will also provide staff to represent the State through written and personal testimony as well as research and documentation in PA appeal matters, grievances, and court cases. We will represent the State in State fair hearings, which includes attending appeals hearings on behalf of the State. We will provide a hearing packet to the State for hearing requests at least five days in advance of the scheduled date of the hearing.

A1.6. Dental and Oral Health UM Technical Requirements (WVCHIP)

This section describes the requirements for the development, implementation, and operation of a UM program for dental services to include:

a. Dental Services
b. Orthodontia Services

The Methodology section of the Technical Proposal must provide information on the Vendor's experience which clearly demonstrates how the Vendor will meet stated requirements and describe in detail the Vendor's experience administering similar UM programs for dental services for commercial and/or government health care programs. Children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontics, prosthodontics, maxillofacial prosthetics, oral and maxillofacial services, and orthodontics. Orthodontia services, covered for children up to 21 years, must be medically necessary, and require prior authorization before the service is provided. Orthognathic surgical procedures associated with orthodontic treatment shall be covered even if the member exceeds 21 years of age AND the needed surgery is documented in the original orthodontic request. Covered dental services for enrolled adults 21 years of age and older are divided into two levels of service: 1) emergent procedures to treat fractures, reduce pain, or eliminate infection and 2) diagnostic, preventative, and restorative services. Prior authorization may be required for specific emergent services and when service limits are exceeded. Services classified as diagnostic, preventative, and restorative in nature will require authorization prior to services being rendered and have a coverage limit of $1,000 per member per calendar year. Members are responsible for payment of service cost exceeding the $1,000 yearly limit. Remaining balances at the end of the year CANNOT be carried over to the following year. Services classified as cosmetic in nature are not covered for adults over the age of 21.

We have performed prior authorization of dental and orthodontal services for four years under the current WVCHIP contract for West Virginia, and for nearly ten years in Minnesota and Florida with established UM processes that benefit our clients and their members. Since 2019, we conducted over 2,300 reviews serving WVCHIP members.

> Kepro Dental Reviewers continue to be my best resources when working through any dental issues with either clients or providers. Thanks everyone... especially "OUR" great partners at Kepro!"
>
> *Hank Jensen,*
> *Customer Care Specialist*
> *HIV Benefits & Eligibility Unit – Disability Services Division*

Our long-term experience with dental services fits well into WV's historical work with WVCHIP. In our time providing these services we have resolved thousands of member and provider claims and ensure that state funds are appropriately managed and utilized.

The prior authorization of dental services is conducted using InterQual®, local medical policies, and WVCHIP policy. Prior authorization will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services**.

A1.6.a. Dental Services

1. Children up to 21 years of age are eligible for covered diagnostic, preventive, restorative, periodontic, and prosthodontics services. When covered services are required and initiated before the member's 21st birthday, the

service shall be completed within the timeframe established by the treatment plan. Covered dental services for enrolled adults 21 years of age and older are divided into two levels of service: 1) emergent procedures to treat fractures, reduce pain, or eliminate infection and 2) diagnostic, preventative, and restorative services. Services classified as diagnostic, preventative, and restorative in nature will require authorization prior to services being rendered and have a coverage limit of
$1,000.00 per member per calendar year. The $1,000.00 cap shall be tracked by the Vendor and required coordination with the MCO's. The Agency requires prior authorization for the following benefits:

a. Specific dental procedures as determined by the Agency;
b. Manually priced procedures;
c. All services under the adult dental benefit $1,000.00 cap.

2. The Vendor shall develop, implement, and maintain a UM program, which includes prior authorization, retrospective review, and eligibility review of dental services requests. Retrospective authorization is available in the following circumstances:

a. A procedure/service denied by the member's primary payor providing all requirements for the primary payor have been followed, including appeal processes; or
b. Retroactive eligibility; or
c. Retrospective review is available for members in instances where it is in the dental practitioner's opinion that a procedure that requires prior authorization is medically necessary and per recommended dental practices delaying the procedure may subject the member to unnecessary or duplicative service if delivery of the service is delayed until prior authorization is granted. In these instances, a request for prior authorization must be made by the provider within ten (10) business days of the date the service is performed. If the procedure(s) does not meet medical necessity criteria upon review by the Utilization Management Vendor (UM) the prior authorization request will be denied, and the provider will not be reimbursed for the service by the Agency or the member. Prior authorization is also available for medical necessity review before the service is provided.
d. A request for retrospective authorization is submitted the next business day following an Emergent procedure/service occurring on weekends, holidays, or at times when the UM is unavailable.

3. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, and other forms or documentation required for prior authorization review of dental services.

4. The Vendor shall determine the medical necessity of the authorization utilizing the Agency approved criteria and policies for dental services to eligible members. The Vendor shall have the capability and established procedures to ensure determinations for authorization reviews are completed in accordance with current policies. In rare cases, this could include retrospective reviews.

5. The Vendor shall return original radiographs and photographs submitted by providers through the prior authorization process to the submitting provider.

6. The Vendor shall establish and maintain a procedure for the dental provider to contact the Vendor's Dental Director to discuss dental cases that have been denied or modified.

Since contract start in 2019, we conducted a total of 2,351 dental service reviews for WVCHIP. Currently prior authorization is required for dental services specified by the Agency in WVCHIP policy. Services requiring prior authorization include, but are not limited to prefabricated crowns, root canals, and other dental surgeries performed in the office setting. As required, a lead dental consultant will be appointed to evaluate training needs, assist with criteria development, and assist other dental consultants.

Kepro's prior authorization process is outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services**.

The prior authorization process begins upon receipt of the prior authorization request for dental services submitted either through the Provider Portal or Kepro staff-entered fax request. Once

entered into the system the request is reviewed automatically and in real-time via Atrezzo, which verifies member eligibility for the requested services and reviews clinical information for service-specific criteria. If the request for services meets medical necessity and funds remain from the benefit amount allotted, the clinical reviewer evaluates the records to ensure that documentation is complete. If no funds are available, the request is closed and we notify the member and provider.

If funds are available, a Dental Consultant will review the case and, if criteria are met, approve the authorization. Once authorization is issued it is sent to the claim payor and is made available in the Atrezzo for the provider. At the end of the authorization process, X-rays and molds, if applicable, are sent to the provider by request. For all adverse determinations, the member receives a denial notice via USPS with information on their appeal rights.

If clinical information is not sufficient, the clinical reviewer pends the request and notification is sent to the provider via the Provider Portal requesting additional clinical information. If the additional information received meets criteria, the request for authorization is approved. If additional information is not received, the request is administratively closed, and we will notify the provider that the case cannot be clinically reviewed. In cases where additional information does not meet criteria, the process follows the same denial procedure as above.

A1.6.b. Orthodontia Services

1. The Agency covers orthodontia-related services for children up to 21 years, which are medically necessary. Orthodontia-related services are only covered for EPSDT eligible members who meet pre-qualifying criteria. As a condition for reimbursement, the Agency requires prior authorization be in accordance with current policies.
2. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, clinical documentation, and other forms or documentation required for prior authorization review of orthodontia services.
3. The Vendor shall return original dental molds/models, radiographs and photographs submitted by providers through the prior authorization process to the submitting provider.
4. The Vendor shall determine the medical necessity of the authorization and retrospective reviews utilizing the Agency approved criteria and policies for orthodontia services to eligible members. The Vendor shall have the capability and established procedures to ensure determinations for authorization reviews are completed shall in accordance with current policies.

We will perform all prior authorization reviews as required for Orthodontia Services and will meet all requirements of this section. Since contract start in 2019, we conducted 23 orthodontia service reviews for WVCHIP members. Currently prior authorization is required for all orthodontia services to ensure the member meets the required eligibility criteria, including eligibility for EPSDT. Orthodontia services, covered for children up to 21 years, must be medically necessary, and require prior authorization before the service is provided. WVCHIP reimburses one treatment of comprehensive orthodontia (CDT Codes D8070, D8080, and D8090) per lifetime per member. If any of the comprehensive orthodontia codes are billed, then none of the remaining can be billed; they are a one per lifetime limit for any of the three and are not looked at as per code lifetime limit.

Orthognathic surgical procedures associated with orthodontic treatment shall be covered even if the member exceeds 21 years of age and the needed surgery is documented in the original orthodontic request. Requests for prior authorization of orthodontia services must include the following:

- Patient's name, address, Medicaid number and date of birth
- provider name, address, provider number, fax and phone numbers
- Ordering physician's name and phone number
- Date patient examined
- Complete diagnosis
- Current treatment status
- Recommendations for comprehensive orthodontic treatment
- Comprehensive orthodontic treatment procedure code
- Post-treatment stabilization procedure code
- Total fee (usual and customary charge)
- Orthodontist signature and date
- Additional information required for assessing handicapping malocclusion
- Dental molds and/or x-rays as appropriate

Currently we use WVCHIP approved policy and Dental Consultant Review for medical necessity review of requests. Orthodontia services review will take place within Atrezzo using the utilization review process outlined in **Figure 65 Prior Authorization Review Process located in Section A1.5.a Inpatient Medical/Surgical Services**.

A1.7. WVCHIP-Optional Services (WVCHIP)

This section details optional services.

a. Clinical/Medical Consulting Services
b. Personal Care Functions
c. Ambulance Transportation

In this section, we describe how we will address optional services for:

- Clinical/Medical Consulting Services
- Personal Care Functions
- Ambulance Transportation

A1.7.a. Clinical/Medical Consulting Services

1. The Vendor shall have the capacity and established procedures for clinical/medical consultation at an established hourly rate through the Vendor's Medical Director or Dental Director, as appropriate, in order to assist the Agency in addressing medical necessity issues, researching new technology, developing medical policies, addressing quality issues, etc.
2. At the request of the Agency, the Vendor may also provide clinical/medical consultation for various types of healthcare practitioner participating in the Agency program. Healthcare practitioner types may include, but are not limited to, medical doctors, doctors of osteopathy, podiatrists, chiropractors, nurse practitioners, certified

registered nurse anesthetists, nurse midwives, dentists, therapists, optometrists, and mental health practitioners. All consults conducted by the Vendor shall be performed by a consultant of the same provider type and/or specialty.

3. The Vendor shall have a written program which outlines the program structure and accountability and includes, at a minimum, procedures, and process for clinical/medical consultations through the Medical Director or Dental Director, as appropriate, and consultant advisors of the same provider type and/or specialty or as directed by the Agency and mechanisms providing the Agency with consultant review summaries in accordance with current policies.

4. The Agency may assess penalties in the amount of up to $500.00 per fifteen (15) calendar day period each report, data or other material is late, unavailable, or unacceptable as specified in Appendix 4 of this RFP.

We will provide clinical/medical consultation services to the Agency at an hourly rate by utilizing our local WV Medical Director, Dr. Paul Kuryla or, depending on the specialty, one of our expert Physician Consultants. We are well equipped today with specialty-matched practitioners who stand ready to provide consultation services as defined in the RFP. In addition to our local WV Medical Director and Physician Consultants, we maintain a national Physician Panel of over 4,500 contracted practitioners who are board-certified and actively practicing within their specialty domain. Our Physician Panel physician specialties include, but are not limited to, the following areas of practice:

- General, Family and/or Internal Medicine
- ENT
- General Surgeon
- Geneticist
- Nephrologist
- Neurologist
- Neurosurgeon
- Oncologist
- Orthopedist
- Urologist
- Pathologist
- Pediatrician
- Podiatrist
- Radiologist
- Thoracic Surgeon
- Cardiologist
- Obstetrics & Gynecology
- Chiropractor
- Ophthalmology
- Dentist
- Orthodontist
- Spinal Cord Injury Specialist

We also offer the Agency access to our local WV licensed allied professional staff for consultation 9as needed. These identified individuals are subject matter experts (SMEs) in their area of expertise with a wealth of WV Medicaid policy knowledge and knowledge across the various Home and Community Based Waiver programs, Children's Services (BSS and Medicaid programs), Behavioral Health Services, Health Homes, and other programs.

Our written program for the Agency will outline our Consultative Services program structure and accountability and will include, at a minimum, procedures, and process for clinical/medical consultations through the Medical Director or Dental Director, as appropriate, and consultant advisors of the same provider type and/or specialty or as directed by the Agency and mechanisms providing the Agency with consultant review summaries in accordance with current policies.

Our process for Consultation Service requests will begins with our clinical staff as the contact team for incoming requests. Upon receipt of all requests, our staff direct the Agency requestor to complete a Consultation Request form. Upon receipt of the written request, the steps below are then followed:

- A Consultation Request form is completed by the Agency, which outlines the type of consultation desired; the target audience for the consultation report; and the timeframe for completing the consultation
- Kepro develops a scope of work, which includes the delivery date for the consultation report, the format of the report and target audience, the scope of the consultation, and the consultant(s) or SME assigned to complete the report
- The assigned consultant prepares a consulting plan which outlines how information is to be gathered (e.g., literature search, focus groups etc.) and the proposed number of hours to complete the consultation by the specified due date
- The Agency approves the Consultation plan/scope of work
- Upon completion of the consultation, the report is delivered to the Agency

A1.7.b. Personal Care Functions

1. Plan, advertise, and produce provider meetings up to four (4) times per year which will be either face-to-face or by virtual platform upon the request of the Agency to include hospitality and conference room rental if face-to-face. If virtual, the Vendor must use a platform that is accessible for large groups of providers.
2. Assist with planning and facilitate monthly virtual meetings/conference calls with provider agencies to include announcements, updates, and policy clarifications. Maintain written Frequently Asked Questions (FAQs) regarding IDDW policies and procedures and make the FAQs electronically available to stakeholders.
3. Develop and maintain a member handbook and a provider reference guide of all available Personal Care agencies and the services offered in each county. The handbook and reference guide are to be kept up to date and available to members electronically or in printed format upon request at no additional cost to the Agency.
4. The Vendor shall conduct quality assurance activities with members, families, and agencies, the Fiscal/Employer Agency vendor (if applicable), stakeholders, and the general community, as necessary and at the request of the Agency. All quality review tools/materials must be approved by the Agency in advance, including whether the reviews will be on-site, virtual or desk reviews. These activities shall include, but not limited to the following:

a. Notify the Agency of the schedule of the quality review cycle at least a quarter in advance.

b. Conduct initial and annual certification reviews of new and existing Personal Care agencies to include on-site, and desk review as requested by the Agency.

c. Conduct quality reviews of all Personal Care agencies to verify compliance with current policies, appropriate utilization management and documentation of authorized services. This includes, but is not limited to, notifying the provider agencies of reviews based upon timelines established by the Agency, identifying issues that potentially result in disallowances of provider agency claims payments and calculating the disallowance amounts. This review shall include providers with active/enrolled members at the time of the specified review period. The findings of the quality reviews shall be verbally presented to the agency at the time of the review and provided in writing to the agency at the completion of the review. The Vendor will track the agency's Plan of Correction (when applicable).

d. Conduct a quality review of the self-directed program annually to verify compliance with current policies (upon availability of self-directed PC services). The findings of the quality review shall be verbally presented to the Fiscal/Employer vendor at the time of the review and provided in writing to the vendor at the completion of the review. The Vendor will track the vendor's Plan of Correction (when applicable).

e. Conduct follow up reviews to monitor the implementation of approved Plans of Correction. Follow up reviews may be conducted on site or virtually six (6) months following the approval of the Plan of Correction or at a timeline specified by the Agency.
f. Provide the Agency with a monthly comprehensive report of findings of the quality reviews including identification of trends.
5. Conduct interviews of members annually using a mutually agreed upon sample of enrolled members. The Agency will determine the interview tool and whether the interviews will be face-to-face or by telephone.
6. Receive, track, triage or investigate complaints submitted by providers, members, or other stakeholders. Complaints will be reported to the Agency each month.
7. Perform daily monitoring of PC member incidents reported via the state's Incident Management System (IMS). Investigate critical incidents as needed to protect members' health and welfare. Provide monthly and quarterly reporting of incidents to the Agency.
8. Report and follow up with the DHHR Protective Services Unit when member abuse, neglect or exploitation is suspected.
9. Report suspected Fraud to the DHHR Office of Program Integrity (OPI) and follow-up as required with the Medicaid Fraud Control Unit.
10. Provide the Agency with a monthly comprehensive report on incidents and follow-up activities.
11. Make recommendations regarding enhancements to the IMS and assist with development of specifications and testing of the system as needed.
12. Provide ongoing technical assistance, at no additional cost to the Agency, to provider agencies and stakeholders upon request of the Agency via email, telephone, or other requested medium.
13. Manage and report monthly, during the regular monthly contract meeting, on the Centers for Medicare and Medicaid Services (CMS) quality measures.
14. Maintain current Freedom of Choice/Agency Selection forms.
15. Maintain a current provider agency register that includes services provided by each agency by county with provider agency contact information in the format to be determined by the Agency.
16. Maintain ADW provider agency files, information, and reports related to agency certification, quality reviews, complaints, incidents, and other provider data.

Based on current WVCHIP regulations, Personal Care Services is not a covered program. If WVCHIP offers Personal Care as a covered service, Kepro would follow our proven prior authorization methodology and processes to provide these services. We would work with the state to define and document any unique requirements related to these services and implement in accordance with WVCHIP.

A1.7.c. Ambulance Transportation

1. The Vendor shall develop, implement, and maintain a UM program, which includes prior authorizations for ambulance transports from Ambulance providers.
2. The Vendor shall ensure the Ambulance provider meets all Agency requirements and utilizes the appropriate mode of transport for the requested trip type.
Trip Types: Specific authorization standards unique to specific trip types are defined as follows:
a. Single Trips Requests: The Vendor shall require that requests for non-emergent ground Ambulance Services to a single appointment be made via a toll-free telephone number. Other methods of single trip requests may be allowed with the Agency approval.
b. Standing Order Trip Requests: The Vendor shall establish procedures to handle trip requests so that Members are not required to continually make arrangement for repetitive appointments. The Vendor shall include in its procedure to recertify the need of a Standing Order with the Medical provider at least every thirty (30) calendar days.

c. Return Trip After Emergency Transports: In limited situations, a Member may be transported by emergency medical air ambulance (fixed-wing or helicopter) or emergency medical ground ambulance to a medical facility. Upon discharge, if the Member requires transport home via ambulance, the Vendor shall process the ambulance transportation authorization request for the one-way transport for the Member.
d. Air Ambulance Transports: The Vendor shall process utilization/prior authorization/retrospective authorization requests for all air transports.
e. Hospital to Hospital Transports: In limited situations, the medical care required for a Member cannot be provided at a specific facility or within the State of West Virginia. The Agency has enrolled specialty hospitals located elsewhere in the United States. The Vendor shall process utilization/prior authorization/retrospective authorization requests for all hospital-to-hospital transports to these facilities.
3. The Vendor shall evaluate the most appropriate transport method based on the Member's medical condition, the reason for the transport, the urgency of the transport, and the destination of the transport.
The Vendor may propose a method to prior authorize air ambulance transportation flights. The Vendor shall make provisions for retrospective reviews of authorization requests for air ambulance transports in emergencies that occur after business hours, on weekends, and on holidays.
4. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, evaluations, and other forms or documentation required for prior authorization and eligibility review of ambulance transportation services.
5. The Vendor shall refer all non-emergency medical transportation requests to the appropriate resource, such as the NEMT Broker, when the Member's medical need does not require an ambulance level of transportation.

Kepro implements comprehensive guidelines governing our delivery of Ambulance Transportation Services. Our processes include strict adherence to InterQual® criteria, WVCHIP regulations, and can easily accommodate client criteria or requests. We will modify and adapt our processes based on updates to applicable state regulations to ensure continued compliance with the latest version of official controlling policies and regulations. As part of quality program, governing regulations are monitored on a routine basis to ensure processes are up to date.

For emergency air transportation program specifically, **we have provided authorization for these services for WVCHIP since 2019. We have completed 138 total authorizations covering fixed and rotary wing transport vehicles from 2019 through 2022.**

In our work with West Virginia we have put that practice to good use and with WV DHHR's guidance, created a prior authorization process for all emergency transportation services as required by Chapter 524.

Non-Emergency Ambulance Transport:

- This may be provided to obtain treatment or diagnosis for a health condition if the use of any other transportation could endanger the member's health or well-being
- Non-emergency transportation must be prior authorized as medically necessary before the service is provided
- Non-emergency transport will be evaluated based on the member's medical condition, the reason for the transport, the medical necessity of the transport for treatment and/or diagnosis, and the destination of the transport
- In some cases, a physician may order ambulance transportation to a hospital or medical facility based on a member's medical condition; in these instances, the order must be attached to the

request and the medical necessity will be based on information provided by the ordering physician

- Medical transport of bed confined individuals may be approved when the following are met:
  - The patient condition is such that any other means of transportation is contraindicated
  - The patient is unable to get up from bed without assistance, and is unable to ambulate, and unable to sit in a chair or wheelchair or can only be transported by stretcher
  - The patient's symptoms and physical or functional status require monitoring for safety
- Transportation from one hospital facility to another may meet NEMT guidelines when medically necessary to obtain diagnostic or therapeutic services (e.g. MRI, CT scan, acute interventional cardiology) not available at the originating facility. The provider of the specialized service must be the nearest facility to the originating facility that is capable of performing the required service. All of the following conditions must be met for approval:
  - The patient is a registered inpatient in an acute care hospital
  - The required specialized services are considered medically necessary and covered by Medicaid
  - The required service is unavailable in the facility where the patient is registered
- NEMT requests will be evaluated and authorized as either single trip requests or standing order trip requests
- Non-emergency transport requests that do not meet requirements will be referred to the Agency's NEMT broker when it is determined the member does not require ambulance transport to be safely transported to the requested service. The denial letter sent to the member will include information regarding how to contact the NEMT vendor and arrange transportation
- NEMT may be approved retrospectively in the following instances: the patient is pronounced dead while in route or upon arrival at the hospital or final destination, or the patient was pronounced dead by a legally authorized individual (physician or medical examiner) after the ambulance call was made but prior to pick up. In all other instances prior authorization must be received for NEMT in an ambulance

Emergency Ambulance Ground Transports:

- The retrospective request must meet medical necessity criteria for emergency ambulance transport as approved by the Agency
- The patient's condition must be such that any of form of transportation is medically contraindicated
- The medical necessity criteria will be applied to the following ground transportation (ambulance) services: emergency room transports/return trip after emergency transport with appropriate order and Certificate of Medical Necessity (CMN); Hospital to Hospital Transports
- The transport must meet one of the following classifications: Advanced Life Support; Basic Life Support-Emergency; Interfacility Transport requiring medical supplies and equipment; Paramedic Intercept

- The member must be transported to the nearest hospital with the appropriate facilities for the treatment of the patient's illness or injury
- The criteria will be based on the Agency's Medical Necessity Chart for Ground Ambulance and Medicare criteria and will be approved by the Agency prior to implementation

Emergency Air Transports:

- Air transportation - Fixed Wing (airplane) or Rotary Wing (helicopter) - will be retrospectively approved if the patient's medical condition at the time of transport indicated that immediate and rapid ambulance transportation was required (e.g. life-threatening injury that requires stabilization in a medical facility; pick-up location cannot be easily reached by ground transportation; long distances or other obstacles, like heavy traffic, will impede timely medical attention if ground ambulance is utilized)
- Medical necessity criteria are applied in instances of air transport and must be met

Non-covered ambulance or medical transport services:

- When medical necessity guidelines are not met
- If the patient is pronounced dead before the ambulance is called the service is not considered medically necessary
- Ambulance transportation is primarily for the convenience of the member, their family or caregiver or their physician
- Transportation to any service not covered by West Virginia Medicaid
- Transportation to any provider not enrolled with West Virginia Medicaid
- Transportation using inadequate or inappropriate staff personnel on board transporting vehicle
- Services provided when the request was for post transportation authorization and was not received timely or did not meet established criteria
- Transportation to a service considered not medically necessary, even if the destination is an appropriate facility
- Transportation of members who do not meet the medical necessity requirements for level of service billed
- Transportation provided when the member refuses the appropriate mode of transportation
- Transportation to a service that requires prior authorization but has not been prior authorized

A toll-free number will be established for transportation requests. Additionally, the Atrezzo application will be expanded to include transportation requests. The provider may select non-emergency transport or emergency transport. If emergency transport is selected, then ground or air transport may be selected. providers may direct data enter (DDE) requests or fax requests to be keyed by Kepro staff. providers will register with Kepro and must be licensed as an Emergency Medical Services (EMS) agency by the West Virginia Office of EMS and be Medicare Part B certified.

Medical necessity criteria will be developed in conjunction with the Agency and a representative provider group within 90 days of program award. Criteria will be congruent with Chapter 524

Appendix A. Ground Ambulance Medical Necessity and will comply with all state and federal guidelines related to ambulance transportation. After approval of criteria, providers training webinars will be conducted to include the following:

- Covered services, criteria, and guidelines for authorization
- Registering with Kepro
- Obtaining authorization
- Timelines for obtaining prior authorization for NEMT ambulance transport and retrospective authorization for emergency transport
- Other topics requested by the Agency

We will implement the transportation program within 90 days of Agency sign-off on requirements and criteria. provider training will be offered during this period to ensure providers are prepared for implementation of the process. Training and technical assistance will be provided on an ongoing basis following the implementation of the program.

An overview of the process is as follows:

1. The provider submits a request for NEMT or emergency ambulance or air transport
2. Member Medicaid eligibility is verified for the date(s) of service
3. Request is reviewed for completeness: physicians orders, CMN, plan of care, evaluations, and other required documentation
4. Complete NEMT requests are routed to a transportation specialist who applies approved NEMT criteria, if approved the authorization is recorded in C3. If denied, the request is routed to a RN and is screened for approval based on medical information provided. If approved the authorization is recorded in C3. If the nurse cannot approve the request, it is sent to a physician for final review, if approved the approval is recorded in C3, if denied the appropriate denial letter is attached in C3 for the provider and is mailed to the member. The letter will include the member's appeal rights and information for contacting the NEMT vendor
5. NEMT requests are screened for appropriateness for medical case management based on member diagnosis and frequency of trips
6. Complete emergency requests for ground or air ambulance are routed to a RN. Medical necessity criteria are applied based on medical information provided. If approved the authorization is recorded in C3. If the nurse cannot approve the request, it is sent to a physician for final review, if approved the approval is recorded in C3, if denied the appropriate denial letter is attached in C3 for the provider and is mailed to the member. The letter will include the member's appeal rights and reason for denial
7. Emergency ground and air ambulance requests are screened for appropriateness for medical case management based on member diagnosis and utilization history

Hierarchical Conditions for Air Ambulance Service Transports

We will comply with the hierarchy to issue an Authorization Number or a Denial for Air Ambulance Services:

Medical Necessity – Medical necessity is only established when the participant's condition is such that the time needed to transport a participant by ground, or the instability of transportation by ground, poses a threat to the participant's survival or seriously endangers the participant's health. Following is an advisory list of examples of cases for which use of air ambulance could be justified. The list is not inclusive of all situations that justify air transportation, nor is it intended to justify air transportation in all locales in the circumstances listed: Intracranial bleeding-requiring; neurosurgical intervention; Cardiogenic shock; Burns requiring treatment in a burn center; Conditions requiring treatment in a Hyperbaric Oxygen Unit; Multiple severe injuries; or Life-threatening trauma. Any potential adverse determination is referred to a physician reviewer who may opt to contact the requesting/treating provider to best determine medical necessity of Air Ambulance Transport that may not be adequately reflected in the medical records submitted at the time of the request.

Time and Distance – Staff measure time and distance qualifiers against the condition and needs of the participant. Differing Statewide Emergency Medical Services (EMS) systems determine the amount and level of basic and advanced life support ground transportation available; this assessment considers the transit time to reach the participant, transit time to an emergency facility, as well as patient's condition. However, there are very limited emergency cases where ground transportation is available, but the time required to transport the patient by ground as opposed to air endangers the participant's life or health. As a general guideline contractors should consider air transportation to be appropriate. when it would take a ground ambulance 30-60 minutes or more to transport a participant whose medical condition at the time of pick-up requires immediate and rapid transport due to the nature and/or severity of the participant's illness/injury. While these are the initial guidelines in place Kepro can incorporate any State requirements and amendments into our processes and procedures.

Appropriate Provider – Air ambulance transport is covered for transfer of a participant from one hospital to another if the medical appropriateness criteria are met, defined as: transportation by ground ambulance would endanger the participant's health and the transferring hospital does not have adequate facilities to provide the medical services needed by the patient. Examples of such specialized medical services that are generally not available at all type of facilities may include but are not limited to: burn care, cardiac care, trauma care, and critical care. A participant transported from one hospital to another hospital is covered only if the hospital to which the patient is transferred is the nearest one with appropriate facilities. Coverage is not available for transport from a hospital capable of treating the patient because the participant and/or the participant's family prefer a specific hospital or physician. Coverage is also available only to providers that meet State qualifications required for air ambulance. In addition, we will ensure that the provider meets the qualifications for air transport, if applicable, per MD regulation.

West Virginia Medicaid Provider – We will ensure that, if the requesting organization is an Air Ambulance Service provider, the organization is active and contracted as a Maryland Medicaid

provider. By ensuring that the provider Maryland Medicaid status for Air Ambulance Kepro ensures that the provider is qualified and meets all safety requirements.

Fixed Wing – After satisfying the above criterion, we will seek CM approval prior to authorizing. We will not make an approval determination without CM approval. The CM must first approve the request before we inform the requester of the approval.

Appendix 2: BSS Detailed Specifications

BUREAU FOR MEDICAL SERVICES PRIOR AUTHORIZATION REQUIREMENTS

A2.A. General Requirements

BSS provides and/or arranges for a variety of medical and non-medical services that are necessary for children, youth, and families in WV. The Services to be covered are those medical and non-medical direct services covered under Child Protective Services (CPS), Youth Services (VS), Foster Care and Adoption. The Services also include children who are at immediate risk of being placed in a residential treatment facility. Vendor is to utilize established service definitions according to BSS policies and standards. Any deviation from these standards must have BSS prior approval. Vendor is to work collaboratively with the Agency and to perform functions necessary to support compliance with state and federal funding requirements for Child Welfare Services. The following list of services requires prior authorization. Specific definitions of services may be subject to change due to changes in federal or state regulations, or changes in state child welfare policy.

1. Special Medical Card
2. Group residential facilities located outside the borders of WV
3. Psychiatric residential facilities located outside the borders of WV
4. Special evaluations
5. Therapeutic Foster Care
6. Stability and Treatment (STAT) Homes

We have been providing the services necessary to support compliance with State and federal funding requirements for Child Welfare Services since the start of our contract with the West Virginia Department of Health and Human Resources (WV DHHR) in 2000. For 22+ years we have prioritized West Virginia's vulnerable children, youth, and families by ensuring optimal outcomes within each of our existing programs, supporting the mission of the Bureau for Social Services (BSS) to promote safety and well-being for this population. BSS can expect us to manage Stability and Treatment (STAT) Homes, the new scope of work included in this RFP, with the same commitment to excellence and care that we have provided over the past two decades for BSS including Special Medical Card, group residential facilities located outside the borders of WV, psychiatric residential facilities located outside the borders of WV, special evaluations, and Therapeutic Foster Care services.

Through our established processes, we will continue to proactively support the state in complying with the standards established by the Department of Justice (DOJ) in 2019, related to the child welfare service system. As we do today, we will collaborate with BSS to develop and implement reforms to help children and youth with serious mental health conditions receive appropriate mental health and social services in their homes, schools, and communities, efficiently and effectively. We have accomplished this joint goal by supporting BSS as it continues to improve access to community based mental health and social services and, whenever possible, assist children and youth in receiving the care and services they need while remaining within their homes and communities.

Service Excellence

Kepro's excellence in achieving client-prescribed review timeliness is evident across our West Virginia programs. We achieved a 99.4% timeliness rate in 2022 across BSS programs.

We are proud of the work we have completed with the State to develop these programs. Our collaboration with the development, implementation, and quality assurance processes for Special Medical Card, group residential, psychiatric residential, special evaluations, and Therapeutic Foster Care gives us unique insight into the history and needs of this vulnerable population across programs. Additionally, as evident in our development of the established and in-use Retrospective Review processes across these programs, we are well positioned with the experience and clinical expertise to continue to modify and improve program tools and processes in alignment with the State's changing requirements and the evolving needs of the members we serve.

Our approach to providing these program services prioritizes the State and DOJ's mission to provide home and community-based Waiver services by providing on-site reviews. The reviews across the BSS services programs that we conduct are conducted on-site by a licensed clinical expert, either a nurse or master's level social worker. Our team has conducted more than 6,000 on-site reviews for these types of programs since the start of our contract. Conducting face-to-face interactions with providers and members is essential to maintaining the long-standing rapport we have built with all BSS stakeholders, and the trust our team has earned over the last 22 years.

The Atrezzo Platform

The Atrezzo platform, our proprietary Care Management system, will support BSS' Child Welfare Services program as an end-to-end solution. Atrezzo is highly configurable and customizable to accommodate the State's needs across all program requirements. Most importantly, we stand ready today to deliver on BSS' desire for enhanced data monitoring, reporting, and analysis requirements. Successfully used across 17 state Medicaid contracts today, we assure BSS that through the Atrezzo migration you will benefit from significant improvements and efficiencies across the program.

We will implement Atrezzo as our prior authorization solution for Special Medical Cards, group residential facilities outside of West Virginia borders, psychiatric residential treatment facilities located outside of West Virginia, Special Evaluations, Therapeutic Foster Care, and Stability and Treatment Homes. We have extensive experience implementing Atrezzo for utilization management and prior authorization programs for other State clients nationwide – with optimal outcomes in the state Medicaid programs utilizing Atrezzo today.

The prior authorization process for each of these programs follows the standard process we implement across most services offered; however, with Atrezzo's ease of configuration this process flow can be modified as needed for BSS upon implementation as well as throughout the life of the contract. **Figure 87 Prior Authorization of BSS Services** illustrates our prior authorization process.

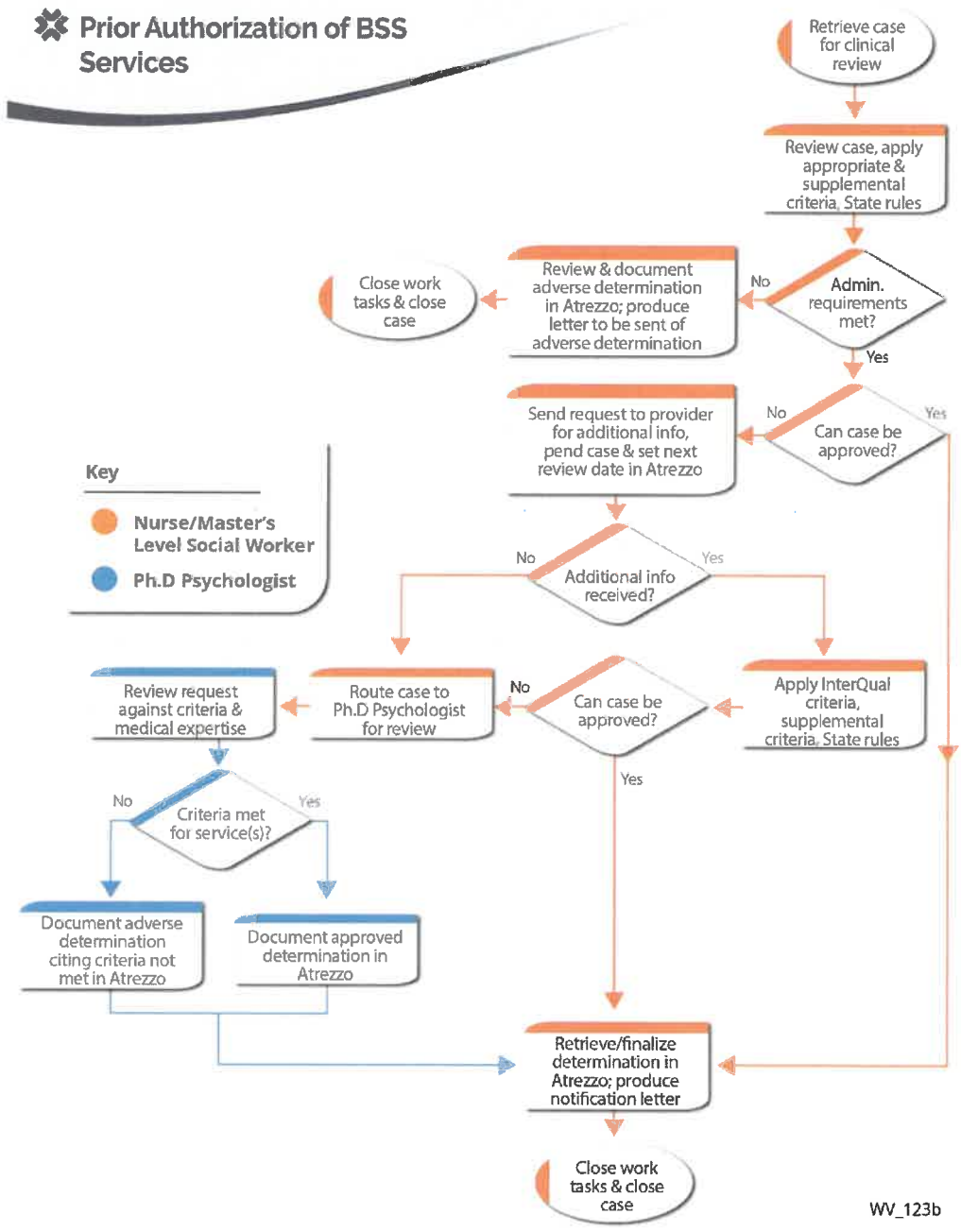

Figure 87. Prior Authorization of BSS Services

We follow the same standard prior authorization process across BSS programs to promote consistency.

A nurse or Master's level social worker (clinical reviewer) evaluates prior authorization requests for BSS services. When a case is retrieved from Atrezzo, the clinical reviewer will review the case and apply the appropriate and supplemental criteria and State rules to determine if case requirements are met. When case requirements are not met, we follow BMS guidelines relating to policy denials. If it is determined that administrative requirements are not met, the clinical reviewer will

document the adverse determination in Atrezzo, and an automated notice of adverse decision is generated and sent to the provider. For all adverse determinations, the member receives the denial notification with instructions for requesting a fair hearing.

If case requirements are met, the clinical reviewer will determine if the case can be approved based on information provided. If the case requires additional information, a request will be sent to the provider, a "next review date" will be assigned in Atrezzo, and the case will be pended until the information is received or the next review date is reached. If additional information is not received at this point in the process, the case is routed to Ph.D. psychologist for an additional level of internal review. In addition, if supplemental information is received but the clinical reviewer cannot make a determination based on the available documentation, the case is also routed to the Ph.D. psychologist. We provide a Ph.D. psychologist from our Physician Review panel.

With the clinical reviewer and Ph.D. Psychologist, if applicable, West Virginia-specific criteria and rules are applied to the case to determine if it can be approved. If the case cannot be approved, the case is sent to the DHHR Review committee. If the case can be approved using InterQual® criteria, supplemental criteria, and State rules, the determination is finalized in Atrezzo, and the case is closed.

Provider authorization requests will be acted upon within 2 business days. Resulting actions may include authorization, requesting additional information for review, re-authorization, closure, denial or contacting the BSS worker when needed. Existing denial processes will remain in place but may be refined as needed or requested by the Bureau. Denial protocols for any new services will be developed in agreement with the appropriate BSS staff.

We provide denial notices through certified mail but appreciate the necessity of expeditious reviews and will gladly accommodate sending denial notifications via a secure email system. Doing so will ensure determinations are communicated in a timely, cost-effective, and secure manner to the appropriate recipient, including out-of-state providers. We will apply this manner of notification to relevant denial notifications across BSS programs. We do note that notifications under some program types are sent to guardians; for cases in which the State acts as a child's guardian, the Bureau will receive this denial notification.

A2.B. Bureau for Social Services- Non-Medical Services

1. The West Virginia Bureau for Social Services covers medical and non-medical services for children and families who meet eligibility guidelines.
2. As a condition for reimbursement, BSS requires that all non-medical services receive prior authorization in accordance with current state policy guidelines. Current policy guidelines can be found at: https://dhhr.wv.gov/bcf/policy/Pages/default.aspx.
3. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests and other documentation required for prior authorization and eligibility review of non-medical services that will:
a. Manage web-user's passwords and security issues.

b. Create daily authorization files that are placed on the Agency secured FTP site and made available to the provider.
c. Receive and accept the referral files and the roll-back file, when necessary, from the Agency's secured FTP site and loading it into the Vendors site on a daily basis, at a mutually agreed upon time.
d. The Vendor shall develop, publish, and maintain revisions on a guide for the usage and understanding of the secure web-based submissions and management process which will include guidance regarding:
e. Electronic Data Interface file formats.
f. Utilization manual instructions.
g. Instructions for navigation of the submission criteria.
4. The Vendor shall develop, publish, and maintain revisions on a service guide for Agency social services workers and providers which detail the criteria for eligibility for each medical and non-medical service.
5. The Vendor shall develop processes and tools to be approved by BSS for the execution of retrospective reviews of the medical and non-medical services, provider charts and records, at a schedule to be mutually agreed upon by Agency and Vendor. The retrospective review process must include, at minimum:
a. Authorizations.
b. Invoices.
c. Personnel files.
d. Case files, including case plans and treatment plans.
6. The Vendor shall provide a detailed report of the retrospective review to the provider to ensure proper communication channels for continuous quality improvement.
7. The Vendor shall contact the provider ten (10) business days after the report is sent to determine if the provider wishes to receive technical assistance.
8. The Vendor shall produce, on a monthly basis, utilization reports regarding each provider on a county, regional and statewide level.
9. The provider shall process service requests within two (2) business days, which includes:
a. Authorization.
b. Review.
c. Contacting the Agency social worker.
d. Re-authorization.
e. Closure, if necessary.
10. The Vendor shall develop a process, to be approved by BSS, for service denials to ensure the processing is completed, including a secondary internal review.
11. The Vendor shall have the capacity to develop educational trainings and provide technical assistance about policy, available services, service delivery models, and the choice between Therapeutic Foster Care program and other forms of care for members, families, agencies, stakeholders, and the general community. To include but not limited to:
a. Service issues and authorization processes for the Agency's social workers and the Therapeutic Foster Care program providers.
b. New Therapeutic Foster Care program provider orientation.
c. Quality improvement technical assistance for Therapeutic Foster Care Program providers based on retrospective review findings or other issues as they arise.
d. Submission criteria, services definitions, service eligibility criteria and service availability to the Agency's social workers.
e. The application, registration, referral, enrollment, and billing processes for the parent provider enrollees.
f. The role of each party (biological parent/adoptive parent and Agency social workers) in the Therapeutic Foster Care program process and provide referrals, as necessary.
12. The Vendor shall develop a data collection process for the Therapeutic Foster Care program, which captures child-specific outcome data to be developed with BSS upon contract award.
a. The Vendor shall maintain an accurate enrollment list based on the utilization management authorizations and state policy, sent to BSS at close of business each Friday.

13. Upon the Agency's request, the Vendor shall conduct quality assurance activities with members, families receiving services, agencies, stakeholders including Agency Social Workers and their supervisors and the general community as necessary or at the request of the Agency. These activities shall include, but not be limited to the following:
a. Ten (10) educational forums representing stakeholders statewide each contract year and a complete summary of the group within two (2) weeks for review by the contract Management Team.
b. Conduct, at a minimum, six (6) focus groups statewide which consists of the recipients of Non-Medical Services including biological parents, foster parents, and children as well as Agency social workers and their supervisors using the Agency's pre-approved questions. A complete summary of the group is due within two (2) weeks for review by the contract Management Team.
14. The Vendor shall provide the following reports and notifications related to Non- Medical Services to the Agency for Social Services:
a. Data analysis reports, as requested.
b. The annual Consumer Focus Group Summary and analysis report within ten (10) business days of the end of each contract year.
c. Case summaries for the Agency's Review Committee, when requested by the Agency social worker.
d. Notification to providers of the results of the Agency's Review Committee.
e. Notification of the Agency's social worker, community services manager and regional program manager with denial information and reason for denial via a secure email network.
15. The Vendor shall provide consultation and research to the Agency, as needed.
16. The Vendor shall participate in New Service development and revisions of existing services, as requested.
17. The Vendor shall refer any instances of suspected fraud to the Agency's Office of Finance and Administration for any BSS services covered under this contract.
18. Upon request, the Vendor shall develop data sharing agreements with relevant entities including, but not limited to, universities.

We will continue to support the BSS with their provision of medical and non-medical services for children and families who meet eligibility guidelines. Along with our vast experience and deep expertise conducting utilization management and prior authorization reviews, we bring to WV DHHR our clinical reviewers who are well-trained in URAC standards, InterQual® clinical guidelines, and person-centered review processes. All reviews are conducted with a primary focus on optimizing the services available for each individual's needs to facilitate achieving the best outcome. Our expert clinical reviewers comply with WV DHHR's policies as we maintain a keen focus on quality and the appropriate level of service and setting with each review. Ultimately, our authorization reviews determine if beneficiaries are receiving the appropriate care and services or if they may be better served in a lower level of care or with alternative services to meet their individual needs. **The end result of the advantage we provide is that the individual is provided the most appropriate service option to achieve good health and optimal outcomes. WV DHHR can be assured that it is maximizing its taxpayer investment in the best holistic care approach available for each member based on that member's unique circumstances.**

Receipt of Prior Authorization Requests

Regardless of the mode of receipt, we have established procedures and sufficient capacity to receive review requests and other documentation required for prior authorization and eligibility review of non-medical services. Depending on program policy, we offer providers flexibility with convenient options for submitting prior authorization requests via the Provider Portal, telephone,

fax, and mail. **Figure 88 Process for Receiving and Processing Prior Authorization Requests** outlines the initial prior authorization (PA) request workflow in Atrezzo via the Provider Portal.

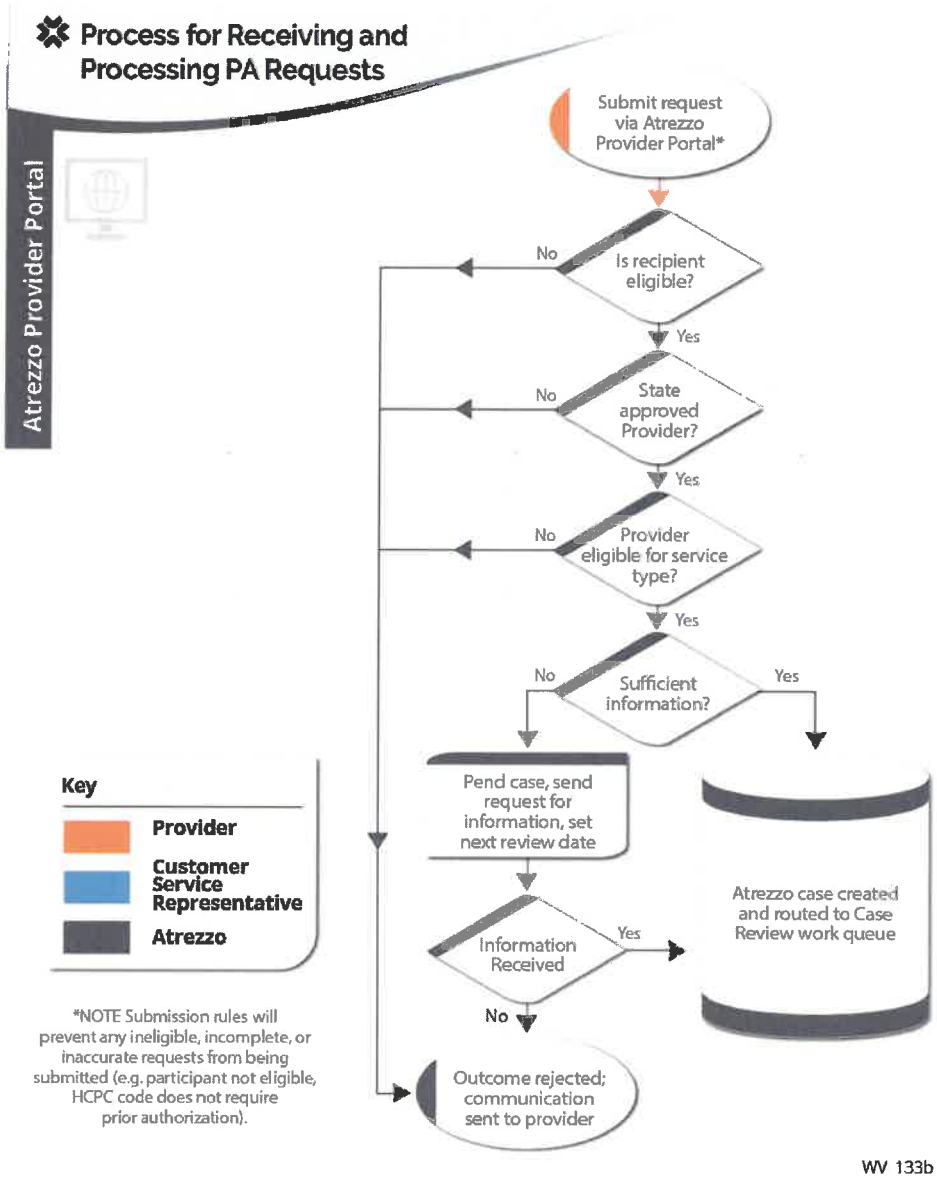

Figure 88. Process for Receiving and Processing Prior Authorization Requests

Optimized processes, focus reviews and refine prior authorization provide the best care approach for each individual member.

A local Technical Liaison in West Virginia supports the program during business hours. **The Technical Liaison assists provider's management of web-user passwords and security issues as well as technical support through our Service Desk 24 hours a day, 7 days a week.**

We will utilize Atrezzo as the prior authorization platform for these services, including Therapeutic Foster Care. Atrezzo has functionality that allows users to upload documentation needed to

support the request in a secure environment. Atrezzo allows providers to manage their own users' access levels and passwords all within the secure application environment. Atrezzo is configured to create daily authorization files to be placed on BSS' secure FTP site for their use as well as the authorization information made available to providers through the portal. We will accept daily referral and roll back files when necessary and as new requirements are developed at specified times agreed upon with BSS. Atrezzo is also equipped to handle all data exchange requirements outlined in the RFP. We conduct thousands of data exchanges every day, using secure FTP sites to post and retrieve data records for utilization and quality review. We manage over 420 unique daily, weekly, and monthly file transaction processes that account for over 2,500 daily job executions that involve data exchanges between us and our clients.

Did You Know?

In 2021, the Atrezzo provider Portal received more than 1.14 million total service lines/ procedures.

Prior Authorization Request and File Upload

Prior authorization requests can be submitted via the Atrezzo Provider Portal. Requests submitted directly to the Provider Portal are immediately queued for review or immediately approved using auto approval logic if criteria are met. Atrezzo is optimized to prevent duplicative data entries, therefore any duplicative requests are entered into one Atrezzo module.

All prior authorization requests and supporting documentation are housed in our Atrezzo system—from start to finish our clinical staff and providers can view all information and documentation for a specific request through a single, web-based system. Providers can add/upload supporting documentation, either by uploading documentation directly into Atrezzo, or by sending to us via mail or fax and CSRs upload the information into the system. We pend a case when the authorization requires clinical review and supporting documentation, and we request the additional information from the provider. As shown in **Figure 89 File Upload Screen**, uploading files into Atrezzo is a simple, efficient process for providers.

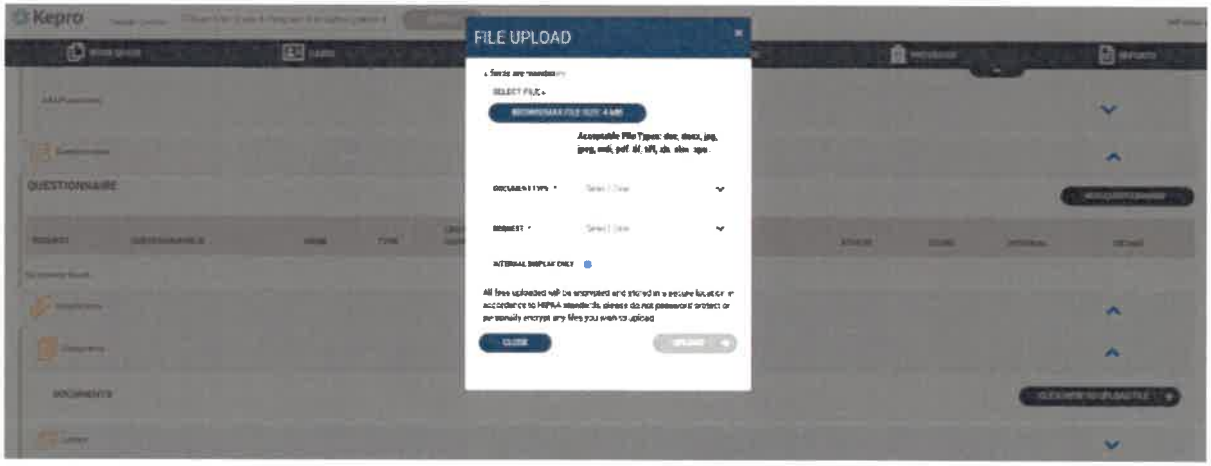

Figure 89. File Upload Screen

From this view, relevant documentation can be uploaded through the Provider Portal.

Maintaining all Documentation in an Electronic Record Format – All documentation is housed within Atrezzo, regardless of how it arrives. Providers (and our staff) upload files to a case and can enter clinical documentation and other notes directly into the case even if it is submitted via electronic data interchange (EDI). Our secure Provider Portal facilitates communications between providers and our clinical review staff. Our design of the Atrezzo system is based on years of interaction with various provider communities. We continuously look for ways to make the system more efficient and easier to use for providers and their staff.

Process for Matching Prior Authorization Request with Supporting Documentation – All documentation related to a specific case is available in one place for ease of review, as shown in **Figure 90 Documentation Screen**.

Figure 90. Documentation Screen
Documentation is centralized in this screen for ease of access to case information.

Ensure Documentation is Complete and Request Additional Information as Needed

Once we receive the supporting documentation from a provider, a clinical reviewer will review the documentation and determine if it is complete or if additional information is needed. If the documentation does not include all the required documents, we will contact the provider requesting additional information in the manner and timeframes required by WV DHHR. The clinical reviewer will contact the provider, indicating the information needed and the timeframe the provider must return the information.

We will request the provider submit the missing information within approved timeframes via the Atrezzo Provider Portal. The use of the Atrezzo Provider Portal is an important feature of our system that improves record submission by making it possible to upload materials 24/7 and immediately validate acceptance of the upload. Our staff is also available to assist providers during office hours, and we will scan the records into the system if we receive them in hardcopy format. Our administrative process validates that the records are complete and ready to review. If needed information is still missing, we will notify the providers and request them to submit just the specific materials. If providers do not submit the requested documentation in response to the first and second requests, we will close the case. The entire prior authorization process is outlined in **Figure 87. Prior Authorization of BSS Services located in Section A2.A General Requirements.**

Additionally, our provider training will focus on educating providers to the required components in submitting complete records. Ensuring providers are well educated in key processes and procedures, including the submission of complete documentation, is key to our ongoing, successful partnership with our state program providers.

Utilization Guides for Atrezzo Provider Portal Submissions

To assist service providers and BSS workers, we will maintain instruction manuals and Utilization Guidelines on our public facing web site as instructed. Special Medical Cards will follow the same requirements and policies as Medicaid providers. Therapeutic Foster Care, STAT homes, out-of-state group residential psychiatric treatment facilities, and Special Evaluations will each have their own Utilization Management Guidelines as well as user guides, as needed. Complimentary guides for BSS social service workers will be created and posted to our web site as well to support their understanding of services available.

Providers of these services no longer use electronic data file formats. Instead, providers access our systems via the appropriate web portal that we maintain, thus reducing the financial burden for providers to maintain the programming costs associated with electronic file transfers.

Providers say: Portal

Our providers consistently give us excellent feedback on their experience using our provider portal:

"I like to use Kepro because it (the portal) is fast, and the response time is also fast. The people are courteous and willing to help you solve problems."

"Thankful that Kepro service authorization process is consistent and reliable."

We maintain revisions on a service guide for Agency social services workers and providers which detail the criteria for eligibility for each medical and non-medical service.

Retrospective Review

Service Excellence

Kepro's excellence in achieving client-prescribed review timeliness is evident across our West Virginia programs. We achieved a 99.4% timeliness rate in 2022 across BSS programs.

In addition to the prior authorization of services outlined in **Figure 87 Prior Authorization of BSS Services located in A2.A General Requirements** and funded by BSS, we will continue to provide retrospective reviews of these services on a mutually agreed upon schedule. We will use the retrospective tools already approved by BSS and continue to refine them as well as work with the Bureau to develop new ones for newly identified services.

We will verify that processes and tools for our on-site retrospective review of the medical and non-medical services meet all requirements outlined in this RFP and will be approved by BSS. We will use at a minimum the authorization records, provider invoices, personnel files, case files, care plans and treatment plans in the process to ensure records are accurate and providers are fully credentialled. Other documentation may also be reviewed depending upon the service and may include medical records, medicine administration records (MARs), incident reports and agency policy and

procedures. Key components of our thorough, on-site Retrospective Review of BSS services includes review of:

- Provider's employee files to validate all credentialling and training requirements are met.
- Agency's policies, which are compared to the minimum standards set by the Agency. During this review, any deficiencies are identified and referenced back to the policy or rule that is not in compliance so that the provider can remediate the situations.
- Member's clinical records, such as case files/plans and treatment plans, are reviewed to verify the admission and/or continued stay criteria have been fully substantiated within the documentation, to evaluate whether the agency's policies are being implemented as written.
- Incident reports

Once the review is conducted, we will develop and provide a detailed report of the retrospective review to the provider to support proper communication channels for continuous quality improvement. We will produce a retrospective review report within 30 business days for the provider and Bureau's review. Each provider will receive follow up within 10 days of the report being sent to determine their needs and participation in training to better meet program standards.

In addition, we will contact the provider ten business days after the report is sent to determine if the provider wishes to receive technical assistance. This report outlines a summary of each area as well as specific examples for each deficiency. In addition, if any fraud is detected, it is reported to the appropriate source, depending on the funding source. Once the report is approved for distribution, it is provided to the agency and our employee responsible for the review contacts the provider to make sure there are no questions regarding the report and establish training opportunities for the agency.

We are currently 100% compliant with BSS required reporting and we will continue to produce timely and detailed utilization reports regarding each provider on a county, regional and Agencywide level monthly. During the implementation period, we will reconfirm required data fields, report format and schedule with WV DHHR, to ensure continued compliance with WV DHHR requirements under a new contract.

We currently maintain a BSS-approved process for service denials to **make sure** processing is completed **timely and accurately**, including a secondary internal review. Existing denial processes will remain in place but may be refined as needed or requested by the Bureau.

It is important to note that with optional services, there will be variance in the denial process depending on West Virginia-specific needs as well as the nature of the program, and we are prepared to make these adjustments expeditiously during the implementation phase. Under our Qualified Residential Treatment Program (QRTP) program, service denials are not permissible, as the service requires our staff to complete assessments, which are then passed on to the Bureau for consideration. In addition, for Therapeutic Foster Care and STAT Homes, we recognize our position as a trusted assessor and advisor following the child's assessment; we understand that in these

programs, we will offer the State our evidence-based recommendations, but that the State has the final authority on the outcome.

Educational Trainings and Technical Assistance

We have the capacity to develop educational training and provide technical assistance on policy, available services, service delivery models, and the choice between Therapeutic Foster Care program and other forms of care for members, families, agencies, stakeholders, and the general community.

Additionally, outside of the Therapeutic Foster Care program we will continue to provide educational training and technical assistance for BSS staff and their stakeholders regarding the differing service arrays and levels of care at the request of the Bureau. We have provided training over the years regarding different Waiver programs, the different levels of care in residential services, types of psychological evaluations, and service reviews to best address shifting provider needs and trends. Standard training for all groups includes education on the submission process, review criteria developed by the Bureau, as well as authorizations and denial processes per policy.

As part of new provider orientation, we offer training in all the above areas as well as program-specific sessions. Most recently we trained new therapeutic foster care tiered service providers in a program specific session that helped equip incoming providers to carry out WV DHHR policies and procedures. Training and new provider orientation sessions are provided virtually as well as on-site as determined by provider needs. Training and technical assistance are also included in the retrospective review process. Retrospective review results as well as provider needs determine the level of required training.

We provide training for parent/kin/relative providers on how to access services, based on the need. Trainers are available to present at groups in the community. These individuals are also free to communicate directly with our care managers at the time of their first submission, and our care managers will provide step by step instruction on the submittal process. Parents or other relative providers are encouraged to call at each submittal, if needed. Our team can also assist with invoice completion and help families and BSS workers with other service options as needed.

Data Collection Process for the Therapeutic Foster Care program

Our data collection process for the Therapeutic Foster Care program captures child-specific outcome data to be developed with BSS upon contract award. As we do today with other workflow processes, Atrezzo's QBuilder will allow us to build a questionnaire based on the State's desired data collection for outcome analysis. During the implementation period, our Health Intelligence team will collaborate with BSS to help understand the desired outcome measures needed and identify the data elements required to obtain said measures. Following development and implementation of questionnaires, we can provide reporting on subsequent outcomes as desired by BSS. Our team stands ready to leverage this data to assist WV DHHR with outcome analysis should the State desire.

We currently maintain an accurate list, based on the utilization management authorizations and State policy, sent to BSS monthly. We are happy to modify our reporting frequency and provide an accurate list as well as all required data elements at close of business each Friday.

Quality Assurance Activities

We previously provided the Quality Assurance activities described in this RFP during our work with the State from 2010-2018. At that time, we collaborated with BSS to develop the required questionnaires that met the needs of the Bureau. We are prepared to resume this function and follow the same diligent processes as we return to completing this work for the focus group program under the new contract requirements.

As we have done in the past, we will conduct quality assurance activities with members, families receiving services, agencies, stakeholders including Agency social workers and their supervisors, and the general community as needed and/or upon request of the Agency. These activities will include, but not be limited to the following:

- Ten educational forums representing stakeholders Agencywide each contract year and a complete summary within two weeks for review by the contract Management Team.
- Minimum of six focus groups Agencywide which consists of the recipients of Non-Medical Services including biological parents, foster parents, and children as well as Agency social workers and their supervisors using the Agency's pre-approved questions. A complete summary of the group is due within two weeks for review by the contract Management Team.

Reports and Notification Related to Non-Medical Services

We are pleased to offer the Bureau the following reports and notifications related to Non-Medical Services to the Agency for Social Services:

- We will provide consultation, analysis of data and information contained in Atrezzo and research for the Agency. We will participate in new service development and revisions of existing services, as requested.
- We will work with the Bureau to establish the questions for the Consumer Focus Groups and provide an annual report within ten business days for the end of each contract year. The BSS Contract Manager and their Office Quality Improvement will be engaged with the process.
- We will complete case summaries when requested by the BSS worker by providing the history of clinical information on record in our systems or by recommending the youth complete the QRTP process.
- As indicated in the prior authorization section, we will notify the provider of results of a WV DHHR Agency Review Committee as a follow up to a denied service request via secure email.
- We will notify the BSS social worker, Community Service Manager, and Regional Program Manager of all denials with rational via secure email as it is currently outlined in our standard operating procedures with the Bureau.

- We will refer any instances of suspected fraud to the Agency's Office of Finance and Administration for any BSS services covered under this contract.
- We will establish data sharing agreements with relevant entities, including universities during the implementation phase and will gladly work with BSS to incorporate additional entities.

A2.C. BSS-Qualified Residential Treatment Program and Qualified Independent Assessments

1. The Vendor shall complete eligibility assessments within thirty (30) calendar days, including the CAFAS and CANS, for children who are at immediate risk of being placed in a residential treatment facility.
2. The Vendor shall provide education, training, and technical assistance for DHHR Staff and MDT members.
3. The Vendor will conduct Face to Face eligibility assessments within 30 calendar days for Qualified Residential Treatment Programs as required by the Family First Prevention Services Act.
4. The Vendor shall maintain an accurate enrollment list based on the utilization management authorizations and Agency policy, sent to BSS at close of business each Friday.
5. The Vendor will develop and provide education, training, and technical assistance for DHHR Staff and Stakeholders
6. The Vendor will develop interpretive guidelines for all assessments administered.
7. The Vendor will participate in any court-ordered legal proceedings, at no additional cost to the Agency.

We are a leader in delivering conflict-free assessments to vulnerable individuals and priority populations. As we currently fulfill all elements of the RFP requirements outlined above, our team stands ready to continue its support of the WV DHHR Qualified Residential Treatment Program.

We received an expansion of the scope of work from the Bureau for Social Services in 2022 to provide more assessment services as the qualified individual for the Assessment Pathway, to comply with the Department of Justice (DOJ) Agreement.

QRTP Process Requirements

We currently meet all process and turnaround time requirements in our QRTP process flow, which are outlined in **Figure 91 QRTP Process Flow** below.

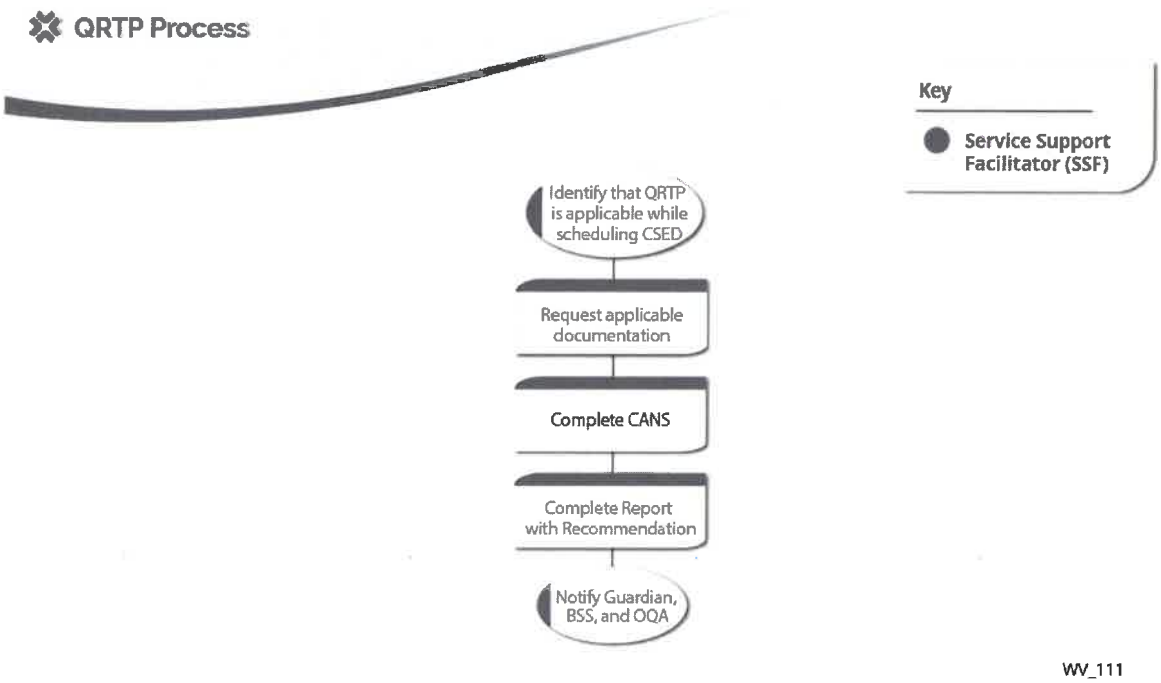

Figure 91. QRTP Process Flow

Our process is integrated into our larger CSED Waiver services to support comprehensive care

The QRTP process begins with the BSS worker submitting the referral called the Intensity of Intervention Services Assessment to us. We will first review to determine if the member has been assessed for Children with Serious Emotional Disorder (CSED) Waiver. If they have not, a CSED Waiver assessment will be completed as well as the Qualified Independent Assessment Results and Recommendations Report. Additional available documentation such as service plans, psychological evaluations, previous Child and Adolescent Needs and Strengths (CANS) results, social histories, Individualized Education Plans (IEPs), and progress notes will be requested from the BSS worker assigned to the case. Time will be scheduled with all available parties to complete the assessments. The report is completed and distributed to the appropriate parties. We will participate in any court ordered proceeding on the Bureau's behalf to review the findings of the evaluation at no extra cost to the Bureau.

This scope of work includes level of care assessments for children at risk of out of home residential placement and/or referred for residential placement within 30 days of referral. We complete eligibility assessments within thirty (30) calendar days, including the Child and Adolescent Functional Assessment Scale® (CAFAS) and CANS, for children who are at immediate risk of being placed in a residential treatment facility. Eligibility assessments will be completed within 30 days which include the completion the CAFAS and CANS, the appropriate level of care determination and recommendations all within an individualized written report. The completed assessment is called Qualified Independent Assessment Results and Recommendations Report.

We follow a stringent process when developing interpretive guidelines for the assessments we conduct. All assessors are certified in CANS – with a program certified through Marshall University – and CAFAS-certified through the CAFAS assessment tool provider. CANS recertification is required annually, while CAFAS is every two years. During monthly staff meetings, Assessors complete inter-rater training to make sure scores remain consistent across our personnel. If deficiencies are noted across any particular area, we develop guidelines to address, providing Assessors with additional resources while completing their assessments.

As part of our quality review process, we work with BSS and providers to obtain weekly enrollment list. Once our team receives the list, we compare the members on this list to assessments completed within Atrezzo and identify any members that have not yet received their assessment, ideally prior to placement within the facility. This weekly enrollment review allows our assessors to prioritize these members when scheduling assessments.

Training and Technical Assistance

Education, training and technical assistance for behavioral health providers, families, guardians, BSS staff and community stakeholders will also be provided. Reporting, analysis and tracking of data will be completed and placed in our Atrezzo application.

A2.D. BSS-Behavioral Health Services Children's Out-Of-State Residential Programs

1. West Virginia Bureau for Social Services covers out-of-Agency residential services for members who meet eligibility guidelines for out-of-Agency residential services. Members will receive annual assessments to determine re-eligibility guidelines.
2. As a condition for reimbursement, BSS requires that all out-of-Agency residential services receive prior authorization.
3. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity, to be approved by BSS in advance, to receive review requests, physician's orders, plans of care, assessments, and other forms or documentation required for prior authorization and eligibility review of out-of- Agency residential services.
4, In performing out-of-Agency residential programs service determinations, the Vendor shall use nationally accredited, research-based, criteria in reviewing each prior authorization and pre-payment review requests. BSS shall have prior approval of the criteria used for automated and manual review. The criteria shall provide a clinically sound basis for professional determinations of the medical necessity for all out-of-Agency residential children's services reviewed under the resulting contract.

a. The Vendor shall maintain the capacity to update the review criteria for out- of-Agency children's residential services reviewed under the resulting contract. The Vendor shall make recommendations about policy, procedures, and best practices to BSS annually, regarding what, if any, changes should be made to the criteria that will be used for the following calendar year, along with draft forms or modified forms already in use for approval by BSS.

b. The Vendor shall provide BSS with access to a complete set of materials associated with the criteria recommendations, should any criteria updates be needed.

c. Any modifications to the criteria or guidelines must be prior approved by BSS. Based on the best interest of the State and the review outcome, BSS reserves the right to specify the use of different criteria/guideline products during the resulting contract.

d. The Vendor is responsible for any costs associated with the purchase of any review criteria.
5. The Vendor shall provide prior authorization review for in-patient out-of-Agency residential psychiatric services.
a. Re-determinations for medical necessity will be made within (30) calendar days from the anniversary date of the initial eligibility.
6. The Vendor shall appear and provide necessary testimony and documentation for member fair hearings.
7. The Vendor will develop, implement, and maintain a system to validate eligibility of members to receive out-of-Agency residential services.
8. The Vendor shall develop, implement, and maintain criteria and tools to evaluate out-of-Agency residential providers' self-assessments to assign the appropriate level of care.
9. The Vendor shall develop, implement, and maintain a cost-efficient secure, email system for transmission of denial letters to out-of-Agency providers.
10. The Vendor shall develop, implement, and maintain tools and processes for conducting annual retrospective reviews of the behavioral health services provided in out-of-Agency residential programs for children that include:
a. An on-site review completed at the out-of-Agency facility.
b. The reviewer must be a licensed registered nurse due to the medication management and administration, physician's orders, nursing notes and restraint-related injuries requirements of the review.
11. The Vendor shall provide the following reports and notifications related to out- of-Agency children's residential programs to the Bureau for Social Services:
a. Data analysis reports, as requested.
b. The annual Focus Group Summary and analysis report within ten (10) business days of the end of each contract year.
c. Notification of the Agency's social worker, community services manager and regional program manager with denial information and reason for denial via a secure email network.
d. Clinical summaries on all youth who are in the Agency's custody who are under the age of eleven (11) and placed in out-of-Agency residential care.
e. Clinical summaries on all youth who are in the Agency's custody who are seventeen (17) years or older and placed in out-of-Agency residential care.
f. Monthly reports regarding adopted children and parentally placed children in out-of-Agency psychiatric residential facilities (PRTF).
12. Upon BSS's request, the Vendor shall conduct quality assurance activities with members, families, agencies, stakeholders, and the general community as necessary or at the request of BSS. These activities shall include, but not be limited to the following:
a. Ten (10) educational forums representing stakeholders Agencywide each contract year and a complete summary of the group within two (2) weeks for review by the Contract Management Team.
b. Conduct, at a minimum, six (6) out-of Agency children's residential focus groups which consists of the recipients of out-of-Agency residential behavioral health services including biological parents, legal guardians, and children using the Agency's pre-approved questions. A complete summary of the group is due within two (2) weeks for review by the Contract Management Team.
c. Consultation and support to the Agency's social workers and supervisors.
d. Training and technical assistance.
13. The Vendor shall develop educational trainings and provide technical assistance about policy, available services, service delivery models, and the choice between medically necessary services and other forms of care for members, families, agencies, stakeholders, and the general community. All training shall be approved in advance by BSS.

We have served West Virginia's vulnerable children since 2000. For 22 years, we have worked hand in hand with WV DHHR to develop, implement, and realize West Virginia's mission to provide appropriate care and services to those youth who need it most. Our two decades of partnership with West Virginia has cemented our deep knowledge of the State, its priorities, and its

populations. It is our standing as WV DHHR's long-time partner and our established roots within the community that make us the ideal candidate to take on work related to children's services.

Out-of-State Residential Services

We will conduct prior authorization of all out-of-state residential services following the process outlined in **Figure 87 Prior Authorization of BSS Services located in A2.A General Requirements**.

This process is performed by a clinical reviewer (such as a nurse or Master's level social worker). When a case is retrieved from Atrezzo for review, the clinical review evaluates the case and applies the appropriate and supplemental criteria and State rules to determine if case requirements are met. If case requirements are not met, the clinical reviewer will document the adverse determination in Atrezzo, which will produce a notice of adverse determination to be sent to the provider. The work tasks and case will be closed in Atrezzo.

Exceeding Standards

Kepro's excellence in achieving client-prescribed review timeliness is evident across our West Virginia programs. We achieved a timeliness rate of 100% in 2022 for Out-of-State Residential Services program.

If case requirements are met, the clinical reviewer will determine if the case can be approved based on information provided. If the case requires additional information, a request will be sent to the provider, a "next review date" will be assigned in Atrezzo, and the case will be pended until the information is received or the next review date is reached. If additional information is not received at this point in the process, the case is closed in Atrezzo. If the additional information is received, InterQual® criteria, supplemental criteria, and state rules are applied to the case to determine if it can be approved. If the case cannot be approved, the case is sent to the DHHR Review committee. If the case can be approved using InterQual® criteria, supplemental criteria, and state rules, the determination is finalized in Atrezzo, and the case is closed.

Provider authorization requests will be acted upon within two business days. Resulting actions may include authorization, requesting additional information for review, re-authorization, closure, denial or contacting the BSS worker when needed. Existing denial processes will remain in place but may be refined as needed or requested by the Bureau. New services without existing denial protocols will be developed in agreement with the appropriate BSS staff. Should a re-authorization become necessary, we will follow the same prior authorization process and adhere to all applicable time frames.

As outlined in **Section** A2.B Bureau for Social Services – Non-Medical Services, regardless of the mode of receipt, we have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, assessments, and other forms or documentation required for prior authorization and eligibility review of out-of-state residential services.

Atrezzo Case Management System

We stand ready to utilize Atrezzo as the prior authorization platform for all services, including out-

of-state residential programs. Atrezzo is configurable and easily able to accommodate new work the State requires. Atrezzo has functionality that allows users to upload documentation in a secure environment when needed to complete a prior authorization review. We will also accept documentation via secure fax or email as well as through mail. We will utilize Atrezzo as the prior authorization platform for these services, with features that allow users to upload documentation for review in a secure environment when completing a prior authorization.

We use nationally accredited, research-based, criteria in reviewing each prior authorization and pre-payment review request. Our reviews are based on the same national criteria required by the Bureau for Medical Services and if there is no applicable set of criteria, we use the same criteria approved by BMS and our Medical Director, Dr. Paul Kuryla. Together with BSS, we developed a set of criteria for the residential model at the start of our work with West Virginia in 2000. We also partnered with the Bureau in 2004 to tailor the criteria to specifically address the needs of West Virginia's residential program. West Virginia and the managed care organization (MCO) currently overseeing this program continue to use criteria our team helped develop.

BSS has the final decision on the criteria used for automated or manual reviews for all out-of-state residential children's services reviewed under the resulting contract. Criteria can be adjusted as needed at the direction of BSS.

We also provide consultation regarding best practices, policy and criteria and data to assist BSS in making possible alterations on an annual basis. We worked with BSS to develop a complete set of all the review criteria following program finalization. There is no additional cost to the Bureau associated with criteria development, which apply to psychiatric residential treatment facilities and any inpatient admission covered by BSS.

Prior Authorization Review for In-Patient Out-of-State Residential Psychiatric Services

Service requests will be for a period of 30 days and each request will have their eligibility checked via the Agency's MMIS vendor's portal. Our clinical review staff will also be available to provide testimony for court proceedings and fair hearings regarding the prior authorizations of out-of-state residential proceedings.

We will conduct prior authorization of all out-of-state residential services following the process outlined in **Figure 87 Prior Authorization of BSS Services located in A2.A General Requirements.** For development, implementation, and maintenance of criteria and tools, we implement the same criteria outlined in the previous section. We provide a recommendation to the Bureau, but the final determination is made by BSS. A registered nurse completes the on-site reviews to assess whether the member's behavioral health and physical health needs are being met during placement and to make recommendations as well as review incident/accident reports. Both areas are included in the review tools used for the on-site quality retrospective reviews. The nurse reviewer also supports the BSS licensing team in conjunction with the Department of Education to complete on-site reviews and/or certifications.

Annual Retrospective Reviews of the Behavioral Health Services

The service providers receive retrospective reviews based on tools developed and approved by BSS that are reflective of the criteria established for the assigned level of care. These tools are utilized for the annual on-site reviews. The provider's level of care is also re-evaluated while completing the on-site reviews, to verify proper classification in comparison to the self-assessment they submitted. Free secure e-mail and fax are available for providers to transmit all their information when requested and we in turn utilize this information for both retrospective quality reviews and service denials. The same secure email system is used to handle communications regarding service denials and/or confidential clinical information for BSS staff.

A registered nurse completes the on-site reviews to assess whether the member's behavioral health and physical health needs are being met during placement and to make recommendations as well as review incident/accident reports. Both areas are included in the review tools used for the on-site quality retrospective reviews. The nurse reviewer also supports the BSS licensing team in conjunction with the Department of Education to complete on-site reviews and/or certifications.

Reports and Notifications for Out-of- State Children's Residential Programs

We will provide the following reports and notifications related to out-of-state children's residential programs to the Bureau for Social Services:

- Data analysis reports, as requested.
- The annual Focus Group Summary and analysis report within ten business days of the end of each contract year.
- Notification of the Agency's social worker, community services manager and regional program manager with denial information and reason for denial via a secure email network.
- Monthly reports regarding adopted children and parentally placed children in out-of-state psychiatric residential treatment facilities (PRTF).

We will also provide clinical summaries for any children under 11 or over 17 placed out-of-state by referring them to for an independent assessment if a child has been identified through the prior authorization process. We will report on all out-of-state adoptive placements that are prior authorized before they are enrolled with Mountain Health Promise.

Quality Assurance

We believe that, by involving members, Bureau staff, and other stakeholders we manage for the Bureau we help provide quality assurance. To promote quality, we will provide at least 10 educational forums each year with a written summary of the event within two weeks to contract management. At least six focus groups per contract year will be completed utilizing the Bureau's approved list of questions for foster children as well as Bureau workers and their supervisors regarding out-of-state placements. A written report of each focus group will be completed within two weeks of the event and provided to contract management. We will collaborate with the

Bureau's Continuous Quality Improvement staff in this area to determine questions for this contract cycle. An annual report and data analysis will be provided to the Bureau.

Our services will also continue to include development and educational training as well as technical assistance for all stakeholders identified by the Bureau regarding policy, services available, service delivery models, the various types of services. Specifically, providers and workers will be kept apprised of service issues, the authorization process, as well as training on any new Utilization Management Guidelines approved by the Bureau.

A2.E. BSS-Psychological Evaluations

1. West Virginia Bureau for Social Services covers psychological evaluations for members who meet eligibility guidelines for psychological evaluative services.
2. As a condition for reimbursement, all psychological evaluation services shall receive prior authorization.
3. Regardless of the mode of receipt, the Vendor shall have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, assessments, and other forms or documentation required for prior authorization and eligibility review of out-of-state residential services.
4. The Vendor shall establish, implement, and maintain a pre-authorization review procedure from a Ph.D. level psychologist to make determinations for the medical necessity of each psychological review requested by behavioral health providers.

We will continue to review all referrals from BSS field staff for special psychological evaluations as outlined in the Special Evaluation Utilization Management Guidelines. **We have conducted these services since 2015, reviewing 2,173 unduplicated requests in that time**. This volume underscores the critical work we accomplish as the State's steadfast partner in children's services.

We will conduct prior authorization of all psychological evaluation services following the process outlined in **Figure 87 Prior Authorization of BSS Services located in A2.A General Requirements**.

This process is conducted by a clinical reviewer who is a nurse or Master's level social worker. When a case is retrieved from Atrezzo for review, the clinical review evaluates the case and applies the appropriate and supplemental criteria and State rules to determine if case requirements are met. If case requirements are not met, the clinical reviewer will document the adverse determination in Atrezzo, which will produce a notice of adverse determination to be sent to the provider. The work tasks and case will be closed in Atrezzo.

If case requirements are met, the clinical reviewer will determine if the case can be approved based on information provided. If the case requires additional information, a request will be sent to the provider, a "next review date" will be assigned in Atrezzo, and the case will be pended until the information is received or the next review date is reached. If additional information is not received at this point in the process, the case is closed in Atrezzo.

If the additional information is received, InterQual® criteria, supplemental criteria, and State rules are applied to the case to determine if it can be approved. If the case cannot be approved, the case is sent to the DHHR Review committee. If the case can be approved using InterQual® criteria or WV specific rules, the determination is finalized in Atrezzo, and the case is closed.

Provider authorization requests will be acted upon within two business days. Resulting actions may include authorization, requesting additional information for review, re-authorization, closure, denial or contacting the BSS worker when needed. Existing denial processes will remain in place but may be refined and needed or requested by the Bureau. Any new services without existing denial protocols will be developed in agreement with the appropriate BSS staff.

As outlined in **Section A2.B Bureau for Social Services – Non-Medical Services**, regardless of the mode of receipt, we have established procedures and sufficient capacity to receive review requests, physician's orders, plans of care, assessments, and other forms or documentation required for prior authorization and eligibility review of out-of-state residential services.

We have worked extensively with the Agency to establish and validate the criteria needed to appropriately conduct psychological evaluations. If the evaluation being requested does not meet the established criteria require, we have a PhD psychologist from our review panel to make the determination. The steps include:

1. The BSS worker makes an appointment for the evaluation with their chosen psychologist.
2. The BSS worker sends referrals to the Kepro Special Evaluation e-mail box and psychologist.
3. The Kepro clinical reviewer evaluates request and makes a determination.
4. The Kepro staff notify BSS worker and psychologist of the determination.
5. Approvals are assigned a SE number.
6. The BSS worker and psychologist are notified via e-mail.
7. If a determination cannot be made at this level, the request is forwarded to the Kepro. Psychologist and the Kepro psychologist renders a decision.
8. The BSS worker and psychologist are notified via e-mail.

If at any time during this review a more appropriate payer source is identified, the psychologist and BSS worker will be educated and referred to the appropriate source.

In cases where a Special Medical Card has been issued to obtain a psychological evaluation, the prior authorization process established in the Bureau for Medical Services section of this request for proposal will be followed. These determinations will be made in accordance with current federal and State policy guidelines. Plans of care, physician's orders, assessments, and any other pertinent documentation will be reviewed if needed to make these determinations.

A2.F. BSS-OPTIONAL SERVICES

1. CANS-based Necessity Establishment System

a. The Vendor shall develop, implement, and maintain a procedure for the analysis of certain CANS Assessment data elements to be used as criteria for establishing necessity for high fidelity wrap-around services.

b. The Vendor shall develop a fidelity monitoring process, to be approved by BSS, utilizing evidence-based tools recommended by the National Wraparound Initiative (NWI)

c. The Vendor shall develop, implement, and maintain a procedure for the competency analysis of children under the age of 14 who enter the juvenile justice system to determine the child's ability to participate in proceedings.

We have used the CANS tools in West Virginia as part of our CSED and QRTP work with the State for the past 10 years. We also implement CANS in Virginia and Maine, highlighting our extensive experience with the assessment tool. Similarly, we currently conduct Wraparound Services as part of our work with the UM and PA Services contract. With our knowledge, experience, and long history with WV DHHR, we are confident and welcome the chance to develop, implement and maintain a procedure for the analysis of relevant CANS data to establish criteria for medically necessary behavioral health services.

The CANS assessment, developed by Dr. John Lyons, is meant to improve the lives of children and their families through analyzing what is needed to serve the child and family best along the lines of service planning and decision making in addition to quality assurance monitoring. We also recognize that this tool is a pivotal point to assessing the needs of those who will be served in potentially multiple programs that we currently administer as well as potential future optional services in this RFP.

Our extensive experience conducting the CANS assessment, with West Virginia children's services, and the innovative technology we will employ position us to effectively provide data reporting and analysis of assessment scores. As such, we stand ready to work with the State to develop, implement, and monitor any data analysis requirements put forth by WV DHHR, a fidelity monitoring process, to be approved by BSS, utilizing evidence-based tools recommended by the National Wraparound Initiative (NWI). The CANS assessment will be built into our Atrezzo system during the implementation period. The Assessor will complete the CANS and QRTP Assessment in the Atrezzo system, which is available online or in an offline form that can be synchronized once secure online access is available.

Upon contract award, we will meet with WV DHHR to identify the unique program needs of any CANS-related system requirements. Our clinical experts and Community of Practice members are ready to consult on any needed changes and recommend changes that will capture, track, and analyze the needs of both WV DHHR and the child being assessed for services. Once identified, changes needed in Atrezzo are made in a matter of days (often instantly) and are available for production within one business day.

Use of the CANS also assists us in determining the child's competency to participate in the treatment plan as well as, for children under 14, ability to participate in juvenile justice system proceedings. CANS as part of the qualified independent assessment pathway is designed for use at two levels – the individual child and family, and for the system of care, including the juvenile justice system. The CANS provides a structured assessment of children along a set of dimensions relevant to service planning and decision-making, as well as competency. With our extensive experience administering the CANS assessment and supporting WV DHHR in determining a child's needs and strengths, we are confident in our ability to extend the CANS assessment to youth under 14 years of age who enter the juvenile justice system.

Appendix 3: BBH Detailed Specifications

Bureau for Behavioral Health (BBH)

A3.1. General Requirements

BBH provides funding for the support of behavioral health services and programs for the citizens of the state of West Virginia. The majority of BBH services and programs are designed to supplement and support Medicaid-covered services to ensure a statewide system of care and the availability of a full spectrum of services to meet the needs of all applicable individuals. The services to be covered by this contract are those direct services covered under Substance Use Disorder, Adult Mental Health, Children's Mental Health, and Intellectual/Developmental Disability. Vendor is to utilize established BBH definitions according to applicable policies and standards. Any deviation from these service definitions must have BBH prior approval. Vendor is to work collaboratively with the BBH and to perform functions necessary to support compliance with state and federal requirements including both the Mental Health and Substance Abuse Block Grants.
The following is a listing of BBH specific services or programs requiring prior authorization. Services may be subject to change due to changes in federal or state regulations, or changes in state BBH policy.

A3.1.a. BBH Comprehensive Service Data Collection

BBH awards funding to community based behavioral health centers for the provision of prevention, treatment, recovery support, and other evidence-based practices and programs that demonstrate success in improving outcomes and/or supporting recovery. Community based behavioral health centers are the thirteen (13) comprehensive Community Behavioral Health centers identified in code. These programs are all designed to enhance Medicaid, Medicare, and private insurance services, and therefore, many data and reporting elements are not fully integrated into the Medicaid data system.

1. As part of its responsibilities as the State Single Authority, BBH must collect and report varying levels of statewide enrollment, diagnosis, service, and outcome data from its providers. Specific data sets and information needs are primarily based on the following Federal funds and reporting requirements:

a. Substance Abuse Block Grant (SABG) CFDA Number: 93.959
Authorization: Public Health Service Act, Subpart II and III, Title XIX, Part B, as amended by Public Health Service Act, Public Law 106-310, 42 U.S.C 300x.,

b. Mental Health Block Grant (MHBG) CFDA Number: 93.958 Authorization: Public Health Service Act, Subpart 1 and III, Title XIX, Part B, as amended by Public Health Service Act, Public Law 106-310, 42 U.S.C 300x.

c. Center for Mental Health Services (CMHS) Uniform Reporting System (URS) The URS data tables and performance measures incorporate indicators such as penetration rates, use of state hospitals, length of stay, employment, homelessness, major funding sources of services, evidence-based services, readmissions to state hospitals, living situations, criminal justice involvement, and school participation/performance.

d. Treatment Episode Data Set (TEDS),
The Treatment Episode Data Set (TEDS) is a national census data system of annual admissions and discharges to substance abuse treatment facilities. In all States, treatment programs receiving any public funds are required to provide the data on both publicly and privately funded clients.

2. Vendor shall provide a plan to develop and/or incorporate a basic enrollment system for individuals obtaining Behavioral Health services for a community based behavioral health center to include the collection of all data elements necessary to meet the data needs of the BBH. The required data elements will be those necessary to create a unique identifier and to comply with all federal reporting requirements. This enrollment data will be subject to annual review and modification to maintain consistency with all applicable federal and state requirements. (See attachment 3)

3. Vendor shall provide a plan to utilize the enrollment data collected to establish a methodology for establishing unique and unduplicated numbers of individuals served.

4. Vendor shall provide a plan to develop and/or incorporate a supplemental consumer service data report set to capture service level data for BBH funded providers. (See attachment 2)
a. This data set should capture the entirety of an organizations service provision to include Medicaid Services (Fee-for-service or Managed Care Organization), Medicare Services, Third Party Payor, Indigent Care or Private Pay.
b. The collection of information for the data may be incorporated into or in addition to service level data collected for Medicaid and Indigent Care.
5. Vendor should provide a plan to stay current with Federal Behavioral Health Reporting changes and to utilize guidance as it is released and to update and modify the data collection system to meet the applicable requirements.
6. Vendor shall provide their plan for developing and/or incorporating standardized data validation measures, which are subject to annual review and modification to maintain consistency with all applicable federal and state requirements. Data validations should be developed for both the structure of the information and the allowed data values. Vendor must discuss their methods for soliciting and reconciling necessary changes from providers to ensure data accuracy.
7. Vendor shall provide their plan for initial training and on-going technical assistance for BBH providers regarding the system to ensure data is accurately being reported, validated, and submitted to the system and to troubleshoot any issues providers experience with reporting data to the system.
8. Vendor must, in conjunction with the BBH and its designees, describe their plan to conduct an ongoing review of the data to resolve data quality and validity issues. This process shall discuss the capability of holding data improvement meetings to address issues, as appropriate.
9. Vendor must provide a plan for the daily submission and transfer of applicable validated data sets to the BBH.

Kepro understands the importance of data collection for the Bureau of Behavioral Health (BBH). Over the last 18 years, we have worked in partnership with the state, and with BBH, to develop technology systems that gather critical data and adhere to reporting requirements established by State and federal guidelines. To continue to effectively meet BBH's goals and data collection needs, we will use our proprietary Care Management system, Atrezzo, and its Provider Portal. Atrezzo is a configurable, flexible, fully integrated, web-based solution that provides the capability to manage the healthcare experience of individuals across a continuum of health care services including utilization review, care management, and assessments.

The following key features of the Atrezzo Provider Portal ensure a streamlined authorization process through automation and ease of use in submitting authorization requests, removing the administrative burden for providers:

- ✓ **Robust Rules Engine –** Providers are required to enter only necessary fields based on service type, minimizing the information required by the provider to request authorization.
- ✓ **Embedded workflows –** Providers are guided through the request process, promoting efficiency and accuracy of the authorization request.
- ✓ **Automated Notifications –** Providers receive real-time notifications such as insufficient information or incomplete submission and authorization and denial decisions and notifications.
- ✓ **Real-time Communication with our Clinical Reviewers –** Providers can communicate directly with clinical reviewers via the Portal, removing the need to contact the call center for questions or status inquiries.

We also bring significant experience working with state MMIS requirements. **We have successfully exchanged data via file transfer and APIs (Application Programming Interface) with states' MMIS systems for over 3 decades**. We have systems in place to exchange files daily with every major MMIS vendor and selected state-managed systems. Our staff bring best practices we have acquired through decades of handling millions of transactions daily. **Figure 92 Atrezzo System Overview** provides a high-level view of the Atrezzo solution key components and functionality.

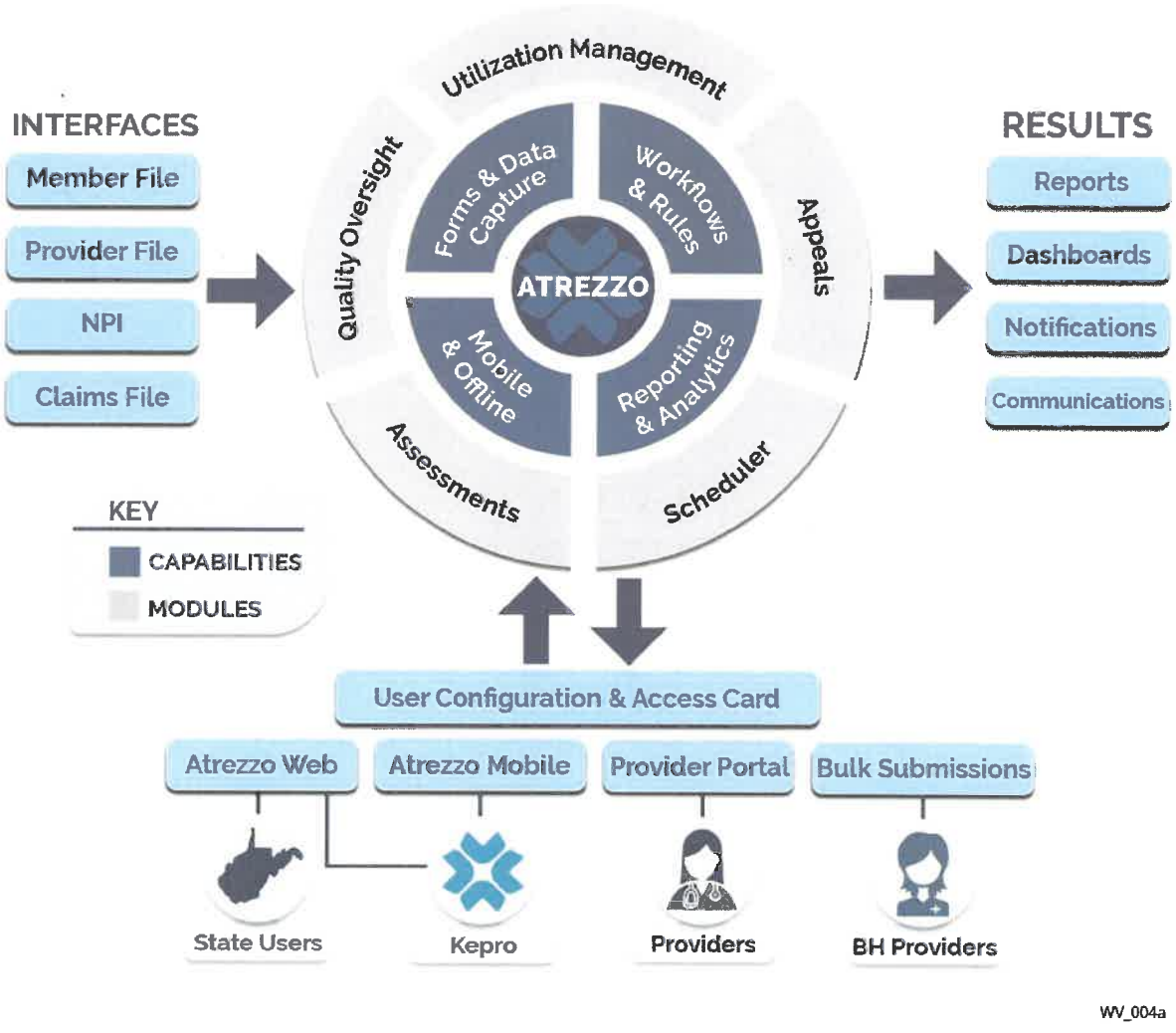

Figure 92. Atrezzo System Overview
The Atrezzo platform is a single, integrated solution for utilization reviews and reporting.

Key Components of the Atrezzo System

Differentiating System Capabilities: Key to the success of our UM and PA Services programs nationally is our Atrezzo system's client-specific configurable workflows and algorithms. These features are driven by Atrezzo's rules-engine, which is composed of customizable Review Forms

that streamline the review process and capture reportable data. Mobile and offline capabilities also enable reviews to be conducted anywhere with automated upload when internet connection is accessible. **Table 25 Atrezzo System Capabilities** describes these capabilities.

Atrezzo Capability	Description
Rules Engine and Workflow	The Atrezzo application is workflow-driven with business rules separate from the application. This results in a significantly shortened implementation period and rapid response to changing contract requirements. Business rules are maintained through an integrated management portal and do not require application development. Our review workflows are embedded in Atrezzo for consistency and reliability of the review processes. Modifications to workflows are easily configurable and can be completed and operational within 24-48 hours of request. Reviewers enter all review interactions and information into Atrezzo, which are easily reportable. • Pseudocode-based rules, easily built and modified by non-developers - low code or no code configuration • Used to define all business logic - completely separated from application code • Access to all inbound eligibility, provider, and request data • Rules manage auto-approvals, workflow, eligibility checks.
Forms and Data Capture	Significant flexibility in report building with drag and drop build of templated questionnaires. • Does not require technical expertise to develop • QBuilder questionnaires are usable in the web version and Mobile Review Application • QBuilder allows any type of question to be created – Text, Yes / No, Single Selection, Multiple Selection, or Numeric, Dates and then to quickly build the associated forms using "Drag and Drop" functionality. • Used for UM related reviews, health risk assessments (HRA), checklists, clinical data collection including problems, goals, and interventions
Mobile and Offline Functions	The Atrezzo Mobile Review Capability provides a secure platform for reviews to be conducted on site, with or without stable internet connection. • Does not require Internet access while conducting on site assessments • Synchronizes data collected when Internet service is available

Table 25. Atrezzo System Capabilities
Key Atrezzo capabilities enable quick and easy configuration changes.

Table 26 Atrezzo Configuration and Access Controls defines user configuration and access controls:

Components of Configuration Access	
Access Control	User registration and authorization in the Atrezzo care management system is an efficient, straightforward process. Access is contract-specific and role-based. Atrezzo requires a unique login ID for every user that accesses the system, and each unique user is assigned specific roles. This role-based system dictates a user's ability to update and/or edit a case or record, upload documents, create new cases, or access

Components of Configuration Access	
	reports. Authorization and creation of Atrezzo accounts is a part of training and completed as part of our implementation process. • To ensure HIPAA compliance, users have access rights to only those programs and files that they are permitted • Access permission, including for WV DHHR staff, is role based and easy to update as user needs change • Any user failing to follow password/access control policies is subject to action that includes removal of all access privileges to our systems
User Configuration	Atrezzo offers flexibility and configurability to meet WV DHHR-specific needs, for both data capture fields and for reporting. The system gives users the capability to produce a wide range of ad hoc management reports in a secure, online environment. • Atrezzo built from the ground up to enable configuration without requiring new development • "Templated" rule configurations in place that can be tailored to specific needs i.e., rules exist, reducing need to create from scratch • WV DHHR can select its chosen data fields to produce a summary of selected indicator findings • Web-based interactive drag and drop reporting through Tableau • Reports can be provided in many formats, including Microsoft Excel as well as PDF and CSV
Access Methods	The Atrezzo system is available via web, mobile and through a provider portal should WV DHHR wish to use the provider portal option. • Atrezzo Provider Portal allows providers to submit and receive information 24-hours, 7 days a week, 365 days a year • Driven by a rules engine that requires the provider to complete only the necessary fields based on the information required for the review

Table 26. Atrezzo Configuration and Access Controls
Atrezzo provides granular role-based access.

Collection and Reporting

We appreciate that the State's single behavioral health authority, BBH, has the responsibility to gather data on the service, enrollment, and diagnostic, which are vital to compliance with the four Federal Funds' reporting requirements. We currently, and will continue to, meet the stated reporting requirements.

Our current reporting requirements to BBH include the collection and transfer of the Consumer Service Data Report, the Military file, and the BBH Data Set (BDS) Report. We can adjust file layouts, add or remove data elements or create entirely new data sets quickly and efficiently.

Basic Enrollment System

We collect data elements from BBH contract providers necessary to create unique identifiers for individuals being served by contract providers. We accomplish this by collecting the enrollment

data presented in RFP Attachment 3, of which there are forty-eight, to meet the Bureau's data needs. We collect this data by working with participating BBH providers to complete the CSDR, Military and Federal Supplemental Data reports. Providers transfer files for each respective report to us via Electronic Data Interchange.

Historically, the reporting requirements of the federal and state governments have at times shifted, making modifications to the data collected necessary from the BBH participating providers on behalf of BBH. As such, the prescribed BBH Enrollment Data Fields may require revision during the annual review process.

Methodology to Establish Unique Individuals Served

We will develop a sound methodology for the identification of the distinct persons for which there was enrollment data submitted by a BBH participating provider. While we will provide the unduplicated counts of individuals reported and receiving service authorization, only the Bureau's fiscal agent can report those served through the compilation of claims paid for services rendered.

We will work with WV DHHR and BBH to determine the most effective rules configuration to minimize the potential for duplication of persons served. Atrezzo offers flexibility and configurability to meet WV DHHR-specific needs, for both data capture fields and for reporting. We can base data validation rules around the data fields outlined in the state-provided Attachment 3. From there, "templated" rule configurations are in place can be furthered tailored to specific needs —rules exist, reducing need to create from scratch.

This ease of configuration in Atrezzo allows for:

- BBH to produce a wide range of ad hoc management reports in a secure, online environment.
- BBH requested program-specific changes without requiring new development.
- BBH to select its chosen data fields to produce a summary of selected indicator findings.
- Web-based interactive drag and drop reporting through Tableau.
- Reports in multiple formats, including Microsoft Excel as well as PDF and CSV.

Supplemental Consumer Service Data

We fully grasp the requirement of the BBH-funded providers to report all services rendered to their clients, regardless of payer source. More specifically, the services provided are not restricted to only those paid by Medicaid, Medicare, other Third-Party Payers, or Private Pay, as there are services outside the traditional behavioral health CPT and HCPCS codes rendered and require reporting to the Bureau.

Staying Current with Federal Behavioral Health Reporting Changes

With the Bureau for Behavioral Health's guidance and approval, we will establish a meaningful plan to remain up to date with Federal Behavioral Health Reporting guidance and reporting

changes. We will share all information that may affect data collection with the Bureau as it is obtained.

At the time of the annual review of the BBH data sets, we will offer recommendations for change to the data sets: Consumer Service Data Report, Enrollment Data Fields, and Data Segment fields that may be freestanding or incorporated into existing system data sets.

With the Comprehensive Behavioral Health Centers submitting nearly all data to us through file transfers, when data sets change need made, it requires centers' modification to both file layouts and in-house information systems now mostly managed by third-party vendors rather than internally. Accordingly, the need adequate time to understand the specifications, gather the requirements, develop, test, and implement new data sets.

Additionally, it may be judicious to require data set modifications as infrequently as is reasonable due to time constraints and expense the BBH contract providers' experience. Regardless of the frequency, allowing a minimum period of six months from announcement to implementation of new data sets would be prudent.

Standardized Data Validation Measures

Through a robust collaborative effort between the Bureau and our team, we will establish a standardized set of data validation rules for the BBH-required data fields, reports, workflows, notifications, and more based on WV DHHR request. This ensures that any modifications required by the state or federal regulations are quickly incorporated, and that our data collection and reporting remain aligned with WV DHHR needs. We will work with WV DHHR to complete a review of data validation rules on an annual basis to determine if any federal or state reporting requirements are cause for rule changes.

We will develop full methodology to identify, advise, then solicit and demand reconciliation of inaccurate data from the Comprehensive Behavioral Health Centers. The enforcement of a defined timeframe for awaiting new data to reconcile faulty data will result in the request closing due to submission of inaccurate data once the time lapsed. The administrative closure of a service request for failing data validation and subsequently not submitting corrected data within timeline is the consequence and likely a motivation to submitting tidy data to obtain prior authorization and ultimately reimbursement for services rendered.

We actively provide education, technical assistance, and communication with providers in efforts to promote use of best practices and obtain better data validation results. Finally, we will work with the Bureau to gain further insight and guidance regarding the means of improving valid data submission from participating entities.

Initial Training and On-going Technical Assistance

We offer 19 years of technical assistance experience to our clients' providers. In these nearly two decades we have noted the importance of prioritizing communication with providers every step of the way as a means of providing program updates and support. We are highly responsive to WV DHHR provider questions and concerns and will continue to provide timely technical assistance to ensure providers successfully coordinate and implement the various aspects of the contract including data sets, specific data validation rules, workflows, and communications. We will meet with Medicaid staff, providers, and associations on a regular basis and upon request. A variety of modalities will be employed to foster continuous communication and engagement, including:

Did You Know?

In West Virginia, Kepro successfully provided one-on-one training to 36 new Behavioral Health providers in FY2022. Topics included provider portal, provider registration, and user management. Sessions were tailored to the type of provider such as Licensed Social Worker or Psychiatrist.

- ✓ Regular emails using provider email listserv
- ✓ Website postings
- ✓ Attending the Data Committee Meetings
- ✓ Virtual and in-person meetings and presentations
- ✓ Phone-based and in person technical support
- ✓ One-on-one communication with those providers

Ongoing Review of Submitted Data

We will facilitate data improvement meetings with the Bureau, the BBH Comprehensive Behavioral Health Centers and/or both. Furthermore, we will develop a data-quality management system that will include the regular examination of submitted data, along with other evaluative measures, which we will employ in its effort to enhance the quality and validity of provider submitted BBH data. Along with BBH we will review submitted data to address quality and validity concerns. With the common goal of securing accurate, meaningful BBH data, with Kepro and the Bureau's support and assistance, the Comprehensive Behavioral Health Centers will clearly understand the criticality of, the reason(s) for, the definitions of, and the dependencies on valid data submission.

Daily Validated Data Sets

We will continue the transfer of data to the BBH, while adhering to the data set validation the Bureau prescribes. Atrezzo is configured to create daily authorization files to be placed on the appropriate secure FTP site for their use as well as the authorization information being available in the application to providers. We accept daily referrals and roll back files when necessary and as new requirements are developed at specified times agreed upon with BBH. Atrezzo is also equipped to handle all data exchange requirements outlined; we conduct thousands of data exchanges every day, using secure FTP sites to post and retrieve data records for utilization and quality review. We manage over 420 unique daily, weekly, and monthly file transaction processes

that account for over 2,500 daily job executions that involve data exchanges between Kepro and our clients.

A3.1.b. Satisfaction Surveys

To ensure the BBH is providing services that are high-quality and person- centered, the BBH administers several consumer satisfaction surveys that are completed by consumers receiving behavioral health services within the state. Currently, three (3) nationally recognized surveys are being used: the Mental Health Statistics Improvement Program Consumer Survey (MHSIP}, the Youth Services Survey (YSS}, and the Youth Services Survey for Families (YSS-F}. Vendor should describe their plan to implement, administer, and report results from consumer satisfaction surveys for all behavioral health services within the state. This plan should address the following items:
l. Vendor's methodology to administer the three (3} consumer surveys mentioned above. This methodology should include Vendor's plan for sampling a representative group of consumers, disseminating the survey, achieving acceptable response rates, and validating and cleaning survey response results. This methodology will be subject to annual review and modification to maintain consistency with any applicable federal and state requirements, as well as common survey research methods and practices.
2. Vendor's plan to use survey results to meet the needs of BBH in preparation of the Community Mental Health Services Block Grant. Vendor must stay current with any and all federal reporting changes in relation to the above- mentioned reports and have the capability to incorporate changes into the existing system

On behalf of the Bureau for Behavioral Health (BBH), we conducted the Youth Services Survey (YSS) and the Youth Services Survey of Families (YSS-F) over our past contract periods. Each survey year, we used the Bureau's prescribed YSS and the YSS-Family surveys and in 2018 the Adult Satisfaction Survey was implemented using the Mental Health Statistics Improvement Program Consumer Survey (MHSIP).

For future consumer satisfaction surveys, we will obtain the Bureau's approval of the final survey methodology. We understand and will comply with providing a representative sample of the State's behavioral health consumers. We will also conduct and make the surveys available to participants by means of hardcopy mailing, direct emailing, telephonically, and electronically using Survey Monkey or a similar product.

Additionally, we will conduct face-to-face surveying on a convenience-sampling basis such as prior to a focus group of persons with behavioral health disorder, consumer educational session by our staff and at the time of a member's assessment. Lastly, we have commonly recruited BH Providers to survey their clients. We will maintain the segregation of these convenience sampled surveys from the representative sample surveys.

Our team will compile the three surveys' results as required to meet the Bureau's consumer satisfaction reporting needs. When received, a review of each hard copy survey for the identification of indecipherable responses, (e.g., the circled response is between two responses, thus the reviewer cannot determine which response was intended) or disallowed responses to survey items (writing in a response of 4.5 when the allowed responses are 1, 2, 3, 4, or 5). When found, we exclude these specific item responses and include other elements if possible. One staff member then keys the survey responses, using a primary key both in the database and on the hardcopy, followed by a different staff member who conducts a quality check to ensure the

hardcopy survey responses match the keyed responses, correcting any identified errors. We then compile the survey results in the required manner to complete the data requested in the Summary Profile of Client Evaluation of Care of the Block Grant Report, which includes:

- Client perception of Care:
  - Access
  - Participation in Treatment
  - Cultural Sensitivity
  - Satisfaction
  - Outcomes
- Additional information contained in the report includes:
  - Percentage of Consumers linked to physical health services.
  - Percentage of Children in family-like arrangements
  - Percentage of Children in residential care

We will prepare an additional summary of the YSS-F Results of Social Connectedness, Arrests, School Attendance/Absences, and Suspensions/Expulsions as requested by the Bureau.

Support BBH Preparation of the Community Mental Health Services Block Grant

As we have successfully done in past survey years for BBH, we will implement a strategy that ensures survey results are used to meet BBH needs, including preparation of the Community Mental Health Services Block Grant. A portion of our strategy will involve remaining abreast of and incorporating any and all federal reporting changes in relation to the above-mentioned reports and incorporate changes into the existing system.

We will compile the three surveys' results as needed to meet the Bureau's consumer satisfaction reporting required of the Community Mental Health Services Block Grant and in accordance with federal reporting changes in relation to consumer satisfaction surveying. Any identified changes be incorporated into the existing surveying model. We will deliver these reports to the Bureau on or before September 30 of each survey year.

Appendix 4: Implementation Specifications

The following specifications have been determined by the Agency for the Implementation Phase of this project. The Agency is to consider responses to this RFP that propose modifications to the following specifications. Modifications should be clearly stated in the Vendor's proposal.

A4.1. Implementation Work Plan

The Vendor's proposal should include a draft Implementation Work Plan to be maintained throughout the implementation period that includes all tasks required to successfully begin operation of the Utilization Management/Prior Authorization Program. The Work Plan should be sufficiently detailed to satisfy the Agency that the work should be performed in a logical sequence, in a timely manner, and with an efficient use of resources. The Vendor should submit the final implementation Work Plan electronically and in hard copy to the Agency no later than fourteen (14) calendar days after the date of contract award.

Kepro presents our draft **Implementation Work Plan and Gantt Chart in Attachment 4**. As the incumbent contractor, we offer the Agency several advantages as it relates to implementation and seamless continuity of service delivery. The following section describes how the nature of our current contract and relationship with the State provide unique advantages for implementation. We also provide information on our management and communication approach that will be used to support implementation and continuation of services following award.

Did You Know?

Kepro's experienced implementation team has a 100% on-time implementation track record, including 13 implementations during COVID-19.

On day one after contract award we will have:

- ✓ Existing Charleston, WV office; lease and critical infrastructure in place
- ✓ 100% of key personnel in place, residing in West Virginia
- ✓ 146 staff in-place and residing in West Virginia
- ✓ West Virginia-native, DHHR-experienced Transition Lead in place
- ✓ Procedure manuals drafted, new requirements identified, ready to submit for approval
- ✓ Data exchange with third party vendors and legacy systems in place
- ✓ Existing network of providers already registered and trained
- ✓ Correspondence templates drafted/pre-approved ready to submit for approval
- ✓ Quality and performance monitoring system (SLA measurements) in place

Kepro's Work with West Virginia

As the incumbent and long-time partner to West Virginia, Kepro represents the lowest-risk implementation compared to our competitors. We bring more than 22 years of West Virginia program-specific experience—our familiarity with the WV programs provides a seamless and efficient onboarding of existing and new scopes of work. Additionally, we bring unmatched knowledge of all the required programs and related processes, policies, and expectations to continue delivery of these services without interruption. Based upon our analysis of the scope requirements, Kepro will only need to hire positions to support enhanced services such as

additional case management, dental, and those services confirmed in response to vendor questions 12-14 in Amendment 2. No other vendor can claim to have the same level of immediately available staffing with the training and experience necessary to meet the requirements of this program. **Figure 93** highlights our implementation readiness on Day 1 after contract award.

IMPLEMENTATION READINESS

IMPLEMENTATION ELEMENT	DAY 1 READINESS	FEATURES & BENEFITS TO THE STATE
ADMINISTRATION	75%	• Implementation Lead in place today • Implementation team will include current WV-based and experienced key staff • Implementation tasks will begin on day 1 post contract award - will include clear, concise communications throughout transition to the new contract
FACILITY	100%	• Existing facility and infrastructure in place today • Established office: 1007 Bullitt Street in Charleston in place today, office site for 146 existing program staff • Facility less than 1 mile from the Department - facilitates in-person transition activities
RECRUITMENT & STAFFING	95%	• 146 staff in place today • 100% of key staff in place today • Transition to new contract will be carried out by Kepro's experienced WV staff
TRAINING	90%	• Current staff only need "refresher" training • Incoming staff training will be provided by Kepro's experienced WV staff
QUALITY ASSURANCE PLAN	75%	• Existing Quality Assurance Plans will be consolidated into a single volume • Leverage current QA Plans
OPERATIONS MANUALS	90%	• Operations manuals in Agency-preferred format in place today • Required modification and additions have been identified – shortening review/approval time for Agency
PROVIDER MANUAL	75%	• Provider manual will be updated to include new scope, programs, and systems • Leverage current in place manual in Agency-approved format as starting point
HEALTH ANALYTICS: REPORTING	95%	• Provider manual will be updated to include new scope, programs, and systems • Leverage current in place manual in Agency-approved format as starting point
HEALTH ANALYTICS: LETTERS	100%	• Program correspondence in place today • Members and providers will have seamless transition to new contract
INFORMATION TECHNOLOGY	90%	• Atrezzo Care Management system in place today • Implementation includes time for configuring, testing and deploying system updates
STAKEHOLDER ENGAGEMENT	100%	• Provider and third party systems in place today • Continuity of services as WV providers, members, advocacy groups, and associations are accustomed to our processes, forms, and communications
CUSTOMER SUPPORT	100%	• Our toll-free numbers, e-fax lines, mail processing and public website already in place today • Zero disruption for providers and members requesting/accessing services
BUSINESS CONTINUITY	100%	• Disaster Recovery Plan in place today • Plan proven successful during COVID will remain in place

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Figure 93. Day 1 Implementation Readiness
On the first day of the new contract, we will be ready to begin a seamless transition.

Transition Team

Kepro's transition team provides West Virginia experienced personnel leading all aspects of transition to the new contract and a direct line to corporate resources and support if needed.

Transition Lead Lori McGurty MS, PMP. Lori, a native West Virginian supported the WV contract for 13 years and is approaching 19 years as a Kepro employee. She brings a wealth of West Virginia-specific knowledge around the Long-term Care programs, as she was the Director of those programs from 2011 through 2017. Lori's career with the company started in 2004 as the Family Support Educator for the (then-titled) Socially Necessary Services Program. Lori then went on to hold various roles within the IDD Waiver program: Service Support Facilitator (2005-2006), Provider Educator (2006-2010), Lead Provider Educator (2010-2011), and Director of Long-Term Care (2011-2017).

Even without her WV DHHR contract experience Lori would be the right person for this important job. She is an implementation expert – serving as Kepro's Director of Implementations since 2017. She has successfully supported all large-scale implementations since then including:

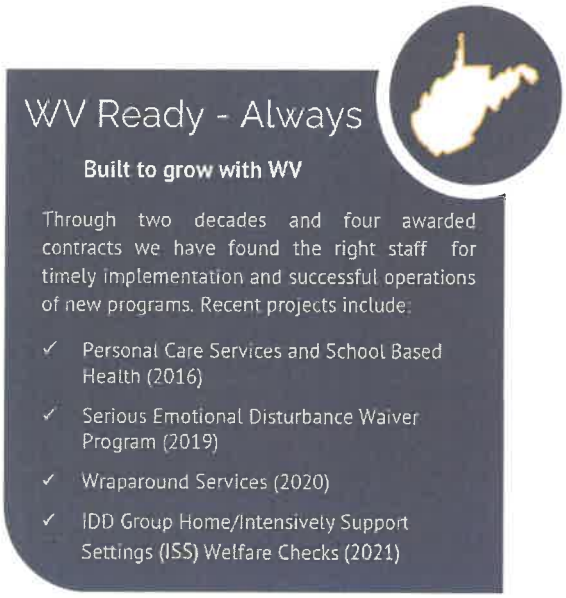
- Tennessee Application Processing Center
- North Carolina Comprehensive Independent Assessment Agency (contract protested)
- California Pre-admission Screening and Resident Review (PASRR)
- North Carolina COVID
- Nebraska PASRR
- Pennsylvania Specialized Services and Nursing Home Transition
- CAlMHSA – concurrent reviews and PA for inpatient psychiatrically hospital services
- Colorado Substance Use Disorder
- Mississippi State Employees' Life and Health Insurance Program
- NY Early Intervention Program Quality Monitoring
- Mississippi Qualified Residential Treatment

Additionally, Lori has supported multiple vital West Virginia system migrations and stand-ups, specifically WV TBI Waiver in Atrezzo, WV PASRR, and the WV Medical program system migration.

During transition Lori will be supported by experienced corporate resources along with West Virginia Executive Director Nancy Sullivan and our five, in place West Virginia Project Managers to ensure a seamless transition to the new contract. Our implementation team includes:

- **Director, IT Implementation Services Wayne Bolton** has been working with our state clients to implement new programs since 2001. He is known to WV DHHR from his work most recently on the Atrezzo migration. Wayne will provide strategic leadership to all aspects of system development for the UM and PA Services contract throughout the life of the contract.

- **Sr. Director, Application Services Lisa Dormann** leads the building of interfaces, modifies the system for new programs, and conducts tests and readiness reviews. Following her role in implementation, she will oversee ongoing maintenance and support of Atrezzo to address issues related to the interfaces between the States's system and other vendor systems.
- **Executive Director, Nancy Sullivan** will provide daily support to each Project Manager in her role including directing the implementation and management of all deliverables for the various programs while overseeing our WV team of more than 140 current and 26 proposed new personnel statewide as well as managing stakeholder relationships and support during transition to the new contract.



- **Project Manager, Long Term Care Services Melody Cottrell** will provide operational oversight to make sure that during transition all contract deliverables are met or exceeded for WV DHHR's Nursing Facility Program, Personal Care Program, and Aged and Disabled Waiver Program. Melody will also lead the efforts to update to our Provider Manual and program reports.
- **Project Manager, Medical, IDD, and Behavioral Health Services Emily Proctor** will lead our clinical staff that support for utilization management and case management functions. During transition she will maintain and enhance relationships with key WV DHHR stakeholders (contract managers, physicians, and corporate staff). She will also oversee implementation and ongoing management of submission platforms for Medical, SUD, IDD, and Behavioral Health services. She will ensure that updates to our Provider Manual, BMS Operations Procedure Manual, and associated BMS reports are completed efficiently and with DHHR approval.
- **Project Manager, Administrative Services Amber Murphy** will manage transition of administrative processes and service center functions including UR certification and necessary upgrades to our main office and infrastructure, call center, and associated infrastructure.
- **Project Manager, Information Technology Rebecca (Becky) Jamnick** will coordinate and oversee the activities and deliverables for the Bureau of Behavioral Health (BBH) and the Contract data and reporting requirements. She will ensure that updates to our BBH Operations Procedure Manual and associated reports are completed efficiently and with DHHR approval.
- **Project Manager, HH, CSED, QRTP, and TBI Waiver Services Caroline Duckworth** will oversee contract performance and quality assurance in deliverables for the following programs: Health Homes, Traumatic Brain Injury Home and Community Based Waiver, Tiered Foster Care, BSS funded Residential Utilization Management and Review, Children with Serious Emotional Disorder Waiver, Children's Wraparound and Residential Level of Care Assessments. She will

ensure that updates to our BSS Operations Procedure Manual, all associated BSS reports, and our Provider Manual are completed efficiently and with DHHR approval.

Benefits of Choosing Kepro

Kepro defines clear processes, controls and responsibilities that lead to a successful implementation and ongoing operations. We proactively identify potential contract risks and develop mitigation strategies to minimize or eliminate any negative impact. There are four key benefits of using an incumbent vendor, as detailed below:

1. **Dramatically Reduced Implementation Effort**. When partnering with Kepro, the infrastructure is in place, so you so you can spend less time, energy, and resources developing processes and procedures. Our existing methods save you that effort on the front end, so that we can partner and focus on tailoring our services to meet your program's next chapter. A new vendor would be faced with building and deploying a new IT system to accommodate the work, as well as navigating file transfers and integrating with the MMIS. These are challenging undertakings that must be completed within a tight timeframe. With Kepro as your vendor, we would be able to bypass these steps and instead focus that time on other parts of the implementation.

2. **West Virginia Service Experience**. Our staff are experienced in the existing West Virginia program infrastructure and the collaboration with the Agency that we took to define and implement the current processes. We have a thorough understanding of what works and where the road bumps were along the way, and we can best serve you with this knowledge in mind. Additionally, as all staff for the exception of new additions would remain in place, your experience would not be adversely affected—rather, it would be further enhanced by the new staff and the experience that they bring.

3. **Existing and Solid Relationships with WV DHHR, Co-Vendors, Providers, Advocacy Groups, other Stakeholders**. At Kepro, our familiarity extends beyond our relationship with the West Virginia program staff, encompassing other stakeholder groups. In this way, we have been a trusted partner for more than 22 years, and we are committed to extending and preserving that relationship. Where staffing and provider networks may be hard for a new vendor to establish throughout the state, Kepro has these networks already in place so that West Virginia members experience no delay or gap in service.

4. **Reduced Risk**. Since our dedicated Kepro staff are experienced in delivering the work for the West Virginia program, we understand the ins and outs of the work. Our staff have worked for more than 22 years to meet the expectations and scope of the West Virginia contract, and this enables us to align with your expectations moving forward better than an outsider could. Potential risks of choosing a new vendor include implementing within the timeframe, finding an adequate working space in the specified location, interruption of service to members, and time needed for discovery, to name a few. As discussed throughout this section, choosing Kepro as your vendor would mitigate these, and potentially other, risks.

It is through these benefits that we can meet and exceed expectations through anticipating what needs, issues, and goals may arise. Our experience serves as the groundwork for the next chapter of our partnership, and we can help build that next chapter on day 1 without any delay that new vendors may require to familiarize themselves with the contract. In this way, our incumbent status serves as a significant value add.

A4.1 A. Work Plan Tasks

The Work Plan and schedule should include a detailed work plan broken down by tasks and subtasks and a schedule for the performance of each task included in each phase of the contract. The schedule should allow fifteen (15) working days for the Agency approval of each submission or re-submission of each individual deliverable. The work plan to be proposed should include all responsibilities, milestones, and deliverables outlined previously in this RFP. This section should cover:

1. Any assumptions or constraints identified by the Vendor, both in developing the work plan and in completing the work plan.
2. Weeks of effort for each task or subtask, showing the Vendor's personnel and the Agency personnel efforts separately.
3. A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.
4. A Gantt chart, showing the planned start and end dates of all tasks and subtasks.
5. A discussion of how the work plan provides for handling of potential and actual problems.
6. A schedule for all deliverables, including a minimum of fifteen (15) days review time by the Agency.

Attachment 4 Implementation Work Plan and Gantt Chart details tasks and subtasks and provides a schedule for the performance of each task included in each phase of the contract. Kepro schedules 15 working days for the Agency approval of each submission or re-submission of each individual deliverable, and the proposed work plan will include all tasks, sub-tasks, people responsible for tasks, milestones, and deliverables outlined in this RFP. This section will cover all RFP provisions outlined in RFP Appendix 4, Items 1 through 6. We will review this schedule with the Agency upon contract award and will submit the final Implementation Work Plan electronically and in hardcopy no later than 14 days after contract award.

A4.1.A 1. ASSUMPTIONS AND CONSTRAINS

1. Any assumptions or constraints identified by the Vendor, both in developing the work plan and in completing the work plan.

In developing the Work Plan for the West Virginia programs, we identify the following assumptions and constraints:

- Kepro and the Agency will adhere to the 15-day review timeline per review cycle.
- The Agency will offer resources (people) capable of serving as subject matter experts with authority to make prompt decisions applicable to each department and scope of work.
- A project kick-off to level-set on project management, status reporting, and communication planning can occur as soon as possible after contract award.

- Our proprietary system, Atrezzo Care Management, will be used to manage the scopes of work, specifically those related to prior authorization, case management, and eligibility workflows for Waivers, personal care, and nursing home.
- Since providers, members, associations, advocacy groups, and associates are already familiar with Kepro's existing systems and processes, we did not include additional activities related to specific training and education of these groups. With "business as usual," we recommend utilizing existing platforms, such as provider meetings, association meetings website updates to notify stakeholders of our continued work with the WV contract.
- Kepro's corporate Business Continuity/Disaster Recovery Plan (**Attachment 5**) will meet the deliverable expectation (understanding there may need to be a WV-specific addendum).

A4.1.A 2. WEEKS OF EFFORT FOR EACH TASK OR SUBTASK

2. Weeks of effort for each task or subtask, showing the Vendor's personnel and the Agency personnel efforts separately.

Attachment 4 Implementation Work Plan and Gantt Chart includes the level of effort for each task or subtask. It shows our personnel and Agency personnel efforts separately.

A4.1.A 3. NETWORK DIAGRAM WITH PLANNED START AND END DATES FOR ALL TASKS AND SUBTASKS

3. A network diagram, showing the planned start and end dates for all tasks and subtasks, indicating the interrelationships of all tasks and subtasks, and identifying the critical path.

Figure 94 is our West Virginia critical path network diagram. In addition to the critical path diagram — all tasks with planned start and end dates are included in **Attachment 4 Implementation Work Plan and Gantt Chart**.

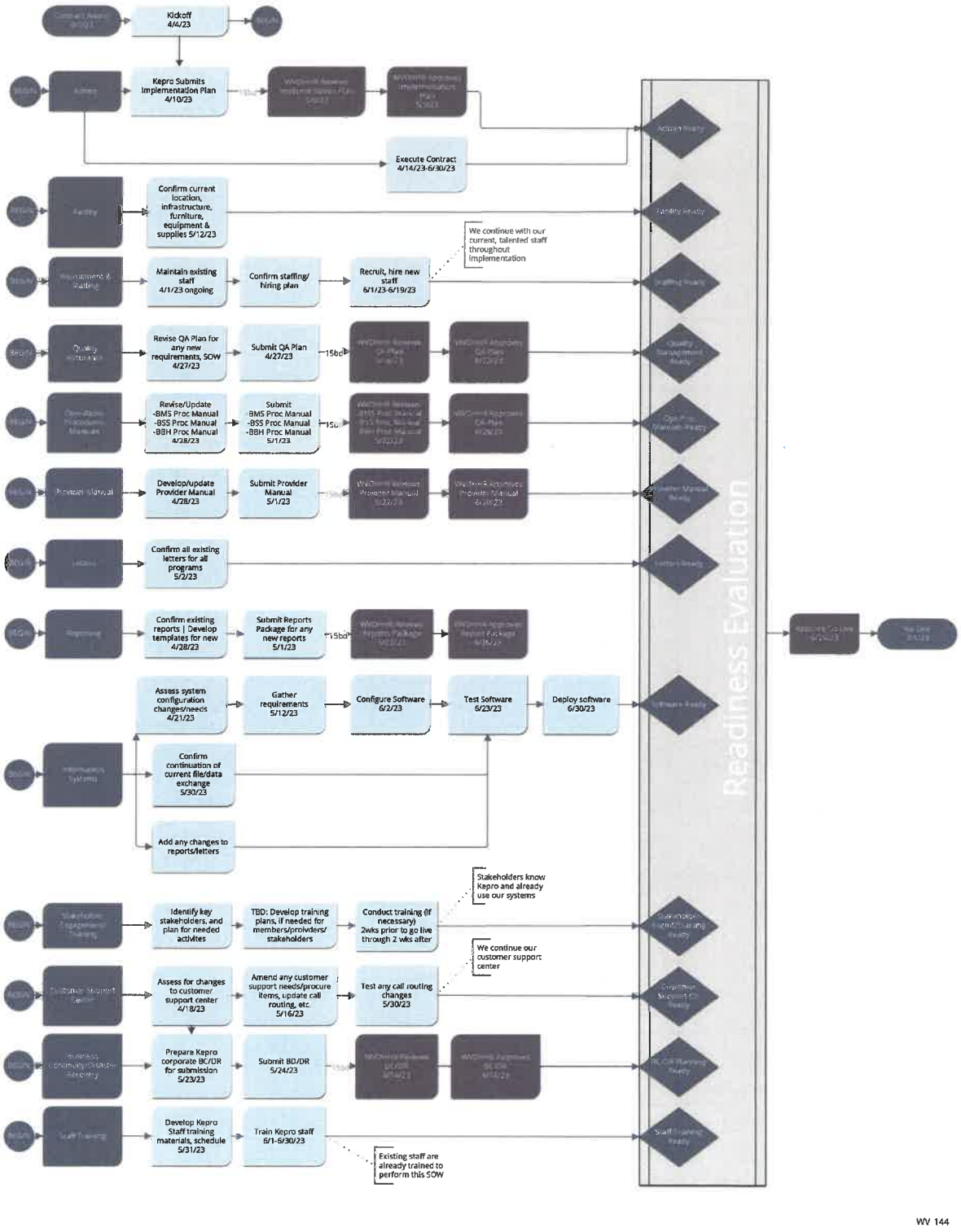


Figure 94. Critical Path Diagram

Kepro's Critical Path Diagram accounts for all key implementation events

A4.1.A 4. GANTT CHART SHOWING THE PLANNED START AND END DATES OF ALL TASKS AND SUBTASKS

4. A Gantt chart, showing the planned start and end dates of all tasks and subtasks.

Attachment 4 Implementation Work Plan and Gantt Chart shows our planned start and end dates for each task and subtask.

A4.1.A 5. HOW THE WORK PLAN PROVIDES HANDLING FOR ALL POTENTIAL AND ACTUAL PROBLEMS

5. A discussion of how the work plan provides for handling of potential and actual problems.

Early identification of potential and actual problems during implementation are vital to program success. Our Work Plan includes a defined critical path analysis (**Figure 94 Critical Path Diagram**), an organized project plan, and a detailed communications plan with defined escalation procedures and direct reach back to corporate resources. Most importantly, every single line item in **Attachment 4 Implementation Work Plan and Gantt Chart** will be led, executed, and reviewed by a member of our West Virginia team.

A4.1.A 6. ALL DELIVERABLES INCLUDING A MINIMUM OF 15 DAYS REVIEW TIME BY THE AGENCY

6. A schedule for all deliverables, including a minimum of fifteen (15) days review time by the Agency

Figure 95 Schedule for All Deliverables identifies 15 days of Agency review time in orange. All deliverables are also marked in green in **Attachment 4 Implementation Work Plan and Gantt Chart.**

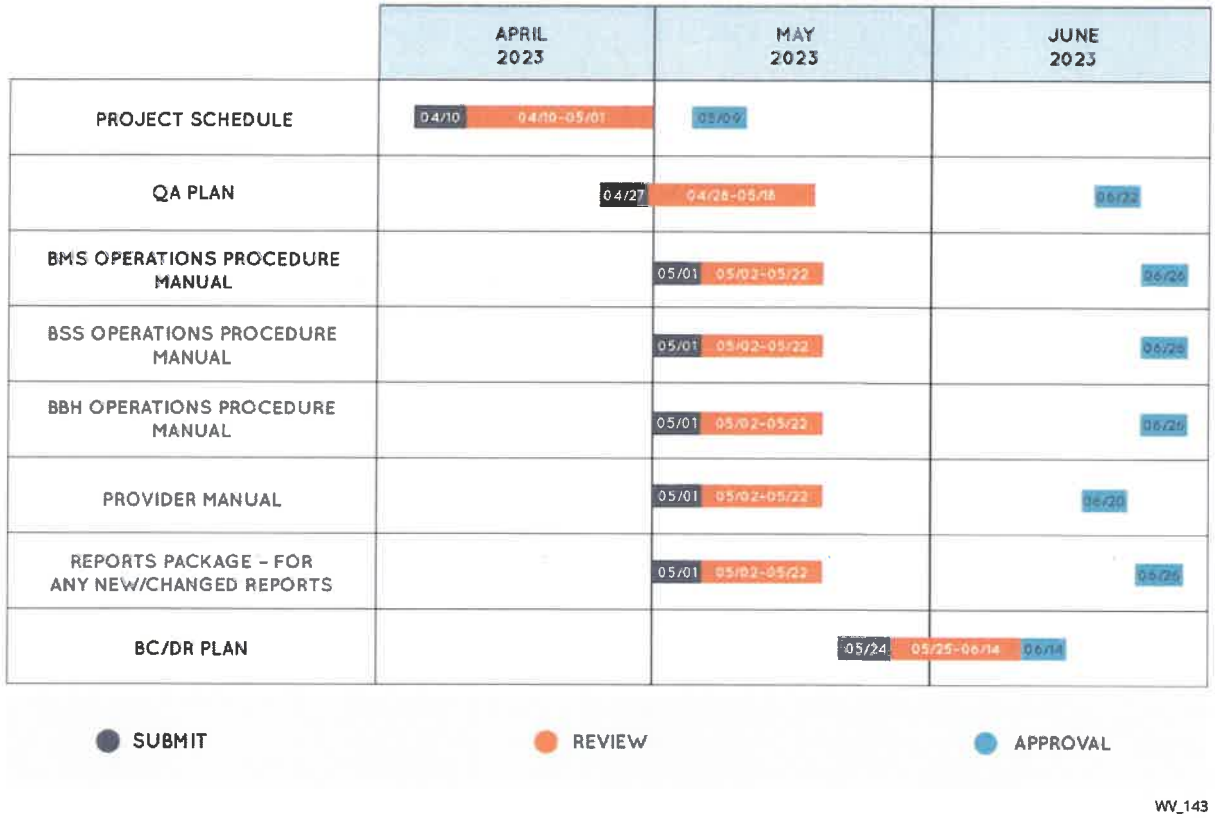


Figure 95. Schedule for all Deliverables

We account for Agency review and revision of all deliverables – with time for follow up reviews if requested.

A4.1 B. Work Plan Schedule for three (3) month implementation

The Work Plan should include task-level detail, including timeframes, milestones and names of Vendor staff members who may be responsible for each task. Each task listed in the Implementation Work Plan should include a description of the activity, a scheduled start date and a scheduled completion date. The types of tasks to be described in the Implementation Work Plan should include, but not be limited to, the following:

1. Testing of daily operational requirements, including, but not limited to, in-house Call Center, to ensure that all components are functioning adequately prior to the Agency's Readiness Review;
2. Member and provider education; and
3. Development of required deliverables, including reports, Operations Procedure Manual, Provider Manual, eligibility file requirement, utilization data submission procedures, Quality Assurance Plan (as described in this appendix), and Business Continuity and Disaster Recovery Plan (as described in this Appendix).

Attachment 4 Implementation Work Plan and Gantt Chart defines the tasks, subtasks, milestones. and deliverables required to achieve a 3-month implementation and successfully fulfill the requirements within the scope of work. Most tasks within our work plan are "confirm" tasks, rather than "develop" tasks. As the incumbent and current operators, we will refresh our policies, procedures, and other workstreams with effort toward quality improvement. **Table 27 Implementation Readiness** highlights our Day 1 implementation preparedness.

Implementation Task/Readiness	Description of Current Status and Transition Requirements
Administration 	After notice of award, we will immediately reach out to understand WV's priorities and get a kickoff meeting scheduled at the direction of DHHR. During this meeting, we will confirm the scope, review a timeline overview, project risks, key project stakeholders, key success factors, a communication plan, and next steps. We submit our project schedule via an electronic and hard copy within fourteen calendar days of award. Our schedule for implementation of these requirements is included in **Attachment 4 rows 10-56.**
Facility 	Our existing facility at 1007 Bullitt Street will continue to meet expectations; therefore, we include some tasks regarding a brief assessment for any new needs (IT, infrastructure, furniture, equipment, or supplies) and procurement of any new items. Our facility is already fully operational. Our schedule for implementation of these requirements is included in **Attachment 4 rows 57-65.**
Recruitment and Staffing 	WV DHHR is already familiar with and has worked with our key staff for decades. These individuals will continue to serve the UM and PA Services contract and provide leadership decision-making and escalation during the project implementation. We have identified a few areas where additional staff could support our continuous quality improvement efforts. New clinical and customer support staff will come on board two weeks prior to go live. Since we are already performing the work with our existing staff, future enhancements will be uniquely positioned for success by learning from existing leaders and shadowing seasoned staff. Our schedule for implementation of these requirements is included in **Attachment 4 rows 66-77.**
QA -Plan 	As our schedule depicts, we will revise our existing quality assurance plans into a new/refreshed consolidated Quality Assurance Plan. Our schedule for implementation of these requirements is included in **Attachment 4 rows 78-85.**
Operations Manuals 	As your current operators of this scope work, we will take this opportunity to refresh our current policies and procedure manuals for all programs, including all within the Bureau for Medical Services, Bureau for Social Services, and Bureau for Behavioral Health. Our schedule outlines each program/task/operation within the RFP as either a "confirm" or "update" task to depict where we need only to refresh our policy vs. update a policy with new information or develop a policy specific to a new item. Because these policy manuals will be so large (especially Bureau for Medical Services), we accommodate two fifteen-day review cycles for the Agency staff. We anticipate having all policy manuals fully approved prior to go-live. Our schedule for implementation of these requirements is included in **Attachment 4 rows 86-227.**
Provider Manual 	We will update our Provider Manual into a consolidated all-scope Provider Manual. Our schedule for implementation of these requirements is included in **Attachment 4 rows 228-235.**

Implementation Task/Readiness	Description of Current Status and Transition Requirements
Health Analytics 	Our Health Analytics team performs work for reporting. As this contract includes a large number of reports (which we are already supplying per the defined cadence), our team leads will work the first month of the project with their Agency counterparts to confirm existing report templates, cadences, and content. Our schedule for implementation of these requirements is included in **Attachment 4 rows 236-327.**
Information Technology 	We will utilize our Atrezzo Care Management system to perform and track utilization management, prior authorization, and assessment work. Our operations leaders will conduct brief assessments for each program to confirm and/or identify any new system needs. We already anticipate some small Atrezzo configuration requirements; therefore, we have built in time for gathering requirements, configuring, testing, and deploying the system changes. Additionally, this scope includes several existing file/data exchanges with the MMIS, with the Bureau for Behavioral Health and with the Behavioral Health Providers. We include confirmation of these files/exchanges in the schedule, though, do not anticipate any substantive change to our current processes. Our schedule for implementation of these requirements is included in **Attachment 4 rows 328-370.**
Stakeholder Engagement 	Improper stakeholder engagement, notices and communications can lead a project straight for disaster. We include tasks to go through the exercise of confirming/identifying all stakeholders that may be impacted by a new contract for this scope of work. We will work with the Agency to identify and confirm stakeholder engagement activities, including any necessary member and provider training and education, notices, website updates. Of note, because providers are already utilizing our technology/systems we did not include specific Provider Training activities in this schedule. Additionally, WV providers, members, advocacy groups, and associations are already accustomed to our processes, forms, and communications. Should the need arise through our stakeholder analysis, we will work with the Agency to adjust the schedule and include any necessary training, education and notification activities. Our schedule for implementation of these requirements is included in **Attachment 4 rows 371-376.**
Customer Support 	Our WV customer support team has been successfully operating since 2000. As your continued vendor, we offer a seamless transition to a new contract. Providers, members, callers already know about and utilize our customer support center daily. We will confirm continued use of our toll-free numbers, e-fax lines, mail processing and public website. We include time to make any needed system updates for new Genesys configurations changes, such as agent call routing, workflows, voicemail scripting or user profiles. Our schedule for implementation of these requirements is included in **Attachment 4 rows 377-398.**

Implementation Task/Readiness	Description of Current Status and Transition Requirements
Disaster Recovery 	We will continue to utilize and submit our Business Continuity/Disaster Recovery plan to support WV operations. We have seen this plan come into action as we continued to meet deliverables during a pandemic when businesses were shut down and employees were sent home. Our schedule for implementation of these requirements is included in **Attachment 4 rows 399-403.**
Staff Training 	Our existing staff will be "refreshed" on our updated/confirmed policies and procedures, per program. Our new staff will be onboarded and participate in systems, operations, and policy training. Our schedule for implementation of these requirements is included in **Attachment 4 rows 404-408.**

Table 27. Implementation Readiness
Our operational readiness provides the lowest-risk transition to the new contract.

A4.1 C. Quality Assurance Plan

At least thirty (30) calendar days prior to the Operations Start Date, the Vendor should submit a final Quality Assurance Plan to the Agency for its review and approval. The Quality Assurance Plan should include at least the following:
1. The Vendor's procedures for certification that all services are properly authorized.
2. The Vendor's plan to develop safeguards against fraud or abuse by providers, members and Vendor staff and fulfill the Agency reporting requirements regarding such activity;
3. The Vendor's agreement to indemnify the Agency against any causes of actions or claims of payment brought by providers or members;
4. The Vendor's plan to ensure that providers meet standards for qualifications and training; complaint resolution; and other requirements specified by the Agency.
The Vendor should not begin operations without the Agency-approved Quality Assurance Plan. The Agency reserves the right to make quality assurance reviews on services provided by the Vendor under the contract anonymously and without advance notice.

Kepro will submit our final Quality Assurance Plan at least 30 calendar days prior to the Operational Start Date in full compliance with all requirements of Appendix 4. As the incumbent contractor Kepro will review and update our existing Quality Assurance plan as highlighted in **Table 27 Implementation Readiness** and detailed in **Attachment 4 Implementation Work Plan and Gantt Chart, rows 78-85.**

A4.1 D. Operational Readiness Review

Approximately two (2) weeks prior to the Operations Start Date, the Vendor should expect that the Agency may conduct an operational readiness review of the Vendor, after which the Agency may approve the Vendor for implementation. The Vendor is to receive written Agency approval of all submission and demonstration requirements prior to the Operations Start Date.

We welcome the opportunity to conduct a Readiness Review approximately two weeks prior to the Operational Start Date. Our location at 1007 Bullitt Street makes it possible for the Agency to

conduct this review at its convenience. The majority of the scope of work is currently in Operational Status (**Table 27 Implementation Readiness**) allowing us to focus on vital new tasks.

A4.1 E. Remediation & Start-Up

The Vendor should have an opportunity to make corrections (if necessary, as determined by the Agency) prior to Operations Start Date and may be required, upon request of the Agency, to submit documentation to the Agency that corrections have been made. Two
(2) weeks prior to the scheduled Operations Start Date, the Vendor is to begin taking calls for requests for services that are scheduled to be provided on or after the scheduled Operation Start Date.

The most significant benefit to continued contracting with Kepro is our readiness to transition to the next contract period seamlessly – eliminating the risk to individuals who depend on Medicaid and State-funded services for safe and healthy community tenure. This benefit relates in particular to our ability to accept calls for services requested for delivery on or after the scheduled Operation Start Date. The current experienced management team has responsibility for these new services and plans for their development and implementation on a timely basis.

A4.1 F. Business Continuity and Disaster Recovery Plan

The Vendor's proposal should include a Business Continuity and Disaster Recovery Plan that details the steps the Vendor should take to enable the Vendor to continue to meet all requirements of the contract in the event of a failure of the Agency's or the Vendor's data, communication, or technical support systems, or in the event of a public health emergency. The plan should include a process for back-up of the Vendor's data systems, phones, and electronic media records in an appropriate location that is protected against fire, theft, or disaster. The Vendor should ensure that its back-up system minimizes the potential for loss of data.

At least thirty (30) calendar days prior to the Operations Start Date, the Vendor should submit a final Business Continuity and Disaster Recovery Plan to the Agency for review and approval. The Vendor should not begin operations without the Agency approved Business Continuity and Disaster Recovery Plan. The Vendor should review and update the Business Continuity Plan and Disaster Recovery Plan at least annually.

Kepro's Business Continuity and Disaster Recovery Plan (BCDR) is designed to prepare for and address the elements necessary to ensure continuity of service to critical business systems and safeguard State data during any emergency. The principles of our BCDR are based on guidance from the National Institute of Standards and Technology (NIST) Contingency Planning Guide for Federal Information Systems, Special Publication 800-34 Rev 1. Please find a copy of the Plan included as **Attachment 5**. Our primary data center is hosted by vXchnge, located at 8025 N Interstate Hwy 35, Austin, TX 78753, with continuous automated backup to Microsoft Azure Site Recovery, West Des Moines, IA, USA. vXchnge is an SSAE 18 Type II, SOC 2 Type II, PCI DSS 3.2, and HIPAA standards with ISO 27001:2013 compliant data center. Redundancy for Atrezzo is built into the hardware platform in the following places: firewalls; core switching; network runs; hypervisor hosts; SQL DB Hosts; storage architecture; and off-site capabilities. Our BCDR covers all systems including computer systems and telecommunications (telephone and fax), and all business processes. The BCDR is reviewed and updated annually or more frequently if issues arise in the twice-annual failover testing and will remain in effect throughout the Contract Term.

Appendix 5: Reporting Requirements

The Vendor must provide a detailed response to reporting requirements included in Appendix 5

A5.1. West Virginia-Specific Reports

Did You Know?

Kepro completed 100% of all required Agency reports within designated timelines and to specification.

Our Atrezzo Care Management platform provides a single, integrated reporting solution for WV DHHR's UM and PA Services program. We will continue to meet all the reporting requirements included in RFP Appendix 5. When a new report is requested, we will review the requirements including the intended content and desired format of each report. We will then develop the report and review it with the Agency representative to obtain approval of the report content and format. We will configure the report and perform quality assurance (QA) testing to make sure that it provides the information required in the format that has been approved. Following successful QA testing, the report will enter production on the requested schedule.

Additionally, report requirements, as well as desired content and formatting, will benefit from periodic review and revision. We recommend an annual review of each Agency-required report with the business owner to assure reports remain meaningful and comprehensive.

Two specific characteristics that differentiate our Atrezzo platform from our competitors include:

- First, Atrezzo enables client staff to directly access monitoring data on demand and in real time. Atrezzo also gives our clients the capability to produce a wide range of ad hoc management reports in a secure, online environment. Our client-configured and out-of-the-box Tableau dashboards display relevant information on program performance, productivity, caseloads, and utilization, to uncover vital information that drives improved results and consistent outcomes.
- Second, our integration and data sharing capabilities are sustained through the Kepro Health Intelligence (HI) Data Lake. The data lake is a server platform populated through transactional replication with data from all active databases supporting the contract, including transactional review data, telephony data, customer satisfaction data, claims data and compliance data. By leveraging transactional replication, the data lake can provide real-time reporting and analysis for on-demand needs. The data lake can be linked to other systems and populated with data in numerous ways. **Figure 96 Kepro's HI Data Lake** illustrates the process for how Atrezzo generates data-driven reports using the data lake.

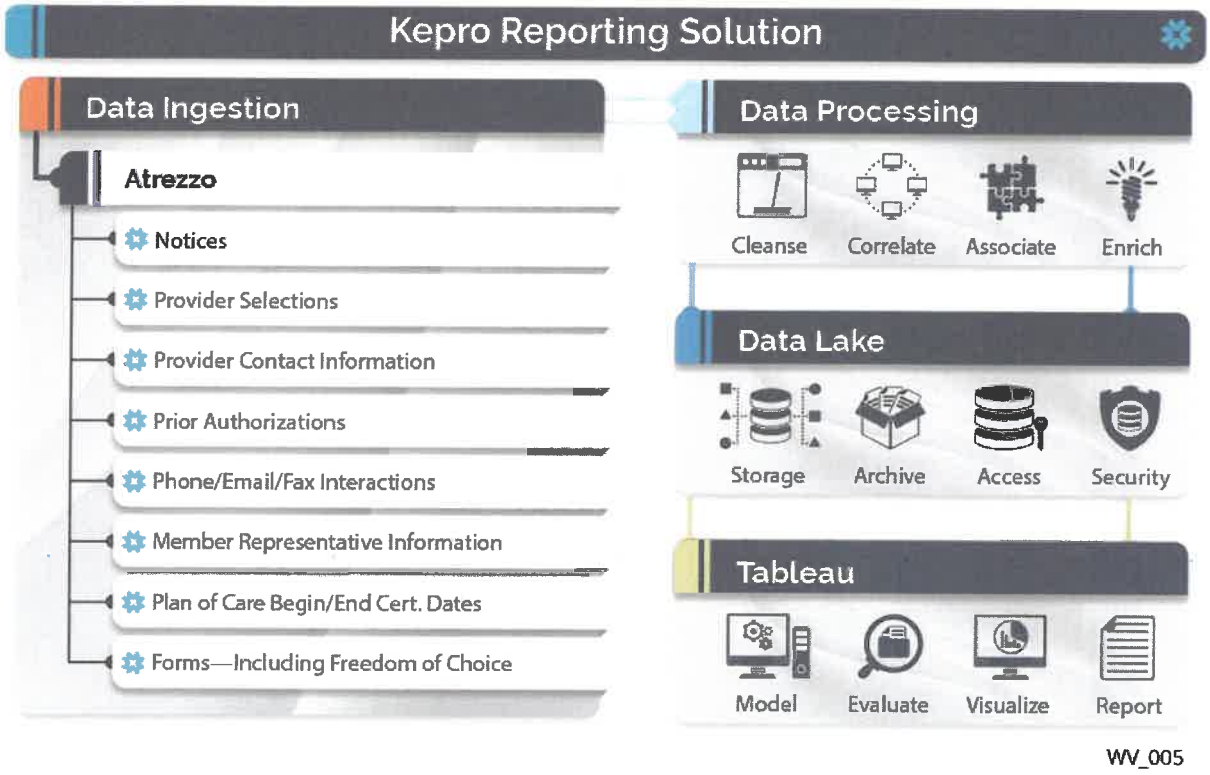
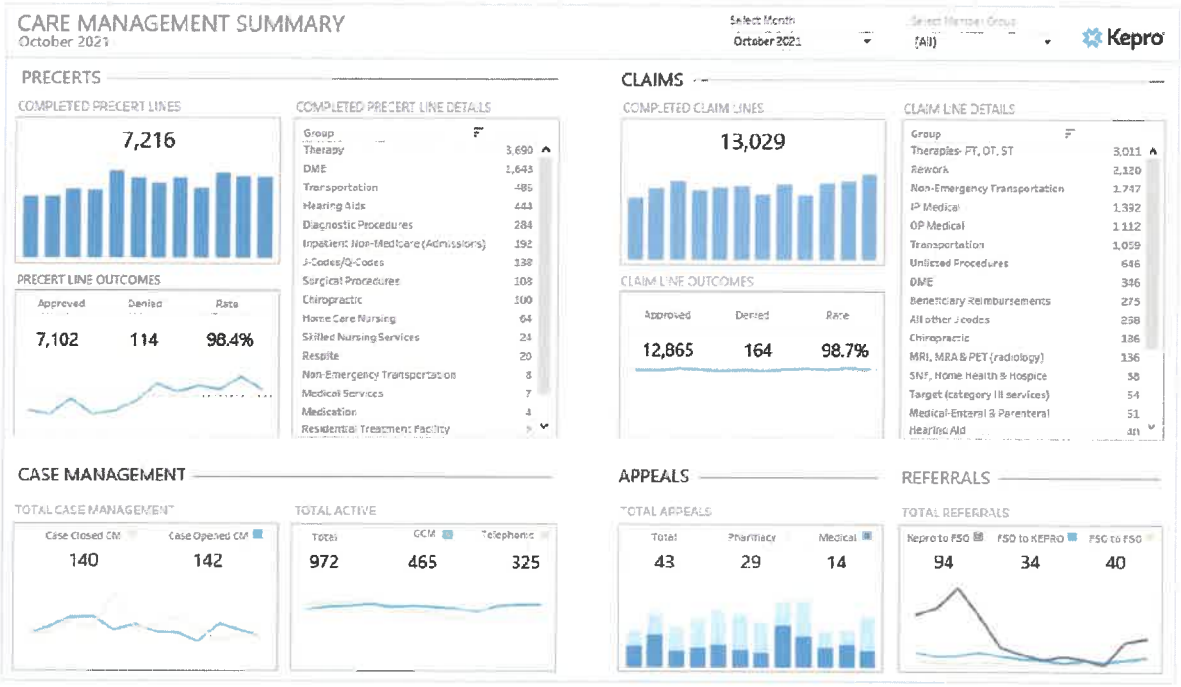


Figure 96. Kepro's HI Data Lake

Our systems ingest a variety of data from multiple sources, then process and store that data in the data lake making it accessible to our clients for subsequent manipulation, analysis, and reporting.

Seamless integration with WV DHHR data sources into our HI Data Lake will provide advanced data analysis, including risk stratification, to enhance the identification of high-risk member needs. As part of our data-driven approach to easing administrative burdens and improving health outcomes, our HI Team is a true differentiator. Our HI Team assists in improving health outcomes with state-of-the art HI tools, leveraging data collection, evaluation, reporting and interactive dashboards to support clients with a comprehensive view of their population. Our highly qualified healthcare analytics experts use the latest in reporting and analytics software to produce custom and ad hoc reports, automatically generate interactive program dashboards, and perform quantitative analysis. Our HI tools assist in providing the evidence needed to track program progress as well as identify and mitigate potential risks to keep the program informed and on point. We leverage this data, alongside our clinical expertise, in our pursuit and commitment of continuous quality improvement for each program.

Our HI Data Lake allows us to provide a true 360° view of available data and the members we serve. We can see trends and develop operational strategies to address those trends. An example dashboard report using sample data can be seen in **Figure 97 Care Management Dashboard**.



WV_006

Figure 97. Care Management Dashboard
Dashboards can be configured specifically for the WV DHHR program.

We already provide most of the reports required in RFP Appendix 5, and under the new contract we will deliver all requested reports and meet all reporting requirements. **Table 28 Kepro Production of RFP Appendix 5 Reports** shows the reports we provide to WV DHHR today as well as our experience providing reports with the same or similar content to other State Medicaid clients.

Appendix 5 Required Reports	Kepro report provided to WV Agencies today	Kepro report provided to other State Medicaid clients
Monthly Administrative Project Summary	✓	✓
Monthly Report Cards for Retrospective, Reconsideration and Member Hearing Reports	✓	✓
Monthly Out-of-Network (OON) Report	✓	✓
UM and PA Services Summary Report	✓	✓
Ambulance Transportation Level of Service Report		✓
Monthly Complaint Summary Report	✓	✓
Monthly IDD and TBI Waiver Complaint Detail Report	✓	✓
Monthly Denial Summary Report	✓	✓

Appendix 5 Required Reports	Kepro report provided to WV Agencies today	Kepro report provided to other State Medicaid clients
UM and PA Services Ad Hoc Reports	✓	✓
Provider Training Schedule	✓	✓
Annual Stakeholder Satisfaction Survey Report		✓
Quarterly Suspected Fraud, Abuse and/or Misuse	✓	✓
UM and PA Services Annual Report	✓	✓
Quarterly Behavioral Health (BH) Investigations Report	✓	✓
Monthly EPSDT Request by Environment/Service Category	✓	✓
Monthly EPSDT Services Request Tracking Report	✓	✓
Quarterly EPSDT numbers and Cost Data	✓	✓
Therapeutic Foster Care UM Reports	✓	✓
Therapeutic Foster Care Data Analysis	✓	✓
Therapeutic Foster Care Focus Group Summary	✓	✓
Non-medical Services Review Committee Report	✓	✓
Diagnostic Reports for Children in Custody of DHHR	✓	✓
Out-of-state Residential Data Analysis	✓	✓
Out-of-state Residential Focus Group Summary	✓	✓
Older Children Clinical Summaries	✓	✓
Parentally Placed Children in Out-of-state PRTF care	✓	✓
TMH Access to Services and Quality Review Reports	✓	✓
TMH Quality Review	✓	✓
Weekly Hospice Report	✓	✓
Weekly ADW Managed Enrollment Wait List	✓	✓
ADW Discovery and Remediation Reports	✓	✓
Personal Care Monthly Activity Report	✓	✓
ADW Monthly Activity Report	✓	✓
Monthly Personal Care Prior Authorizations	✓	✓
I/DD Monthly FBDH/SE Report	✓	
I/DD Monthly Member Activity Report	✓	✓
I/DD Monthly Report/CMS Quality Performance Indicators	✓	✓
I/DD Monthly Provider Report	✓	✓
I/DD Annual Report	✓	✓

Appendix 5 Required Reports	Kepro report provided to WV Agencies today	Kepro report provided to other State Medicaid clients
I/DD 24 Hour Residential Settings Report	✓	✓
I/DD Integrated Settings Report	✓	✓
BBH Indigent Care Monthly Report Card	✓	✓
BBH Statewide Demographic and Clinical Data	✓	✓
BBH Data Quality Report	✓	✓
Community Mental Health Services Block Grant Reporting	✓	✓
Substance Abuse Prevention and Treatment Reporting	✓	✓
Traumatic Brain Injury (TBI) Monthly Activity Report	✓	✓
TBI Monthly Report/CMS Quality Performance Indicators	✓	✓
ICF-IID Monthly, Quarterly and Ad Hoc Reports		✓
ICF-IID Hearings Report		✓
PASRR Level II Monthly, Quarterly and Ad HOC Reports	✓	✓
Nursing Facility Eligibility - PASRR Hearings Report		✓
Nursing Facility Eligibility – PASRR Evaluator Report	✓	✓
BBHHF Consumer Satisfaction Survey Results		✓
Weekly ADW Managed Enrollment Wait List Report	✓	✓
Monthly Discovery and Remediation Report	✓	✓
ADW Monthly Activity Report	✓	✓
Annual ADW Provider Audit Report		✓
Monthly PC Prior Authorizations	✓	✓
Monthly PC Determination and Redetermination Timeliness	✓	✓
Monthly CDCSP Determination and Redetermination Timeliness	✓	✓
Monthly PC Medical Eligibility Determinations Report	✓	✓
Monthly Health Homes Member and Provider Reports	✓	✓
Monthly Dental Report		✓
Quarterly Transplants Report	✓	✓
Quarterly UDS Report	✓	✓

Table 28. Kepro Production of RFP Appendix 5 Reports

Our team already produces most of the required reports for the Agency and we can provide all requested reports

Additionally, for the WV DHHR UM and PA Services contract today we also submit the following reports listed in **Table 29 Additional Reports**. These are reports not listed above or in the RFP.

Report Name	Frequency
ADW Service Delivery – Personal Options	Monthly
ADW and PC Service Continuations	Monthly
Newly Registered BH Providers	Monthly
ADW Legislative Oversight Commission on Health and Human Resources Accountability	Monthly
ADW Weekly Activity Summary Report	Monthly
CSED Demonstration and Remediation Report	Monthly
CSED Activity Report, Active Member List Report, and Monthly Status Report	Monthly
CSED Hearing Report Card	Monthly
BBH Wraparound Referral Report	Monthly
BBH CSED Referral Status Report	Monthly
QRTP Tracking Report	Monthly

Table 29. Additional Reports

A Kepro advantage is our ability to provide a suite of reports built for Agency needs today and tomorrow.

Attachment 1 Job Descriptions

Through our 22 years of experience providing program services for WV DHHR, we have developed the background and knowledge necessary for a firm understanding of the skillsets required of our WV project team. This Exhibit contains the job descriptions for each position within our WV project team and demonstrates our staff meet the following RFP requirements:

- Customer Service (Call Center) staff must have a high school diploma or equivalent certification
- Case Reviewer staff must be Registered Nurses (RNs)
- Physician Reviewer/Medical Director staff must be licensed as a Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO)
- Management staff must hold a bachelor's degree and at least two years qualifying experience

1.1 Key Staff

Job descriptions for our WV Key Staff positions are presented in **Table A1-1 Key Staff Job Descriptions** below:

- Executive Director
- Project Manager, Long Term Care
- Project Manager, Medical, IDD, and Behavioral Health
- Project Manager, Administrative Services
- Project Manager, Information Technology
- Project Manager, HH, CSED, QRTP and TBI Waiver

Position/Role	Responsibilities, Attributes, and Skillsets
Executive Director	**Responsibilities:** This individual is responsible for the overall administration of the contract(s) with the WV DHHR. Additionally, the WV Executive Director is the primary contact with WV DHHR. This individual is responsible for the management and all deliverables for the various programs and makes sure all contract functions are performed to the highest standards and meet or exceed contract requirements and customer expectations. This individual is also responsible for overseeing the design, development, and implementation of all programs; member and community relations; business management functions; program strategy, vision, and leadership; and team development. **Desired Attributes and Skillsets:** • Master's degree in business, human or social services, health management, or related field • 5 years' management experience in healthcare or social services • Working knowledge of best practices in Medicaid, direct care services, behavioral health, and/or other state programs

Position/Role	Responsibilities, Attributes, and Skillsets
	• Strong leadership, problem solving, staff development, and customer relations skills • Demonstrated record of success facilitating progressive change and development of innovative business functions and programs • Must reside in West Virginia
Project Manager, Long Term Care (Also known as Kepro Director, LTC)	**Responsibilities:** This individual is responsible for the management and deliverables of work performed in the Long-Term Care department, which includes the home and community-based services, Aged and Disabled Waiver (ADW), Personal Care, and the Nursing Home-PAS. This individual makes sure that all functions are performed to the highest standards to contract requirements. More specifically, their role includes managing the operations to meet contract deliverables, as well as providing leadership and supervision to staff assigned to the contract. Additionally, this individual will assess policy and procedure to continually promote a high level of customer satisfaction for all stakeholders, as well as monitor, evaluate, and recommend changes to existing contract and potential new business. **Desired Attributes and Skillsets:** • Bachelor's degree in human services or related field (Master's degree preferred) • 3 years' experience in West Virginia Long-Term Care programs • 3-5 years' prior leadership and/or supervisory/management experience • Working knowledge of best practice in content areas and government policy and structure • Ability to lead and manage direct reports, analyze data, and develop reports to meet the contract's goals of quality care and cost-effectiveness • Must reside in West Virginia
Project Manager, Medical, IDD, and Behavioral Health (Also known as Kepro Director, Medical, IDD, and Behavioral Health)	**Responsibilities:** This individual is responsible for the management and deliverables of the Medical UM, SUD and Behavioral Health, Intensively Support Settings (ISS) Group Home, and Intellectual/Developmental Disabilities (IDD) services. This individual's role is to make sure that functions are performed to the highest standards of the contract. These functions Include prior authorization of all medical services; ambulance and air transportation; provider education; training and technical assistance; quality improvement activities; data collection; and analysis of metrics and reports. This individual will also be responsible for effectively managing the team and programs to meet all contract deliverables, providing leadership and supervision for all medical staff, and providing consultation to the Agency. This individual will review and evaluate policy and procedures on an ongoing basis to promote a high level of customer satisfaction for all stakeholders, as well as uphold ongoing communication and collaboration with the Medical Director.

Position/Role	Responsibilities, Attributes, and Skillsets
	Desired Attributes and Skillsets: • Registered Nurse (RN) or Master's degree in a health-related field • Valid WV license as a Registered Nurse, Social Worker, Professional Counselor, Rehabilitation Counselor, Psychologist, or similar • 3-5 years' supervisory and program management experience • Knowledge and experience with medical utilization management processes • Understanding of the customer service approach for medical provider stakeholders • Familiarity with InterQual criteria for all review areas, including Medicaid and Medicare, government structure and policy and related programs • Must reside in West Virginia
Project Manager, Administrative Services **(Also known as Kepro Director, Administrative Services)**	**Responsibilities:** This individual leads the Customer Service team in meeting the needs of provider and individual stakeholders. This individual is responsible for our overall customer service functions, including customer service operations, quality, and training teams. This individual also participates in quality management/quality improvement activities. **Desired Attributes and Skillsets:** • Bachelor's degree in business, health services, or a related field • 5 years' experience in Medicaid programs or similar health related programs and operations • 3-5 years' supervisory/management experience in a customer service or related field • Working knowledge of best practice in customer service and government policy and structure • Must reside in West Virginia
Project Manager, Information Technology **(Also known as Kepro Director, Information Technology)**	**Responsibilities:** This individual is responsible for IT-related deliverables and work performed according to the highest standards and contractual requirements. The individual is responsible for supporting change orders, reports, and related business. This individual also continually assesses IT policy and procedure to promote a high level of customer satisfaction for all stakeholders. Additionally, this position will provide consultation on system and policy issues. **Desired Attributes and Skillsets:** • Bachelor's degree in information management or related field • 3-5 years' supervisory and program management experience in related technical area, preferably in a Medicaid or other healthcare environment • Working knowledge of best practice in content areas and government policy and structure • Must reside in West Virginia

Position/Role	Responsibilities, Attributes, and Skillsets
Project Manager, HH, CSED, QRTP and TBI Waiver (Also known as Kepro Director, HH, CSED, QRTP and TBI Waiver)	**Responsibilities:** This individual is responsible for the management and deliverables of work performed for Health Homes (HH), Children with Serious Emotional Disorder (CSED), school-based programs, qualified residential treatment programs (QRTP), BSS out-of-state residential reviews, tiered foster care, and Traumatic Brain Injury (TBI) Waiver programs. This individual provides general supervision; develops tools for tracking and analysis; conducts staff reviews; analyzes data; and establishes team policies and procedures. The individual identifies, assesses, and maintains operational guidelines and review and assessment tools. **Desired Attributes and Skillsets:** • Master's degree in social work, counseling, or psychology • Valid WV license as a Registered Nurse, Social Worker, Professional Counselor, Rehabilitation Counselor, Psychologist, or similar • 3-5 years' experience related to child welfare, behavioral health services, utilization management, and systems planning • 3-5 years' supervisory and program management experience • Working knowledge of best practice in content areas and government policy and structure • Must reside in West Virginia

Table A1-1. Key Staff Job Descriptions

Each WV Key Personnel position has specific responsibilities, skills, and attributes to support success in providing the service and support that meets WV DHHR's expectations.

1.2 Long Term Care Services Team

Job descriptions for our WV Long Term Care Services team positions are presented in **Table A1-2. Long Term Care Services Job Descriptions** they include:

- UM Manager
- UM Quality Nurse
- Personal Care Services Manager
- Personal Care Case Reviewer
- Aged and Disabled Waiver (ADW) Manager
- ADW Case Reviewer
- ADW UM Support Staff
- Manager Nursing Facility Services
- Case Reviewer, PAS Programs

Position/Role	Responsibilities, Attributes, and Skillsets
UM Manager	**Responsibilities:** The UM Manager provides direction to staff regarding the completion of day-to-day functions for utilization review service deliverables. This Manager provides general supervision, monitors deliverable reports, coordinates inter-rater reliability functions, and establishes nursing staff team policies and procedures. This individual assists with updating utilization criteria and developing internal review protocols. Additionally, this Manager establishes recommendations for provider technical assistance and training related to feedback from medical staff and identified provider needs. **Desired Attributes and Skillsets:** • Associate degree in Nursing, a Bachelor's degree in Nursing is preferred • Valid WV Registered Nurse license • 2 or more years' supervisory experience in a UM setting • Knowledge and experience with medical utilization management processes • Strong customer service skills and understanding of approach for medical provider and related community stakeholders • Familiarity with InterQual criteria for all review areas, including government structure and related programs • Medical coding experience • Must reside in West Virginia
UM Quality Nurse	**Responsibilities:** The UM Quality Nurse performs quality education and evaluation of member assessments. Registered Nurses (RNs) will provide education to applicants/members and conduct the Pre-Admission Screening Assessment. The UM Quality Nurse manages a caseload of assigned members to ensure that assessments are scheduled, appropriate persons are in attendance, assessments are performed, and data is entered into the system within established timelines. The Quality Nurse monitors UM quality, recommends, and implements quality assurance and improvement protocols and assists with training. The Quality Nurse leads inter-rater reliability activities to ensure consistent administration of assessments and adherence to assessment protocols. They also monitor RN quality of work, recommend, and implement quality assurance and improvement protocols, and assist with training. **Desired Attributes and Skillsets:** • Bachelor's degree in Nursing (Master's preferred) • Valid WV Registered Nurse license • • 2 or more years' experience with the aging population or with persons with disabilities (preferably working within the WV Medicaid and related public programs) • Knowledge of UM program policies and procedures

Position/Role	Responsibilities, Attributes, and Skillsets
	• Ability to accurately assess medical conditions, symptoms, and functional abilities • Excellent customer service and communication skills • Capability to be flexible, multi-task, and prioritize activities • Must reside in West Virginia
Personal Care Services Manager	**Responsibilities:** The Manager, Personal Care Services provides direction to staff regarding the achievement of service deliverables related to initial and re-evaluation Personal Care assessments, as well as other functions, as needed. This individual provides general supervision, coordinate inter-rater reliability and quality assurance/improvement functions, and establishes team policies and procedures. The role also includes providing operational oversight to ensure contract deliverables are achieved, developing, and maintaining operational guidelines, and providing leadership and supervision to staff. The Manager, Personal Care Services has a shared role as the Manager, Nursing Facility Services. **Desired Attributes and Skillsets:** • Bachelor's degree in Nursing (Master's degree preferred) • Valid WV Registered Nurse license • 2 or more years' experience in the West Virginia Personal Care program • 2 years' leadership and supervisory experience • Knowledge of the Pre-Admission Screening and the Personal Care program policies and procedures • Must reside in West Virginia
Case Reviewer, Personal Care	**Responsibilities:** The Case Reviewer, Personal Care (PC) educates and performs medical eligibility assessments of WV Medicaid recipients seeking Personal Care services. The Case Reviewer follows prescribed guidelines while administering the Pre-Admission Screening for determination of medical eligibility. They also manage a caseload of assigned members to ensure that assessments are scheduled, appropriate persons are in attendance, assessments are performed, and data is entered within prescribed timelines. This role includes extensive local travel within an assigned catchment area, and periodic travel outside the catchment area will also be required. **Desired Attributes and Skillsets:** • Bachelor's degree in Nursing (Master's degree preferred) • Valid WV Registered Nurse license • 2 or more years' related experience in the West Virginia Personal Care program • 1-2 years' leadership and supervisory experience • Knowledge of the Pre-Admission Screening and the Personal Care program policies and procedures • Must reside in West Virginia

Position/Role	Responsibilities, Attributes, and Skillsets
ADW Manager	**Responsibilities:** The Aged and Disabled Waiver (ADW) Manager provides direction to staff to complete service deliverables related to initial and re-evaluation Aged and Disabled Waiver assessments, Personal Care, and other programs, as needed. The ADW Manager provides general supervision, coordinates inter-rater reliability functions, and establishes team policies and procedures. This individual provides operational oversight to ensure contract deliverables are achieved; develops and maintains operational guidelines; and provides leadership and supervision to staff. Additionally, they review performance measures and problem-solve to improve deliverables, as well as develop and conduct inter-rater reliability activities (including observation) for consistency in ADW assessments. **Desired Attributes and Skillsets:** • Desired Attributes and Skillsets: • Bachelor's degree in Nursing (Master's degree preferred) • Valid WV Registered Nurse license • 2 or more years' experience in the West Virginia Aged and Disabled Waiver program • 1-2 years' leadership and supervisory experience • Knowledge of the Pre-Admission Screening, Aged and Disabled Waiver, and Personal Care program policies and procedures • Ability to travel throughout the State, as needed • Must reside in West Virginia
ADW Case Reviewer	**Responsibilities:** The Case Reviewer, ADW (aka Kepro Nurse Reviewer) performs education and initial/re-evaluation assessments of Aged and Disabled Waiver members for the purposes of determining program medical eligibility. This Individual provides education to applicants/members, manages a caseload of assigned members to ensure that assessments are scheduled, appropriate persons are in attendance, assessments are performed, and data is entered into the UMC portal within prescribed timelines. This individual travels to, conduct, and appropriately administer and document assessments within prescribed timelines. They participate in inter-rater reliability activities to ensure consistent administration of assessments and adherence to assessment protocols, as well as participate in denial hearings, as necessary. This individual also contacts physicians and facilities to confirm medical information. **Desired Attributes and Skillsets:** • Nursing degree (Bachelor's degree preferred) • Valid WV Registered Nurse license • 2 or more years' experience with aging population or with persons with disabilities (preferably working within the WV Aged and Disabled Waiver program)

Position/Role	Responsibilities, Attributes, and Skillsets
	• Knowledge of the Aged and Disabled Waiver program policies and procedures • Ability to travel to homes and facilities within the catchment area (travel outside the catchment area is occasionally required to fill-in for others or to attend staff meetings/events) • Capability to accurately assess medical conditions and symptoms and functional abilities • Must reside in West Virginia
ADW UM Support Staff	**Responsibilities:** The ADW UM Support staff provides a broad range of administrative service support to the WV Aged and Disabled Wavier and Personal Care team and to the external customer. This position supports the ADW and PC clinical staff with day-to-day functions as well as performing primary customer service and technical assistance. The ADW UM staff provides telephone support to ADW members and providers/facilities. More specifically, the ADW UM Support Staff provides program support to the ADW and PC programs. This includes scheduling ADW assessments, preparing and mailing notice of decision and other program letters, and assisting callers with billing, the UMC portal, and general program and other questions. **Desired Attributes and Skillsets:** • High school diploma or GED equivalent (advance degree/certificate preferred) • 1-2 years' experience in an administrative support or customer service position • Knowledge of the Aged and Disabled Wavier program policies and procedures preferred • Possess excellent customer service and communication skills • Ability to multi-task and prioritize • Proficiency with Microsoft Office and other software • Experience with the UMC portal • Must reside in West Virginia
Manager Nursing Facility Services	**Responsibilities:** This individual provides direction to staff to achieve service deliverables related to initial and re-evaluation Personal Care assessments. This Manager provides general supervision, coordinates inter-rater reliability and quality assurance/improvement functions, and establishes team policies and procedures. The role also includes providing operational oversight to ensure contract deliverables are achieved, developing, and maintaining operational guidelines, and providing leadership and supervision to staff. The Manager, Nursing Facility Services has a shared role as the Manager, Personal Care Services. **Desired Attributes and Skillsets:** • Bachelor's degree in Nursing (Master's degree preferred) • Valid WV Registered Nurse license

Position/Role	Responsibilities, Attributes, and Skillsets
	• 2 or more years' experience in the West Virginia Personal Care program • 1-2 years' leadership and supervisory experience • Knowledge of the Pre-Admission Screening and the Personal Care program policies and procedures • Must reside in West Virginia
Case Reviewer, PAS Programs	**Responsibilities:** The Case Reviewer, Pre-Admission Screen (PAS) program (aka Kepro Clinical Assessor) performs education and initial/re-evaluation assessments of Aged and Disabled Waiver participants for the purpose of determining program medical eligibility. The individual conducts, and documents, medical assessments in person and by telephone within prescribed timelines. They also schedule ADW assessments within prescribed timelines, participate in inter-rater reliability activities, and participate in denial hearings, as necessary. Additionally, this individual will contact physicians and facilities to confirm medical information. **Desired Attributes and Skillsets:** • Nursing degree (Bachelor's degree preferred) • Valid WV Registered Nurse license • 2 or more years' experience with the aging population or with persons with disabilities (preferably working within the WV Aged and Disabled Waiver program and Aged Disabled Waiver system) • Knowledge of the WV Aged and Disabled Waiver policies and procedures • Ability willing to travel to homes and facilities • Must be organized and have excellent customer service skills, good interpersonal communication, and be flexible • Capability to accurately assess medical conditions and symptoms and functional abilities • Able to work independently based remotely from their home office and have basic computer skills. • Must reside in West Virginia

Table A1-2. Long Term Care Services Job Descriptions

Each Long Term Care Services position has specific responsibilities, skills, and attributes to support success in providing the service and support that meets WV DHHR's expectations.

1.3 Medical, IDD, and Behavioral Health

Job descriptions for our WV Medical, IDD, and Behavioral Health team positions are presented in **Table A1-3 Medical, IDD, and Behavioral Health Job Descriptions**, below:

- Medical Director
- Behavioral Health and SUD Waiver Provider Educator

- Intensively Support Settings (ISS) Group Home Waiver Manager
- High Intensity Nurse Reviewer
- ISS/Group Home Lead
- ISS/Group Home Provider Educator
- Medical Program Eligibility Specialist
- Medical Program Specialist
- Medical UM Physician Reviewer
- Medical UM Case Reviewer
- Medical UM Manager
- Medical UM Support Staff
- Intellectual/Developmental Disabilities (IDD) Waiver Consumer and Family Educator
- IDD Waiver Registration Coordinator
- Lead IDDW Provider Educator
- IDD Waiver Provider Educator
- Lead IDDW Service Support Facilitator
- IDD Service Support Facilitator

Position/Role	Responsibilities, Attributes, and Skillsets
Medical Director	**Responsibilities:** The Medical Director Is responsible for providing principal leadership to the Medical UM team on all medical aspects of the program. Provides oversight of all utilization management and prior authorization activities. The Medical Director is responsible for evaluating, redirecting and/or responding to physician, provider, and member inquiries. They represent and promote Kepro at seminars, professional societies, hospital medical staff meetings and other professional meetings as appropriate. The Medical Director conducts appropriate external relationships with attending physicians/surgeons by response to telephone calls and letter. They participate in speaking engagements before physician and provider organizations. They analyze and remain updated regarding national, state, and local regulations and legislation impacting the healthcare profession and work with staff in addressing and meeting changing requirements, assuring compliance with regulatory and accreditation requirements. The Medical Director also oversees the medical content of company publications, participating in activities specific to contractual arrangements, and participating in Kepro's Quality Management Committee to ensure organization compliance. The Medical Director also reviews medical information trends, experiences, and approaches, and assists in the development of strategic plans for clinical improvements, while working with medical, nursing, and administrative staff to identify matters that need shared attention. **Desired Attributes and Skillsets:** • Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO)

Position/Role	Responsibilities, Attributes, and Skillsets
	• Current West Virginia Board of Medical Examiners non-restricted license • Board certification in a clinical specialty • 10 or more years of clinical practice with preferable • 5-7 years' experience as a physician executive with significant accomplishments in development programs and coaching medical staff on healthcare business and practice issues • 2 or more years' experience as a Medical Director in a managed care company • Trained in quality assurance and utilization review • Understanding of major trends in healthcare and managed care • Must be a systems thinker with strong organizational skills who can meet deliverables on time and within budget • Preferred qualities include experience in Utilization Management and Case and Disease Management with knowledge of Medicaid and Medicare programs, prior experience or quality assurance committee responsibility in a hospital setting, and knowledge of federal, State, and private health related activities. • Must reside in West Virginia
Provider Educator, Behavioral Health and SUD Waiver	**Responsibilities:** The Behavioral Health and SUD Waiver Provider Educator conducts provider reviews, including completing associated reports. This staff develops and conducts training and provides technical assistance for agency providers and other stakeholders. In this role, the Provider Educator develops and submits reports associated with provider reviews and complete assigned special projects. The Provider Educator also completes inter-rater reliability tasks. **Desired Attributes and Skillsets:** • Bachelor's degree in a healthcare related field • Knowledge of behavioral health and SUD waiver program policies and procedures • Excellent customer service and communication skills • Capability to be flexible, multi-task, and prioritize activities • Proficiency with Microsoft Office and other software • Must reside in West Virginia
Intensively Support Settings (ISS) Group Home Waiver Manager	**Responsibilities:** The Intensively Support Settings (ISS) Group Home Waiver Manager provides direct oversight to the ISS/GH team and to the Provider Educator team, as necessary. This Manager provides general supervision, develops tools for tracking and analysis, conducts onsite reviews of agencies as needed, analyzes data, and develops data reports, and establishes team policies and procedures. This individual provides operational oversight to make sure contract deliverables are achieved. They also conduct face-to-face assessment reviews for a small caseload. The Manager identifies, assesses, and provides training to staff related to their functions. This individual develops and maintains operational

Position/Role	Responsibilities, Attributes, and Skillsets
	guidelines and provider review tools. This Manager for gathers and summarizes review findings into general provider review reports as well as facilitates the review schedule for ISS/GH Assessor Team. This Manager also coordinates and conducts training as needed with providers and stakeholders. This individual is also responsible for aggregating data from review findings, Incident Management System, and other sources. **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field • 2 or more years' experience within the ISS/Group Home and/or I/DD Waiver programs • Knowledge of the ISS/Group Home and I/DD Waiver programs • Strong organization and customer service skills • Excellent written and verbal communication skills • Proficiency with Microsoft Office and other software • Must reside in West Virginia
High Intensity Nurse Reviewer	**Responsibilities:** The High Intensity Nurse Reviewer conducts retrospective reviews of high intensity services. This Nurse Reviewer completes prior authorization medical necessity reviews for outpatient and inpatient behavioral health services within established timelines through review of related documents. The Nurse Reviewer evaluates provider's adherence to Agency standards for quality and appropriateness of care at the treatment location. They provide individualized recommendations and training to providers based upon approved assessment criteria and tools. The Nurse Reviewer also collects clinical data and enters information into database as required. **Desired Attributes and Skillsets:** • Associate degree in Nursing (Bachelor's degree in Nursing is preferred) • Valid WV Registered Nurse license • Psychiatric nursing certification preferred. • 2-3 years' experience in outpatient or inpatient behavioral health settings • Medicaid and/or public sector service experience preferred • Strong organization, customer service skills, and communication skills • Proficiency with Microsoft Office and other software • Ability to travel in-state and out-of-state • Must reside in West Virginia
ISS/Group Home Lead	**Responsibilities:** The ISS/Group Home Lead provides direction to the Provider Educator Team to achieve service deliverables for utilization management, provider education, and customer service related to the ISS/Group Home Waiver program. The Lead coordinates the Quality

Position/Role	Responsibilities, Attributes, and Skillsets
	Improvement Advisory Council quarterly meetings, Quarterly Provider Meetings, and required provider/stakeholder training. This position provides operational oversight to the Provider Educator Team and the Registration Coordinator Team to ensure contract deliverables are achieved. This individual identifies, assesses, and provides training to staff related to their functions within the department. This individual develops and maintains operational guidelines and prepare monthly reports. This individual identifies key training opportunities and implements the training program as needed with providers and stakeholders. This individual also develops and implements training for inter and intra-departmental needs. **Desired Attributes and Skillsets:** • Responsibilities: The ISS/Group Home Provider Educator conducts provider reviews, including completing associated reports. This staff develops and conducts training and provides technical assistance for agency providers and other stakeholders. In this role, the Provider Educator develops and submits reports associated with provider reviews and complete assigned special projects. The Provider Educator also completes inter-rater reliability tasks. • Desired Attributes and Skillsets: • Bachelor's degree in social services, healthcare, or related field • 2 or more years' experience in healthcare, preferably within the ISS/Group Home program • Knowledge of the ISS/Group Home program • Strong organization and customer service skills • Excellent written and verbal communication skills • Proficiency with Microsoft Office and other software • Must reside in West Virginia
ISS/Group Home Provider Educator	Responsibilities: The ISS/Group Home Provider Educator conducts provider reviews, including completing associated reports. This staff develops and conducts training and provides technical assistance for agency providers and other stakeholders. In this role, the Provider Educator develops and submits reports associated with provider reviews and complete assigned special projects. The Provider Educator also completes inter-rater reliability tasks. **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field • 2 or more years' experience in healthcare, preferably within the ISS/Group Home program • Knowledge of the ISS/Group Home program • Strong organization and customer service skills • Excellent written and verbal communication skills • Proficiency with Microsoft Office and other software • Must reside in West Virginia

Position/Role	Responsibilities, Attributes, and Skillsets
Eligibility Specialist – Medical	**Responsibilities:** Within specified timelines, the Eligibility Specialist reviews and verifies Medicaid and program eligibility for members with requests for Medicaid health and behavioral health services requiring prior authorization. This individual follows approved procedures to apply Medicaid eligibility and program requirements and specific guidelines to member data to make valid decisions on program/service eligibility and determine appropriate disposition and notification. Informs relevant parties of requests that do not meet eligibility and/or program requirements and resolves issues related to such requests. The Eligibility Specialist researches, investigates, and assists in resolving inquiries from providers and members related to program and service eligibility and resolves issues or refers to appropriate parties for resolution. The individual handles correspondence related to program and service eligibility and prior authorization of services within specified timelines. **Desired Attributes and Skillsets:** • High school diploma or GED equivalent required (Associates or Bachelor's degree in human services field preferred) • 3 or more years' customer service experience (preferably in the Medicaid or health care industry) • 1 year of claims experience preferred • Knowledge of medical and behavioral health eligibility verification, and medical coding, policies, and procedures • Capability to • Excellent customer service and written and verbal communication skills • Ability to multi-task and prioritize activities • Proficiency with Microsoft Office and other software • Must reside in West Virginia
Medical Program Specialist	**Responsibilities:** The Medical Program Specialist represents the Medical department and Kepro operations through communication and participation in meetings and workgroups with the Agency and other stakeholders. They review all monthly, quarterly, and annual reports prior to submission to the Agency, verifying accuracy of data. The Medical Program Specialist work with IT to resolve data integrity issues and research data to fill any gaps that may exist. Additionally, they promote transition from existing IT applications to new systems including, design, development, and user acceptance testing (UAT) for medical and behavioral health programs. The Medical Program Specialist coordinates, schedules, and facilitates internal staff training in pertinent areas, including but not limited to trainings on Kepro system capabilities, revised workflows, and the claims payment system. **Desired Attributes and Skillsets:** • Bachelor's degree in health care administration or human service preferred

Position/Role	Responsibilities, Attributes, and Skillsets
	• Associate degree and at 3 years' experience in lieu of Bachelor's degree • Capability to independently manage multiple tasks with competing deadlines • Data skills are preferred, specifically management, analysis, and auditing • 3-4 years' experience in the health care industry with preference in medical management, care management, and/or customer service with client or member facing responsibilities • Must reside in West Virginia
Medical UM Physician Reviewer	**Responsibilities:** The Medical UM Physician Reviewer provides medical review in support of the West Virginia Medicaid Program. The Medical Physician Reviewer evaluates cases for determination of medical eligibility that did not meet criteria at nurse reviewer level within specified timelines. Applies relevant utilization criteria (InterQual and any additional applicable criteria) to determine medical necessity. Documents findings and appropriate case information to determine medical necessity of requested medical services. Provides customer service related to internal and external clinical case specific inquires, as appropriate. Maintains an active license and/or recertification in good standing, and immediately notifies Kepro if their active license and/or certification as a healthcare professional becomes restricted, suspended, expires, lapses, is revoked, or lost for any reason. **Desired Attributes and Skillsets:** • Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO) • Current West Virginia Board of Medical Examiners non-restricted license • Board certification in a clinical specialty • Clinical experience treating persons with medically complex needs • Capability to apply relevant utilization criteria and appropriate case information to determine medical necessity of requested medial services • Effective communication skills • Must reside in West Virginia
Medical UM Case Reviewer	**Responsibilities:** The Medical UM Case Reviewer (aka Kepro Nurse Reviewer) reviews medical necessity and clinical criteria to resolve prior authorization requests within established time frames for inpatient and outpatient medical services. The Case Reviewer selects, documents, and applies relevant utilization criteria and appropriate case-specific information to determine medical necessity of requested medical services. The Case Reviewer manages referrals that require Physician Review, as well as requests and clarifies medical information required to resolve inquiries. The Case Reviewer provides optimal and timely

Position/Role	Responsibilities, Attributes, and Skillsets
	customer service related to internal and external clinical case specific inquires, as appropriate. **Desired Attributes and Skillsets:** • Associate degree in Nursing, a Bachelor's degree in Nursing is preferred • Valid WV Registered Nurse license • 2 or more years' experience in • Knowledge and experience with medical utilization management process • Strong customer service skills and approach for medical provider and related community stakeholders • Familiarity with InterQual criteria for all review areas, including government structure and related programs • Background in medical coding is preferred. • Must reside in West Virginia
Medical UM Manager	**Responsibilities:** The Medical UM Manager provides direction to medical nursing staff regarding the completion of day-to-day functions for utilization review service deliverables related to the WV Medical UM program. They frequently collaborate with both the Medical Director and Medical and Behavioral Health Project Manager. This Manager provides general supervision, monitors deliverable reports, coordinates inter-rater reliability functions, and establishes nursing staff team policies and procedures. This Manager supervises clinical UM staff and monitors Medical UM deliverables for the WV UM and PA Services contract. This individual assists with updating utilization criteria and developing internal review protocols. Additionally, this Manager establishes recommendations for provider technical assistance and training related to feedback from medical staff and identified provider needs. **Desired Attributes and Skillsets:** • Associate degree in Nursing, a Bachelor's degree in Nursing is preferred • Valid WV Registered Nurse license • 2 or more years' supervisory experience in a UM setting • Knowledge and experience with medical utilization management processes • Strong customer service skills and approach for medical provider and related community stakeholders • Familiarity with InterQual criteria for all review areas, including government structure and related programs • Medical coding experience • Must reside in West Virginia
Medical UM Support Staff	**Responsibilities:** The Medical UM Support Staff provides a broad range of utilization management support to the medical UN team and external

Position/Role	Responsibilities, Attributes, and Skillsets
	customers. This position supports the medical review staff with completion of day-to-day functions as well as performing primary customer service and technical assistance functions. The Medical UM Support staff provides telephone support to external providers, agencies, and facilities. This staff prepares and mails authorization request decision letters to providers and members, as well as entering prior authorization request on behalf of providers who elect to fax rather than use web-based or electronic submission. They assist external providers, agencies, and facilities with system billing questions, general program and other questions or concerns, and they complete special projects as needed to improve customer service. **Desired Attributes and Skillsets:** • High school diploma or GED equivalent required (Associates or Bachelor's degree in human services field preferred) • 1-2 years' experience in an administrative support or customer service role • Knowledge of medical billing policies and procedures • Excellent customer service and communication skills • Ability to multi-task and prioritize activities • Proficiency with Microsoft Office and other programs • Must reside in West Virginia
IDD Waiver Consumer & Family Educator	**Responsibilities:** The I/DD Waiver Consumer & Family Educator provides support to program members by responding to complaints and providing education about the program to members and their families. This position assists with processing all aspects of service negotiation and Medicaid Fair Hearing for service denials and processes documents and correspondence associated with program eligibility. This position also conducts Participant Experience Surveys for an assigned caseload. The I/DD Waiver Consumer & Family Educator responds to, processes, and tracks all member and family complaints. This individual maintains program flow documents, tracks, and schedules service negotiation hearings related to denial of services or eligibility, and communicates disposition to negotiations and hearings to members, the department, and other stakeholders. **Desired Attributes and Skillsets:** • Bachelor's degree in health care administration or human service • Minimum of 1 year of experience in the I/DD Waiver field • Knowledge of the I/DD Waiver program policies and procedures • Excellent customer service and communication skills • Ability to multi-task and prioritize activities • Proficiency with Microsoft Office and other programs • Must reside in West Virginia

Position/Role	Responsibilities, Attributes, and Skillsets
IDD Waiver Registration Coordinator	**Responsibilities**: The I/DD Waiver Registration Coordinator reviews and makes decisions on provider requests for prior authorization of I/DD Waiver services for program participants. This position works closely with provider agencies to obtain needed information to process requests, facilitates 2nd level negotiation, and provides testimony at Medicaid Fair Hearings related to service denials. **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field • 2 or more years' experience, preferably within the I/DD Waiver program • Knowledge of the I/DD Waiver program policies and procedures • Excellent customer service and communication skills • Ability to multi-task and prioritize activities • Proficiency with Microsoft Office and other programs • Must reside in West Virginia
Lead IDDW Provider Educator	**Responsibilities:** The Lead I/DD Waiver Provider Educator provides operational oversight to the I/DD Waiver Provider Educator Team to achieve service deliverables for utilization management, provider education, and customer service related to the I/DD Waiver program. The Lead Provider Educator provides general supervision, coordinates inter-rater reliability functions, and establishes team policies and procedures. They coordinate the I/DD Waiver Quality Improvement Advisory Council quarterly meetings, Quarterly Provider Meetings, and required provider/stakeholder training. This position also develops and maintains operational guidelines, prepares monthly reports, and identifies, develops, and implements staff training across the I/DD Waiver Team. **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field • 2 or more years' experience, preferably within the I/DD Waiver program • 1-2 years' leadership and supervisory experience • Knowledge of the I/DD Waiver program policies and procedures • Excellent customer service and communication skills • Ability to multi-task and prioritize activities • Proficiency with Microsoft Office and other programs • Must reside in West Virginia
IDD Waiver Provider Educator	**Responsibilities:** The I/DD Waiver Provider Educator conducts provider reviews, including completing associated reports. This individual develops and conducts training and provides technical assistance to agency providers. In this role, the Provider Educator completes inter-rater reliability tasks and special projects, as assigned. **Desired Attributes and Skillsets:**

Position/Role	Responsibilities, Attributes, and Skillsets
	• Bachelor's degree in social services, healthcare, or related field • 2 or more years' experience, preferably within the I/DD Waiver program • 1-2 years 'leadership and supervisory experience • Knowledge of the I/DD Waiver program policies and procedures • Excellent organization, customer service, and communication skills • Ability to multi-task and prioritize activities • Proficiency with Microsoft Office and other programs • Must reside in West Virginia
Lead IDDW Service Support Facilitator	**Responsibilities:** The I/DD Waiver Service Support Facilitator (SSF) Lead provides training, direction, and staff management to achieve service deliverables related to re-evaluation I/DD Waiver assessments. The Lead SSF provides general supervision, coordinates inter-rater reliability functions, and establishes and/or refines team policies and procedures. This individual provides operational oversight to ensure contract deliverables are achieved related to SSF and other functions. This individual develops, maintains, and refines operational guidelines. The Lead SSF provides leadership and supervision to staff as well as reviews performance measures, and if necessary, problem-solve to improve deliverables performance. This individual manages and oversees the I/DD Waiver eligibility processes and reports including liaison with Medical Eligibility Contract Agent, completing monthly reports, managing slots released, processing special requests related to eligibility. **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field, a Master's degree is preferred • 2 or more years' experience, preferably within the I/DD Waiver program • 1-2 years' leadership and supervisory experience • Knowledge of the I/DD Waiver program policies and procedures • Excellent organization and communication skills • Ability to multi-task and prioritize activities • Flexible and open to learning new skills • Proficiency with Microsoft Office and other software • Must reside in West Virginia
IDD Service Support Facilitator	**Responsibilities:** The I/DD Waiver Service Support Facilitator (SSF) performs assessments of I/DD Waiver members for the purpose of determining their individualized budgets which are utilized by the member's planning team to purchase the services necessary to support the individual in the community. Assessments are also used to determine re-eligibility into the program each year. This position manages a large caseload of assigned members. The I/DD Waiver Service Support Facilitator schedules, conducts, and appropriately documents member

Position/Role	Responsibilities, Attributes, and Skillsets
	assessments within prescribed timelines. This individual enters assessment data into designated systems and participates in inter-rater activities to ensure consistency in the administration of the assessment instruments and adherence to assessment protocols. The I/DD Waiver Service Support Facilitator participates in monthly I/DD Waiver staff meetings, quarterly all-staff meetings, and other required trainings and meetings, as necessary. **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field • Certification as a Qualified Mental Retardation Professional (QMRP). • 2 years' experience with the I/DD Waiver population • Medicaid/Public Sector service experience is preferred • Knowledge of I/DD Waiver program policies and procedures as well as other programs/services available to program members • Knowledge of person-centered planning fundamentals • Familiarity with computer applications and be able to navigate through multiple screens • Ability to maintain confidentially standards and HIPAA compliance when evaluating all pertinent issues • Must reside in West Virginia

Table A1-3. WV Medical, IDD, and Behavioral Health Job Descriptions

Each WV Medical, IDD, and Behavioral Health position has specific responsibilities, skills, and attributes to support success in providing the service and support that meets WV DHHR's expectations.

1.4 Administrative Services Team

Job descriptions for the WV Administrative Services team positions are presented in **Table A1-4 Administrative Services Job Descriptions** below:

- Customer Service Representative
- Training Specialist

Position/Role	Responsibilities, Attributes, and Skillsets
Customer Service Representative	**Responsibilities:** The Customer Service Representative (CSR) provides a broad range of administrative support to multiple departments. Their duties include answering telephone, screening, and directing calls appropriately, while establishing a client record for all applicants. The CSR handles and tracks queries from providers and members related to program and service eligibility and resolves issues or refers the issue to the appropriate party for resolution within established timelines. The CSR processes and generates correspondence related to program and service eligibility and prior authorization of services within specified timelines,

Position/Role	Responsibilities, Attributes, and Skillsets
	including completing the required tracking. Additionally, they research, investigate, and assist providers in ensuring appropriate resolution and tracking of inquiries related to prior authorization status. They document activities and log inquiry and complaint information within established timelines and protocol. They also perform other duties as assigned to ensure contract deliverables are complete and within required timelines, which includes assisting other departments as necessary to meet contract deliverables. **Desired Attributes and Skillsets:** • High school diploma or GED equivalent, an Associate's or Bachelor's degree in a human services field in preferred • 1-2 years' experience in administrative support or customer service • Experience in the medical office or other medical setting is preferred • Proficiency with Microsoft Office and other software • General knowledge of office environment and business processes • Strong organization, customer service, and verbal and written communication skills to effectively communicate with team members and external customers • Basic data entry skills • Ability to meet established workload standards • Ability to work well with management and team members to contribute to the achievement of departmental goals • Ability to multi-task and prioritize activities • Must reside in West Virginia
Training Specialist	**Responsibilities:** The Training Specialist provides training and technical assistance to all providers as requested, either onsite or via webinar. The Training Specialist will conduct regional and statewide training that provides efficient and accurate information that directly affect Kepro and our stakeholders. As needed, the Training Specialist will participate in the outreach and education of other stakeholders including members, families, and program participants. The Training Specialist prepares training materials and other educational materials for various stakeholder audiences as necessary and prepares and updates materials on the Kepro website. They participate in monthly Training Specialist meetings, quarterly all-staff meetings and other required meetings as needed. The Training Specialist conducts the Youth Services Survey/Youth Services Survey-Family (YSS/YSS-F) and Mental Health Statistics Improvement Program (MHSIP) surveys to youth, families and adults receiving mental health services. They also work with the team in compiling and analyzing the data to report to the BBH. **Desired Attributes and Skillsets:** • Bachelor's degree in a related field • Excellent verbal and written communication skills • Proficiency with Microsoft Office and other software

Position/Role	Responsibilities, Attributes, and Skillsets
	• Ability to work independently to meet timelines and expectations • General knowledge of the needs of the population being served • Ability to interact appropriately with providers who may be hostile or upset • Must reside in West Virginia

Table A1-4. Administrative Services Job Descriptions

Each WV Administrative Services position has specific responsibilities, skills, and attributes to support success in providing the service and support that meets WV DHHR's expectations.

1.5 Information Technology Team

Job descriptions for the WV Information Technology team positions are presented **in Table A1-5. Information Technology Job Descriptions** below:

- Data Integration and Analytics Data Analyst
- Reporting Specialist
- Technical Liaison

Position/Role	Responsibilities, Attributes, and Skillsets
Data Analyst	**Responsibilities:** The Data Analyst champions the quality and integrity of data collected and ensures consistent reporting of information. Through analyses of data, this individual identifies data integrity gaps, takes correction action, or makes recommendations to management for data improvement opportunities. The Data Analyst assesses the information needs of customers, develops meaningful ad-hoc and production reports to meet those needs, and writes high quality documentation. Furthermore, they facilitate design and creation of data collection and reporting tools with co-workers and customers. The Data Analyst collaborates and works with Kepro corporate IT team (for example, requirements gathering for new systems). This individual also works with the methodology, code, and specifics of routine reports to provide technical assistance and/or training to the provider users and staff regarding the Kepro systems, local operations databases, and reporting. **Desired Attributes and Skillsets:** • Bachelor's degree in computer science or related field • Experience in the healthcare industry • Ability to analyze and plan database design, structure, and development • Working knowledge of relational databases and report writers (such as Crystal Reports) • Proficiency with Microsoft Office and other programs

Position/Role	Responsibilities, Attributes, and Skillsets
	• Commitment to maintaining strict confidentiality and adherence to all policies and procedures • Must reside in West Virginia
Reporting Specialist	**Responsibilities:** The Reporting Specialist is responsible for obtaining the internal and external customers' ad hoc and routine reports' specifications, completing requirements, gaining customers' approval of requirements, developing, testing, demonstrating/sharing with customers, generating reports as scheduled and delivering reports. Primary sources of data are utilization management databases, Medicaid eligibility data, and claims data They are responsible for the methodology, code, and specifics of routine reports. The Reporting Specialist must acquire a working knowledge of all databases and data sources to provide technical assistance and realize the data needed to compile requested reports. **Desired Attributes and Skillsets:** • Bachelor's degree in computer science or related field or a combination of experience and education (such as an Associate degree and experience with WV-Medicaid). • Experience in healthcare is preferred • Ability to multi-task and prioritize activities to meet due dates • Ability to work within a team yet achieve individual objectives • Mastery of a minimum of one reporting software such as Crystal, SQL, Access (pre-hiring testing is required) • Proficiency with Microsoft Office and other programs (subject to pre-hire testing) • Valid driver's license required • Must reside in West Virginia
Reporting Specialist	**Responsibilities:** The Reporting Specialist is responsible for obtaining the internal and external customers' ad hoc and routine reports' specifications, completing requirements, gaining customers' approval of requirements, developing, testing, demonstrating/sharing with customers, generating reports as scheduled and delivering reports. Primary sources of data are utilization management databases, Medicaid eligibility data, and claims data They are responsible for the methodology, code, and specifics of routine reports. The Reporting Specialist must acquire a working knowledge of all databases and data sources to provide technical assistance and realize the data needed to compile requested reports. **Desired Attributes and Skillsets:** • Bachelor's degree in computer science or related field or a combination of experience and education (such as an Associate degree and experience with WV-Medicaid). • Experience in healthcare is preferred • Ability to multi-task and prioritize activities to meet due dates • Ability to work within a team yet achieve individual objectives

Position/Role	Responsibilities, Attributes, and Skillsets
	• Mastery of a minimum of one reporting software such as Crystal, SQL, Access (pre-hiring testing is required) • Proficiency with Microsoft Office and other programs (subject to pre-hire testing) • Valid driver's license required • Must reside in West Virginia

Table A1-5. Information Technology Job Descriptions

Each WV Information Technology position has specific responsibilities, skills, and attributes to support success in providing the service and support that meets WV DHHR's expectations.

1.6 HH, CSED, QRTP and TBI Waiver Team

Job descriptions for the WV HH, CSED, QRTP and TBI Waiver team positions are presented in **Table A1-6. HH, CSED, QRTP and TBI Waiver Job Descriptions** below:

- BSS Care Manager
- Health Homes Manager
- UM Coordinator – HH
- QRTP Service Support Facilitator
- School Based Health Trainer Consultant
- BSS Out of State Residential Reviews Case Reviewer
- TBI Waiver (TBIW) Manager
- TBIW Assessment Coordinator
- TBIW Provider Educator
- CSED Waiver and Wraparound Services Provider Educator
- Lead Service Support Facilitator
- Service Support Facilitator
- Tiered Foster Care Case Reviewer

Position/Role	Responsibilities, Attributes, and Skillsets
BSS Care Manager	**Responsibilities:** The BSS Care Manager is responsible for staff management and related deliverables. The BSS Care Manager ensures that CSED, QRTP, TBIW, and other assigned functions are performed to established standards and contract requirements. This Manager effectively manages the operations to meet contract deliverables. They provide leadership and supervision to staff assigned to contract and provide consultation in area of expertise. This Manager continually assesses policy and procedures to ensure a high level of customer satisfaction to all stakeholders. This Manager also monitors, evaluates, and recommends changes as needed.

Position/Role	Responsibilities, Attributes, and Skillsets
	Desired Attributes and Skillsets: • Master's degree in social work, counseling, or psychology • Valid WV license as a Registered Nurse, Social Worker, Professional Counselor, Rehabilitation Counselor, Psychologist, or similar • 2 or more years' experience related to child welfare, behavioral health services, utilization management and systems planning • 1-2 years' leadership and/or supervisory experience • Knowledge of best practices in child welfare, waiver programs, utilization management and provider education • Excellent organization, customer service, and communication skills • Proficiency with Microsoft Office and other software • Must reside in West Virginia
Health Homes Manager	**Responsibilities:** The Health Homes (HH) Manager designs, implements, and directs the day-to-day operations for the Health Homes Program. The HH Manager consults, refines, and expands the Health Homes project. Specific functions of the role include leading the implementation of the program across various departments/stakeholders, as well as on-going coordination and consultation with the Agency for the design, implementation, policy development and roll out of additional HH projects. The HH Manager will ensure all Kepro functions are performed to established standards and contract deliverables are met including daily operations and staff supervision. **Desired Attributes and Skillsets:** • Associate degree in Nursing, a Bachelor's degree in Nursing is preferred • Valid WV Registered Nurse license • 2 or more years' experience working with Medicaid and/or Medicare Programs, utilization management programs, and providers and other stakeholders • Utilization management skills with Medical and/or behavioral service requests • Ability to research, design and implement policies per the client's requirements • Ability to design, prepare and present training/education to providers and related stakeholders • Knowledge of Medicaid software applications and development • Experience with care coordination, and performing clinical records reviews • Must reside in West Virginia
UM Coordinator – HH	**Responsibilities:** The Health Homes UM Coordinator provides primary non-clinical program support to the Health Homes Program. This position supports the clinical and clerical medical staff with day-to-day functions as well as performing primary customer service and training functions. The HH UM Coordinator provides telephone support to external providers,

Position/Role	Responsibilities, Attributes, and Skillsets
	agencies, and facilities; provides technical support and specific training both via webinar and on-site with the provider; and manages communications with providers and/or members. This support role will perform special projects as needed to improve customer service; as well as other duties as assigned to meet business needs. This individual provides customer service, call triaging, authorization preparation, and data entry. They are responsible for editing and final quality check of training and other materials. **Desired Attributes and Skillsets:** • High school diploma or GED equivalent, an Associate or Bachelor's degree in a related field in preferred • 2-3 years in an administrative support or customer service position • Familiarity with health care, government structure, and preferably WV Medicaid • Knowledge of the office environment and business processes, as well as an understanding of the customer service approach for medical provider stakeholders • Proficiency with Microsoft Office and other software, including Word, Excel, and PowerPoint • Must reside in West Virginia
Service Support Facilitator, QRTP	**Responsibilities:** The QRTP Service Support Facilitator (SSF) answers calls from community members seeking support to ensure their child is receiving the proper level of behavioral health services. They assess the child/family via the telephone and/or face-to-face to gain information to determine which level of care best meets the child's needs. This individual develops, processes, conducts, and appropriately documents member assessments within prescribed timelines. They develop assessment data and enter it into the web-based system. Additionally, they develop in and participate in inter-rater activities to ensure consistency in the administration of the assessment instruments and adherence to assessment protocols. The Service Support Facilitator develops and conducts training with provider agencies and other stakeholders as needed, as well as completing special projects as assigned. **Desired Attributes and Skillsets:** • Bachelor's degree in human or social services, healthcare, or related field • 2 or more years' experience working with children receiving mental health service • Knowledge of child welfare, behavioral health, and Medicaid policies and procedures • Clinical interviewing and assessment skills

Position/Role	Responsibilities, Attributes, and Skillsets
	• Knowledge of person-centered planning fundamentals and a familiarity with computer applications, including the ability to navigate through multiple screens • Ability to maintain strict confidentially standards and HIPAA compliance when evaluating all pertinent issues • Must reside in West Virginia
• **School Based Health Trainer Consultant**	**Responsibilities:** The School-based Health Trainer/Consultant conducts consultative retrospective reviews of medically necessary services funded by Medicaid to ensure compliance with contractor requirements. This position focuses on school-based health programs that receive Medicaid or other public funding. The Trainer/Consultant also provides training and technical assistance to providers as requested. This individual provides necessary information to Kepro care management staff as well as alerting appropriate agencies regarding provider concerns. The Trainer/Consultant conducts and documents provider retrospective reviews within established time frames using establish UM guidelines, Medicaid manuals, and/or BSS manual. They provide training and technical assistance to providers and identify training needs. Additionally, this individual interfaces with Kepro and Agency staff regarding consultative reviews. Finally, they participate in monthly TC meetings, quarterly all-staff meetings, and other required meetings as needed. **Desired Attributes and Skillsets:** • Master's degree in social work, counseling, or psychology • Valid WV license as a Registered Nurse, Social Worker, Professional Counselor, Rehabilitation Counselor, Psychologist, or similar • 1-2 years' experience direct practice with consumers or a be a WV licensed Registered Nurse • Knowledge of best practice guidelines, the needs of the population being served, and the Health Information Privacy and Portability Act (HIPAA) • Ability to review and analyze documentation against established standards • Written and verbal communication skills to adequately communicate findings and recommendations to providers • Must reside in West Virginia
Case Reviewer, BSS Out of State Residential Reviews	**Responsibilities:** The Case Reviewer, BSS Out-of-State Residential Reviews, performs education and initial/re-evaluation assessments of participants for the purpose of determining program medical eligibility. The Case Reviewer conducts, and documents, medical assessments in person and by telephone within prescribed timelines. They schedule assessments within prescribed timelines, participate in inter-rater reliability activities, and participate in denial hearings, as necessary. Additionally, the Case Reviewer contacts physicians and facilities to confirm medical information and perform other duties as needed.

Position/Role	Responsibilities, Attributes, and Skillsets
	Desired Attributes and Skillsets: • Associate degree in Nursing, a Bachelor's degree in Nursing is preferred • Valid WV Registered Nurse license • 2 or more years' experience with the aging population and/or persons with disabilities (preferably working within the WV Aged and Disabled Waiver program and Aged Disabled Waiver system) • Knowledge of the WV Aged and Disabled Waiver policies and procedures • Ability to travel to homes and facilities within and outside State borders and work independently • Excellent organization, customer service, and communication skills • Capability to accurately assess medical conditions, symptoms, and functional abilities • Proficiency with Microsoft Office and other software • Must reside in West Virginia
TBIW Manager	**Responsibilities:** The Traumatic Brain Injury Waiver (TBIW) Manager provides direction to staff to support achievement of service deliverables. The TBIW Manager provides general supervision, coordinates inter-rater reliability functions, prepares reports, and establishes team policies and procedures. The TBIW Manager provides operational oversight of the TBIW Assessment Coordinator and Provider Educator job functions. The TBIW Manager develops, maintains and/or refines operational guidelines, and they also provide leadership and supervision to staff. They review performance measures and problem-solve to improve deliverables, when necessary. This individual develops and conducts inter-rater reliability activities with the staff. The TBIW Manager completes the Care Management review of program participants' prior authorization requests within established timeframes for TBI Waiver services. They manage and oversee the TBI Waiver medical eligibility processes initial and re-evaluations, and they also manage and oversee the various TBI Waiver Provider reviews. **Desired Attributes and Skillsets:** • Master's degree in social work, nursing, rehabilitation counseling, or counselling • Valid WV license as a Registered Nurse, Social Worker, Professional Counselor, Rehabilitation Counselor, Psychologist, or similar • 1-2 years' experience working with individuals with disabilities, Medicaid or public sector experience strongly preferred • 1-2 years' leadership and/or supervisory experience • Knowledge of the TBI Waiver program policies and procedures • Excellent organization and written and verbal communication skills • Ability to multi-task and prioritize activities • Proficiency with Microsoft Office and other software

Position/Role	Responsibilities, Attributes, and Skillsets
	• Must reside in West Virginia
TBIW Assessment Coordinator	**Responsibilities:** The TBIW Assessment Coordinator performs initial and re-evaluation medical eligibility assessments for TBI Waiver applicants and/or members for the purposes of determining program medical eligibility. The Assessment Coordinator also provides education to applicants/members on covered services, service delivery options, and rights and responsibilities. They facilitate training regarding recognizing and reporting abuse, neglect, and exploitation, which is conducted annually during the member's re-evaluations. The Assessment Coordinator conducts the Pre-Admission Screening Assessment and the Rancho Los Amigos Scale and reviews supporting medical documentation to verify assessment observation and findings. The Assessment Coordinator manages a caseload of assigned members to ensure that assessments are scheduled, appropriate persons are in attendance, assessments are performed, and medical eligibility determinations are rendered in prescribed timelines. The Assessment Coordinator participates in inter-rater reliability activities to ensure consistent administration of assessments and adherence to assessment protocols. They also participate in denial hearings, as necessary. **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field, a Master's degree preferred • Valid WV license as a Registered Nurse, Social Worker, Professional Counselor, Rehabilitation Counselor, Psychologist, or similar • Certification as a Certified Brain Injury Specialist (CBIS) • Minimum of 1 year of experience working with individuals with disabilities • Capability to accurately assess medical conditions, symptoms, and functional abilities • Must reside in West Virginia
TBIW Assessment Coordinator	**Responsibilities:** The TBIW Assessment Coordinator performs initial and re-evaluation medical eligibility assessments for TBI Waiver applicants and/or members for the purposes of determining program medical eligibility. The Assessment Coordinator also provides education to applicants/members on covered services, service delivery options, and rights and responsibilities. They facilitate training regarding recognizing and reporting abuse, neglect, and exploitation, which is conducted annually during the member's re-evaluations. The Assessment Coordinator conducts the Pre-Admission Screening Assessment and the Rancho Los Amigos Scale and reviews supporting medical documentation to verify assessment observation and findings. The Assessment Coordinator manages a caseload of assigned members to ensure that assessments are scheduled, appropriate persons are in attendance, assessments are performed, and medical eligibility determinations are

Position/Role	Responsibilities, Attributes, and Skillsets
	rendered in prescribed timelines. The Assessment Coordinator participates in inter-rater reliability activities to ensure consistent administration of assessments and adherence to assessment protocols. They also participate in denial hearings, as necessary. **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field, a Master's degree preferred • Valid WV license as a Registered Nurse, Social Worker, Professional Counselor, Rehabilitation Counselor, Psychologist, or similar • Certification as a Certified Brain Injury Specialist (CBIS) • Minimum of 1 year of experience working with individuals with disabilities • Capability to accurately assess medical conditions, symptoms, and functional abilities • Must reside in West Virginia
Provider Educator, CSED Waiver and Wraparound Services	**Responsibilities:** The CSED Waiver and Wraparound Services Provider Educator conducts provider reviews, including completing associated reports. This individual develops and conducts training and technical assistance with agency providers, and completes special projects as assigned. This Provider Educator conducts agency provider reviews, completes, and submits reports associated with provider reviews, and develops and conducts training with provider agencies and other stakeholders as needed/assigned. Additionally, the Provider Educator conducts technical assistance with provider agencies as required or requested and completes inter-rater reliability tasks as assigned. Finally, they complete special projects and other duties as assigned **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field • 2 or more years' experience working with children receiving mental health service • Knowledge of the Medicaid program policies and procedures • Excellent organization, customer service, and communication skills • Proficiency with Microsoft Office and other software • Ability to maintain strict confidentially standards and HIPAA compliance when evaluating all pertinent issues • Must reside in West Virginia
Lead Service Support Facilitator (SSF), CSED Waiver and Wraparound Services	**Responsibilities:** The Lead CSED Waiver and Wraparound Services SSF provides training, direction, and staff management to achieve service deliverables for eligibility CSED Waiver and Wraparound Services assessments. The Lead SSF provides general supervision, coordinates inter-rater reliability functions, es and/or refines team policies and procedures, and handles provider and customer relations. Specifically, the Lead SSF provides operational oversight to ensure contract deliverables

Position/Role	Responsibilities, Attributes, and Skillsets
	are achieved. They develop, maintain, and/or refine operational guidelines, while providing leadership and supervision to the staff. The Lead SSF reviews performance measures and problem-solves to improve deliverables, when necessary. They also develop and conduct inter-rater reliability activities with staff, as well as manage and oversee the CSED Waiver and Wraparound Services eligibility processes and reports. This includes liaising with the Medical Eligibility Contract Agent, completing monthly reports, managing slots released, and processing special requests related to eligibility. **Desired Attributes and Skillsets:** • Master's degree in social work, counseling, or psychology • 2 years' experience with assessment of similar population • 1-2 years' leadership and/or supervisory experience required, project management experience is preferred • Proficiency with Microsoft Office and other software • Knowledge of the CSED Waiver and Wraparound Services programs' policies and procedures • Excellent organization and written and verbal communication skills • Ability to multi-task and prioritize activities • Flexible and open to learning new skills and tasks • Must reside in West Virginia
Service Support Facilitator, CSED Waiver and Wraparound Services	**Responsibilities:** The CSED Waiver and Wraparound SSF performs assessments of members for CSED Waiver and Wraparound services. Assessments are also used to determine re-eligibility into the program. The Service Support Facilitator schedules, conducts and appropriately documents member assessments within prescribed timelines. This individual enters assessment data into designated systems and participates in inter-rater activities to ensure consistency in the administration of the assessment instruments and adherence to assessment protocols. The SSF participates in monthly staff meetings, quarterly all-staff meetings, and other required training and meetings as necessary **Desired Attributes and Skillsets:** • Bachelor's degree in social services, healthcare, or related field • 2 years' experience with working with children receiving mental health service • Knowledge of child welfare, behavioral health, and Medicaid policies and procedures • Knowledge of person-centered planning fundamentals and a familiarity with computer applications, including the ability to navigate through multiple screens • Ability to maintain strict confidentially standards and HIPAA compliance when evaluating all pertinent issues • Must reside in West Virginia

Position/Role	Responsibilities, Attributes, and Skillsets
Case Reviewer, Tiered Foster Care	**Responsibilities:** The Case Reviewer, Tiered Foster Care, performs education and initial/re-evaluation assessments of participants for the purpose of determining program medical eligibility for tiered foster care services. Specifically, Case Reviewer conducts, and documents, medical assessments in person and by telephone within prescribed timelines. They schedule assessments within prescribed timelines, participate in inter-rater reliability activities, and participate in denial hearings as necessary. Additionally, the Case Reviewer contacts physicians and facilities to confirm medical information and perform other duties as needed. **Desired Attributes and Skillsets:** • Associate degree in Nursing, a Bachelor's degree in Nursing is preferred • Valid WV Registered Nurse license • 2 or more years' experience with similar population and/or persons with disabilities (preferably working within the WV program) • Knowledge of the WV policies and procedures • Ability to travel to homes and facilities within and outside State borders and work independently • Excellent organization, customer service, and communication skills • Capability to accurately assess medical conditions, symptoms, and functional abilities • Proficiency with Microsoft Office and other software • Must reside in West Virginia

Table A1-6. HH, CSED, QRTP and TBI Waiver Job Descriptions

Each WV HH, CSED, QRTP and TBI Waiver position has specific responsibilities, skills, and attributes to support success in providing the service and support that meets WV DHHR's expectations.

Attachment 2 Kepro Resumes for Named Staff

This Exhibit contains the resumes for each named staff of our named West Virginia team (shown in Section 4.3.1.1 of our proposal) and demonstrates our staff meet the requirements of the RFP.

2.1 Key Staff

Our key staff positions for the program, which include our core management staff, are in-place today and meet the RFP requirements for their position. Kepro is pleased to present resumes for our key staff that detail their education, licenses, skills, and experience:

- Nancy Sullivan, MAJ – Executive Director
- Melody Cottrell, MSN, APRN, FNP-BC – Project Manager, Long Term Care Services
- Emily Proctor, MA, LPC, AADC, CEAP – Project Manager, Medical, IDD, and Behavioral Health Services
- Amber Murphy – Project Manager, Administrative Services
- Rebecca (Becky) Jamnick, MSW – Project Manager, Information Technology
- Caroline Duckworth MSW, LCSW – Project Manager, HH, CSED, QRTP, and TBI Waiver Services

Nancy Sullivan, MAJ

Executive Director

PROFILE

Ms. Sullivan is a healthcare management professional with more than 19 years in the space. In her leadership roles, she has provided direct oversight of people, personnel, and resources related to state healthcare programs. This has included implementation, oversight, and managing deliverables. Her experience with business management functions include responsibility over budgeting and staff.

PROFESSIONAL WORK HISTORY

Kepro, WV DHHR ASO Contract

Executive Director, WV DHHR | 2019 – Present

- Responsible for the implementation, direction, oversight, and management of all deliverables for the various programs of the WV Department of Health and Human Resources Administrative Services Organization (ASO) contract.
- Ensure that all the ASO functions are performed to the highest standards and meets or exceeds contract requirements and customer expectations.
- Oversee the design, development, and implementation of all programs.
- Serve as the liaison and primary contact for state, regional and community stakeholders.
- Responsible for all business management functions including budgeting and staffing.
- Guide the program strategy, vision and leadership and team development.

Kepro, WV DHHR ASO Contract

Assistant to the Cabinet Secretary | 2010 – 2019

- Represented the Cabinet Secretary with national, state, and local agencies; public and private groups; and interested parties and advised of issues, concerns or opportunities that may affect the operation of the department.
- Researched, monitored, and evaluated programs, issues, and events to support department services and initiatives.
- Convened and coordinated public and private stakeholders to pursue funding opportunities to provide services in a coordinated and cost-efficient manner.

Acting Commissioner | 2017 – 2018

- Managed multi-site department across five worksites with 300+ department clinical and non-clinical staff
- Promoted an effective, collaborative approach to work product, quality outcomes, program development, customer service and targeted metrics

EDUCATION

Masters, Journalism
Marshall University, 1987

Bachelor's, Public Relations
Marshall University, 1984

ACCOMPLISHMENTS

Board member: Affordable Housing Trust, 2013 – 2018
Cabell Huntington Coalition for the Homeless, 2003 to 2013
President of the American Heart Association's Charleston Metro Board of Directors, 2001 to 2003
National accommodation "Outstanding Club President" for the Huntington Kiwanis Club, 1993-94

Melody Cottrell, MSN, APRN, FNP-BC

Project Manager, Long Term Care Services

PROFILE

Ms. Cottrell is a registered nurse that has worked and coordinated a variety of healthcare settings for more than 20 years. In leadership positions Ms. Cottrell oversees dozens of staff as well as ensures contract and performance deliverables are met and exceeded.

PROFESSIONAL WORK HISTORY

Kepro, WV ASO Contract

Program Director, Long-term Care Department | 2015 – Present

- Providing operational oversight to certify contract deliverables are met for the WV Nursing Facility Program, Personal Care Program, and Aged and Disabled Waiver Program.
- Developing and maintaining operational guidelines.
- Providing leadership and supervision to staff.
- Reviewing performance measures and problem solving to improve work processes when necessary.
- Developing and conducting inter-rater reliability activities. Completing quality home assessments with staff.
- Collaboration with current program managers to provide support, employee training, process development, and policy implementation.
- Extensive experience with Care Connection© and Atrezzo. Proficient with technical assistance, testing system updates, training, and offering new developments.

Clay Development

Case Manager and Personal Care RN | 2011 - 2015

- Provided case management to Aged and Disabled Waiver program members.
- Managed clients for the Personal Care Program/WV Traumatic Brain Injury Waiver Program.
- Obtained authorizations for each program per policy.
- Maintained regular contact with clients and completed home visits per program policy.

Patel and Patel MD Inc

Nurse and Clinical Coordinator | 2008 – 2012

- Worked with Leela & Kiran Patel to provide direct care to women, children, and families.
- Scheduled Test and Completed Referrals.
- Assisted with in office procedures and medical examinations.
- Provided Case Management to Family Practice Patients.
- Assessed need for, ordered, obtained, and interpreted appropriate lab tests.
- Effective counseling in health maintenance and disease management.
- Clinical Coordinator who provided in-sight and management of the medical office staff and workflow.

EDUCATION

Master of Science, Nursing, Family Nurse Practitioner
Marshall University

Bachelor of Science, Nursing; Registered Nurse
Davis and Elkins College

LICENSURE/CERTIFICATION

Current RN License – Active Status [redacted]
APRN-CNP License – Active Status

LPN Certificate, Garnet Career Center – 2007
BLS Certification

Emily Proctor, LPC, AADC, CEAP

Project Manager, Medical, IDD, and Behavioral Health Services

PROFILE

Ms. Proctor is a licensed professional counselor with more than 20 years of experience in healthcare programs. Ms. Proctor directs numerous behavioral health and other programs, overseeing staff, program design and implementation, as well as performance and quality improvement to ensure contract requirements are met.

PROFESSIONAL WORK HISTORY

Kepro, WV DHHR ASO Contract

Director of Medical Services, Behavioral Health, Substance Use Disorder (SUD)Waiver, and I/DD Waiver Programs | 2001 – Present

- Director of Medical Services beginning July 2021. Interim Director from October 2020 - July 2021
- Operational oversight of clinical staff for Utilization Management and Case Management functions
- Maintain and enhance relationships with DHHR Contract Managers, Physicians, and corporate staff
- Implementation and ongoing management of submission platforms for Medical, IDD, and Behavioral Health services
- Director of Behavioral Health, Substance Use Disorder (SUD) Waiver, and I/DD Waiver Programs
- Direct behavioral health staff related to prior authorization functions, provider retrospective documentation reviews and trainings
- Participate in State requested meetings, policy discussion, and planning regarding behavioral health, SUD, and I/DD Wavier programs. Contract management for each of the program areas to ensure operational goals are achieved
- Manage WV Medicaid's I/DD Wavier program to ensure smooth daily operations with the expectation of excellence, quality assurance/improvement, consistency and customer service; Daily processes include: Eligibility assessments, individualized budgeting (I/DD), authorization reviews, provider utilization and quality reviews, inter-rater reliability, developing and implementing quality measures for internal and external deliverables, data collection/analysis for state, federal and ad hoc reporting, training development/implementation and technical assistance
- Behavioral Health Team Leader
- Provide oversight of staff determining medical necessity for WV Medicaid behavioral health services
- Develop, maintain, and distribute utilization management guides, operational instructions, and provider reference documents
- Interface with IT on customization of the CareConnection© including design, development, and end-user testing

Behavioral Health Care Manager

- Integrate clinical information presented by providers to determine medical necessity for services provided under the West Virginia Medicaid Clinic, Rehabilitation, Targeted Case Management and Private Practitioner Options
- Provide continual review of provider's utilization management systems, implement provider technical assistance and training, and encourage adherence with clinical best practice parameters for services
- Renegotiate services requested utilizing current clinical parameters in the event medical necessity is not demonstrated

Thomas Memorial Hospital

Per Diem Social Worker

- Completed psychosocial assessments, develop therapeutic plans for treatment, and implemented discharge planning
- Implemented intensive and educational groups for dual diagnosis population
- Crisis on-call team member utilizing community/private referral sources

EDUCATION

Masters, Counseling and Rehabilitation
Marshall University

Bachelors, Psychology
West Virginia Wesleyan College

LICENSURE/CERTIFICATION

WV Licensed Social Worker (currently inactive status)
WV Licensed Professional Counselor [redacted]

WV Advanced Alcohol and Drug Counselor [redacted]
Certified Employee Assistance Professional [redacted]

Amber R. Murphy

Project Manager, Administrative Services

PROFILE

Ms. Murphy is an administrative services professional with 18 years of experience providing administrative support and leadership to healthcare management programs within West Virginia. As an administrative services leader, Ms. Murphy supervises numerous staff and oversees program Service Center operations. MS. Murphy is also adept in program finances and liaises with leadership in personnel, budgeting, and facilities management.

PROFESSIONAL WORK HISTORY

Kepro, WV DHHR ASO Contract

Director of Administrative Services, WV DHHR | 2019 – Present

- Supervision of 8 full time administrative assistants
- Provide leadership and guidance on financial (track revenues and expenses)
- Work collaboratively with the leadership team serving as a liaison and representative in areas of finance, budgeting, personnel, and facilities management.
- Ensure administrative processes and daily Service Center operations run smoothly, including managing communications within the organization and with external stakeholders.
- Develop and manage the implementation and maintenance of administrative policies and procedures; managing special projects; leading financial underwriting of new programs
- Quality Improvement Manager - Lead the LQIC committee meetings, facilitate the annual review of local level policies and procedures, and coordinate our annual QIP.

APS Healthcare, Inc.

Office Manager, WV DHHR | 2005 – 2019

- Supervision of 3 full time administrative assistants
- Responsible for the tracking, review, and analysis of all financials for entire contract.
- Prepares monthly reports of changes to the Executive Director and assist in the preparation of annual budget.
- Ensure timely processing of payment to vendors.
- Ensures proper handling and safeguarding of classified, confidential, private, or sensitive material.
- Responsible for supporting the clinical needs of other waiver staff, e.g., data entry, releasing budgets to the web, distributing documentation to appropriate parties.
- Administrative Assistant, WV DHHR | 2004 – 2005
- Provided a broad range of administrative support to behavioral health outpatient department.
- Supported numerous office employees with day-to-day office functions, training, and clinical support functions (e.g., data entry and report tracking) and performed functions to support external member access to APS staff and services.
- Prepared Weekly Reports of Trainer/Consultant activity

EDUCATION

Bachelor of Science, Health Service Administration
West Virginia University Institute of Technology

Associate of Science, Office Technology Management
West Virginia University Institute of Technology

Rebecca (Becky) Jamnick, MSW

Project Manager, Information Technology

PROFILE

Ms. Jamnick leverages her 40 years of experience in clinical service as Director of IT, drawing on her years providing clinical, administrative, and operational management of clinical facilities in supporting clients.

PROFESSIONAL WORK HISTORY

Kepro, WV DHHR ASO

Director IT | 2000 – Present

- Coordination and oversight of the activities and deliverables for the Bureau of Behavioral Health (BBH) and the Contract data and reporting requirements.
- • The Scope of BBH Program includes the completion of specified block grant tables, receipt, validation, and transfer to BBH of the Comprehensive Behavioral Health Centers' BBH Data Segment (BDS), Consumer Service Data Reports (CSDR) and all CareConnection© records regardless of payer, and the coordination of mutual data updates and new activities.
- Scope of data activities includes: monthly UM reports to contractors, various summary reports of ASO activities such as Member and Applicant Satisfaction with the Waiver Assessor and the Assessment Process (ADW, TBIW, IDDW and Personal Care Services), the daily, weekly and monthly reporting of the Aged and Disabled Waiver Program's enrollment, slot releases, discharges, activations and other monitoring and managing data and the coordination/completion of ad hoc reporting and data requests from the Bureaus.

Shawnee Hills, Inc.

Medical Necessity Assessment Unit Director | 1983 – 2000

- Lead Center-wide Implementation, Monitoring, Data Management of New Directions Medical Necessity Assessment Program, Medicaid Service Coding Specialist, and direct supervision of support staff. Front Desk Functions Monitoring, Front Desk Training, MIS Report Writing.

Administrative Information Specialist
Information Services Team Member
Outpatient Clinic – Operations Manager
Director of I/DD Adult Residential Services
Director of Day Program for Adults with an Intellectual/Developmental Disability
Shawnee Hills Industries - Director
Residential Supervisor

EDUCATION

Master's Social Work
West Virginia University

Bachelors, Psychology and Sociology, Minor - Computer Science
Concord University

LICENSURE/CERTIFICATION

WV Board of Social Work - License Eligible

Caroline Duckworth, MSW, LCSW

Project Manager, HH, CSED, QRTP, and TBI Waiver Services

PROFILE

Licensed clinical social worker and trained professional with over 25 years of experience in family and social services. She has directed a wide range of programs, including programs specializing in children and youth as well as behavioral health.

PROFESSIONAL WORK HISTORY

Kepro, WV DHHR ASO Contract

Program Director | 2001 – Present

- Oversee contract performance, ensure quality assurance in Kepro deliverables for the following programs: Health Homes, Traumatic Brain Injury Home and Community Based Waiver, Tiered Foster Care, BSS funded Residential Utilization Management and Review, Children with Serious Emotional Disorder Waiver, Children's Wraparound and Residential Level of Care Assessments
- Supervise Clinical Assessor staff, Program Managers, Review Assistants and Customer Service Representatives
- Socially Necessary Services Program Manager
- Implemented the Socially Necessary Services program; oversee daily operations
- Coordinate communication between DHHR Bureau for Children and Families and Kepro regarding Socially Necessary Services Program
- Evaluate and analyze Bureau for Children and Families data, quality, and outcome measures
- Provide training and technical assistance for Child Protective Services and Youth Services DHHR workers, foster parents and biological parents
- Consult on cases in which children are involved in both child welfare and behavioral health services
- Participate in the Certificate of Need Summary Review Committee
- Children's Specialist
- Provide consultation and review of the West Virginia Children's Home to assist in becoming a Medicaid provider
- Implemented prior authorization process and provided training for out of state contracted residential providers
- Trained WV DHHR Bureau for Children and Families employees and members of the legal community on the out of state residential prior authorization process
- Developed utilization guidelines for socially necessary services provided by the Bureau for Children and Families to the Child Protective and Youth Services population
- Care Manager
- Utilized data set with knowledge of all functional assessments to prior authorize requests within a two-day timeframe

- Integrated use of diagnostic formulation, clinical assessment, and treatment plan to prior authorize medically necessary services
- Provided individualized technical assistance and training regarding implementation of Utilization Management Guidelines, Medicaid and Targeted Case Management manuals and clinical best practice parameters
- Monitored for service outliers to address possible clinical or administrative issues with providers

Master of Social Work Program, West Virginia University

Adjunct Professor

- Teach Child Welfare Continuum - administration, policy, supervision, and practice
- Field Instructor for foundation and advanced practice level students

EDUCATION

Masters, Social Work
School Counseling Program, Marshall Graduate College

Bachelor of Science, Family and Consumer Science
Shepherd College

CERTIFICATION/LICENSURE

West Virginia Temporary Licensed Social Worker, 1997
West Virginia Licensed Social Worker, May 2000
West Virginia Licensed Graduate Social Worker, June 2000
West Virginia Licensed Certified Social Worker, January 2003

Certified Child and Adolescent Functional Assessment Scales Trainer of Trainers (CAFAS)
Child Adolescent Needs and Strengths Trainer of Trainers (CANS)
WV Child Care Association Away from Supervision Trainer
Living with 10-15 Year Olds Trainer
Echo Structural Family Therapy

2.2 Resumes for Additional Named Staff

In addition to our key staff roles, we present resumes for four additional roles we deem essential to the success of the program:

- Paul Kuryla, MD – Medical Director
- Lori McGurty, MS, PMP – Transition Lead
- Wayne Bolton – IT Implementation Services Director
- Lisa Dormann – IM/IT Manager

Paul Kuryla, MD

Medical Director

PROFILE

Experienced and licensed medical doctor with 35 years of experience practicing medicine. Dr. Kuryla has practiced in a variety of healthcare settings, including a private practice, Medical Examiner's office, nursing home facilities, and in family centers. His expertise ranges from providing physician services to teaching as a Clinical Professor in a healthcare professional training program. Dr. Kuryla has also held numerous leadership positions as a Medical Director and Chief Resident in hospitals and in healthcare program offerings.

PROFESSIONAL WORK HISTORY

Kepro, WV ASO Contract

Medical Director | 2019 – Present

- Provides principal leadership to the operation on all medical aspects relating to the peer review process, utilization review activities, case management, and other activities requiring clinical leadership and consultation.
- Clinical line responsibilities including evaluating, redirecting, and responding to inquiries from physicians, providers, and member s.
- Analyze and remain abreast of national, state, and local regulations and legislation, which impacts the health care profession. Works with staff in addressing and meeting changing requirements
- Responsible for oversight of medical content of company publications
- Participate in activities specific to contractual arrangements, i.e., Fair Hearings
- Participate in Kepro's Quality Management Committee to ensure organization compliance
- Provide medical expertise with respect to planning and establishing goals and policies to improve medical management
- Provides oversight of physician consultants and advisors

University of Charleston, Physician Assistant Program

Adjunct Clinical Professor | 2014 - Present

West Virginia Medical Institute

Medical Director | 2005 – 2015

Dunbar Medical Associates, Private Practice

Partner | 1990 – 2015

EDUCATION

Doctor of Medicine (MD).
Marshall University School of Medicine

Bachelor of Science, Chemistry
Marshall University

LICENSURE/CERTIFICATION

Diplomate of The American Board of Family Practice, 1996-continuous recertification

Lori McGurty, MS, PMP

Transition Lead

PROFILE

Detail-oriented and self-motivated Project Management Professional with extensive operations, implementation, and project management experience related to healthcare and technology.

PROFESSIONAL WORK HISTORY

Kepro

Director of Implementations | 2017 – Present

- Project Leader for implementation of new business and corporate initiatives, specifically IT system migrations and implementations; develop team templates and best practices to create consistency, efficiency and transparency across solutions and operations
- Business Analysis - IT system, analytics, and reporting, operational BRDs, design and document operational and system workflows
- Process Automation - Recommend and build low/no code solutions to meet operational and functional business needs, including development of automations to facilitate workflows, approvals, and standardization
- Business Development - Solution Architect and content contributor for proposals with a focus on scheduling and PM tools/techniques
- Project Management - Schedule tasks, deliverables, milestones to deliver within timeline and budget; manage communication, risk, process, scope, budget, stakeholders, resources/capacity etc. across internal/external teams, executive status reporting

Kepro, WV ASO DHHR Contract

Director of Long Term Care | 2011 – 2017

- Directed all admin and ops functions, >75 staff, for 6 statewide Medicaid programs including: Intellectual and Developmental Disabilities, Aged & Disabled and Traumatic Brain Injury Waivers,
- Personal Care, Nursing Facility PAS and Take Me Home (Money Follows the Person)
- Managed client relations
- Provided system requirements, performed UAT and supported training of medical records systems
- Implemented internal QI templates and procedures, business process documentation, leadership and mentoring for managers in all departments
- Lead Provider Educator IDDW | 2010 – 2011
- Managed reviewers and processes to conduct timely retrospective reviews and provide training/technical assistance for all statewide program providers and stakeholders
- Designed on-site and self-review tools, reports, and procedures to facilitate providers' compliance with Medicaid and federal policy
- Coordinated data trending, analysis and reporting of CMS quality assurance, WV's IDDW Quality Plan
- Coordinated QI Advisory Council and statewide provider meetings and training

Provider Educator, IDD Waiver | 2006 – 2010

- Developed and implemented statewide training programs, materials, and protocols for providers of the WV I/DD Waiver program related to utilization management, compliance with federal and state regulation, electronic medical records, person-centered planning, individualized budgeting, and prior authorization
- Conducted on-site provider reviews to evaluate the quality and compliance of documentation and practice

Service Support Facilitator, I/DD Waiver | 2005 – 2006

- Part of the development team that implemented the ASO's role in the WV I/DD Waiver program
- Conducted training with a variety of stakeholders at various venues on stated topics
- Conducted assessments with program members to determine level of functioning and individualized budgets

Family Support Coordinator, Socially Necessary Services | 2004 – 2005

- Provided training and technical assistance to assist families and providers with accessing WV Medicaid Socially Necessity Services related to quality, receiving referrals, prior authorization, and service provision

EDUCATION

Master of Science, Healthcare Administration
Marshall University Graduate College

Bachelor of Arts, Communication Disorders
Marshall University

CERTIFICATION

Project Management Professional (PMP) Project Management Institute | 08/2018-08/2024
Citizen Developer Practitioner, Project Management Institute
Smartsheet Certified

Wayne Bolton, MBA

IT Implementation Services Director

PROFILE

Excellent record of developing and implementing cost effective solutions, and building and managing operations that increase operational efficiency, improve customer service levels, and support business processes. 20+ years' experience in the Healthcare field, with over fourteen years of leadership experience in Florida Medicaid Prior Authorization programs. Proven ability to spearhead organizational change and large implementation efforts–Lead an international organization from mainframe to Client/Server environment, and implemented statewide Medicaid systems in Florida, Virginia, Maryland, and Tennessee.

PROFESSIONAL WORK HISTORY

Kepro

IT Implementation Services Director | 2001 – Present

- Provide strategic leadership to all aspects of new business development and contract implementation throughout the company, evaluating new and existing technologies.
- Participate in the development of contract proposals by specifying, designing, and configuring systems to meet the needs of clients, based on collaboration with other operational departments.
- Provide project management oversight during the implementation phase of new contracts, new systems, and upgrades.
- Led the ITS implementation for several state-wide contracts, most notably the Internet based systems for utilization review of Medicaid services in Florida (AHCA), Virginia (DMAS), Maryland (DHMH), Tennessee (TennCare), South Carolina (DHHS), Minnesota (DHS), Illinois (DHS), New Hampshire (DHHS), and Wyoming(DOH).

Manager, Information Systems

Working closely with AHCA staff, specified, designed, and implemented all technology components for a "first of its kind" Internet based statewide Medicaid In-Patient Prior Authorization program, including back-office equipment, software, and Internet and frame relay circuits. Coordinated the implementations of comprehensive countywide health plan management system, and statewide Medicaid Private Duty Nursing Prior Authorization program. Assisted in the migration of a fax-based Home Health Prior Authorization program to an Internet based system. Led the specification, design, and implementation of Kepro South's Internet, Intranet, and Hospital Secure Provider Web Site portal, providing a secure, encrypted connection to Kepro South that allows access to facility-based reports, denial letters, and tools to update information remotely. Responsible for growth planning, identifying and fulfilling management and end user information needs, supporting proposal efforts, and assist the company in acquiring new business.

Myskinmd.com, Inc.

Director, Information Systems | 1998 – 2001

- Led development of websites Myskinmd.com and Dermplace.com. Hired, trained, and managed IT support staff as well as consultant developers.
- Supported major applications on development, staging, and production environments including: Broadvision One to One e-commerce engine, Interwoven Teamsite content management and code versioning system, Oracle 8i, Netscape/iPlanet web server applications running on Solaris 2.7.
- Monitored and maintained day to day operations of websites: newsfeed links, transfer of sales information to and from fulfillment house, weather map updates, other external links.

Dermatology Partners, Tampa, FL

Director, Information Systems | 1998 – 2001

- Hired, trained, and managed IT support staff of 6 (2 internal and 4 contract programmers) and supported WAN user base of 150 in 3 states.
- Consolidated 6 different practice management systems into one consolidated system to meet the needs of the corporate office as well as the individual practices.
- Developed RFP for billing and patient scheduling system that would integrate directly with SQL based financial accounting system, resulting in more timely billing, increased cash flow, and financial reports with uniform revenue stream tracking.

EDUCATION

Master of Business Administration (MBA)
University of South Florida

Bachelor of Science, Business Administration
University of South Florida

Lisa Dormann

IM/IT Manager

PROFILE

Lisa Dormann has over 10 years of experience programming custom applications and system automation. In her role at Kepro Ms. Dormann is the technical project manager for new client and system implementations. Her experience includes workflow analysis and requirements gathering to facilitate troubleshooting and system changes, conducting in-person and remote training sessions for end users as well as working directly with clients.

PROFESSIONAL WORK HISTORY

Kepro

Director, Application Services | 2015 – Present

- Manage developer staff, balancing workload requirements and priorities. Responsible for hire/fire, coaching, and performance appraisals of all staff.
- Team with operations and other technical staff to implement new clients on our existing systems, including custom work for each client.
- Work directly with clients and end users to gather requirements, provide system demonstrations, technical explanations of products, and system integrations.
- Assist executive management with the development and implementation of goals, policies, and priorities.
- Track progress of projects and system fixes by having regular update meetings with developer staff and using software to track application change requests.
- Lead regular meetings with business unit management staff to give updates on the progress of current projects.
- Work with business unit managers to analyze cost savings for new projects and make recommendations for most efficient products/applications.
- Work with data analytics team to ensure that application data elements are set up for optimum reporting performance.
- Negotiate project due dates and timelines according to business needs and staffing resources.

Highmark

Sr. Program Manager, Clinical Systems | 2014–2015

- Managed a matrix of employees and contractors who serve on project teams and within departmental work groups.
- Led project managers and work group leaders in the development and maintenance of comprehensive plans
- Reported progress on the program goals to the Vice President executive sponsor and other management as required.

- Monitored and evaluated the progress, alignment, and financial health of a cross-functional group of projects
- Assessed risks that might jeopardize successful achievement of the goals of the program. Develop risk mitigation strategies and tactics and implement risk mitigation plans when necessary.

Coventry Health Care (An Aetna Company)

Director of Operations, Support and Testing | 2013 – 2014

- Manage team of 20 business analysts and project consultants handling requirements analysis, data analysis, software development, testing, and training for internal Medicare Operations team.
- Serve as technical liaison between IT and Medicare Operations team.
- Oversee progress of projects and testing to move toward completion within defined timetables and resources.
- Develop and manage the department budget.
- Report project status and team process improvement initiatives to senior management teams.

EDUCATION

Bachelor of Science, Mathematics with Minor in Computer Science
Elizabethtown College

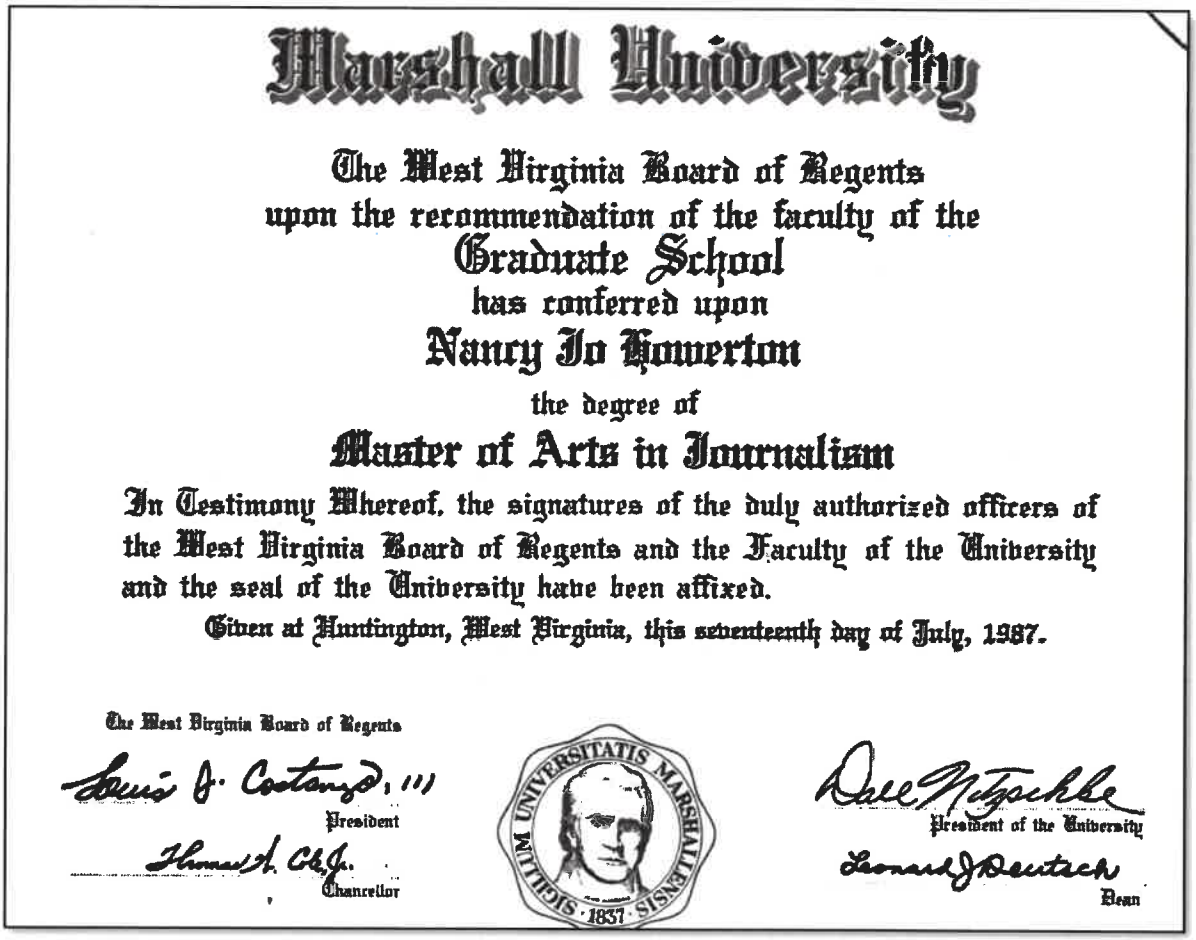
CERTIFICATIONS

Certified Scrum Master, Agile Alliance
Certified Project Management Professional, Project Management Institute

Attachment 3 Licenses and Certifications

3.1 Key and Essential Staff

The following pages includes copies of Key and essential staff certifications or degrees applicable to this project.



Marshall University

The West Virginia Board of Regents
upon the recommendation of the faculty of the
Graduate School
has conferred upon
Nancy Jo Howerton
the degree of
Master of Arts in Journalism

In Testimony Whereof, the signatures of the duly authorized officers of the West Virginia Board of Regents and the Faculty of the University and the seal of the University have been affixed.

Given at Huntington, West Virginia, this seventeenth day of July, 1987.

The West Virginia Board of Regents

President

Chancellor

SIGILLVM VNIVERSITATIS MARSHALLENSIS 1837

President of the University

Dean

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

MELODY COTTRELL

Monday, March 06 2023 02:35:55 PM

• For a more broad search, select Search by License Number or Search by NCSBN ID above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification service to request the required verification of licensure.

Contact the board of nursing for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
COTTRELL, MELODY ANN	RN	[redacted]	Active	11/10/2010	10/31/2024	Multistate	NO

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
COTTRELL, MELODY ANN	APRN-CNP	[redacted]	Active	09/09/2022	06/30/2023	N/A	NO

Advanced Practice license/recognition information

- Population Focus/Specialty:
  - Focus/Specialty: Family/individual across the lifespan
  - Has discipline: NO
  - Certification expiration date: 08/14/2027
  - Status: Active
- Prescriptive Authority:
  - Prescriptive Authority:
  - Prescriptive Authority Number:
  - Expiration Date:
  - Original Issuance Date:
  - Current Issue Date:
  - Has Discipline: NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC)

Marshall University

The University of West Virginia Board of Trustees
upon the recommendation of the faculty of the
Graduate School
has conferred upon
Emily Beth Gray
the degree of
Master of Arts

In Testimony Whereof, the signatures of the duly authorized officers of the University of West Virginia Board of Trustees and the faculty of the University and the seal of the University have been affixed.
Given at Huntington, West Virginia, this seventeenth day of December, 1993.

The University of
West Virginia Board of Trustees
Chairman

President of the University

West Virginia Certification Board for Addiction and Prevention Professionals, Inc.

Emily Proctor

having given satisfactory evidence and demonstration of knowledge, skills and competency and having met all other criteria subject to the provisions of the established standards and procedures in the State of West Virginia, is hereby authorized to use the designated credential

Advanced Alcohol and Drug Counselor

given under the hands and seal by the West Virginia Certification Board for Addiction and Prevention Professionals, Inc.

this 30th *day of* September *A.D.* 2004

Certification Board President

Certification Committee Chairperson

Certification Board Secretary

Certification Board Director

Certificate No. [redacted]

State of West Virginia
Board of Examiners in Counseling

815 Quarrier Street, Suite 212
Charleston, West Virginia 25301
(304) 558-5494

Cheryl.J.Henry@wv.gov
www.wvbec.org

Verification of West Virginia Licensure

Date Verification Created: Thursday, June 30, 2022
Verification Created by Cheryl Henry, Executive Director

NAME OF LICENSEE:	**Emily Beth Proctor**
PROFESSION:	**Licensed Professional Counselor**
LICENSE NUMBER:	[redacted]
LICENSURE STATUS:	**CURRENT**
ORIGINAL ISSUE DATE:	**01/18/2000**
EXPIRATION DATE:	**06/30/2023**

Disclaimer

The information provided is accurate and correct.

EAPA International Employee Assistance Professionals Association

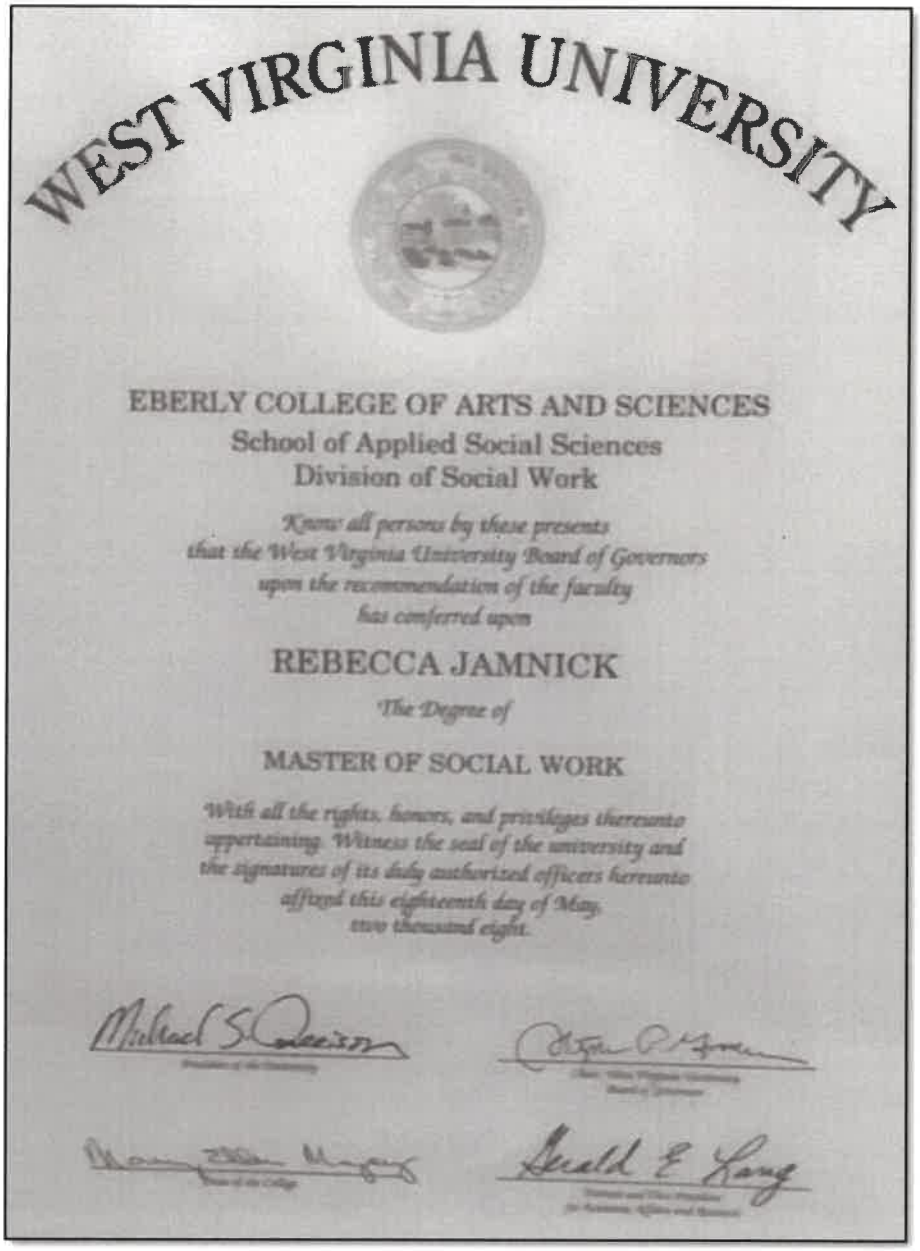
Emily Proctor, CEAP

CEAP No. [redacted]

Original CEAP – 4/1/2007

Current CEAP Recertification 4/1/2022 through 3/31/2025

Rosemary Byrne, Credentials Administrator



WEST VIRGINIA UNIVERSITY

EBERLY COLLEGE OF ARTS AND SCIENCES
School of Applied Social Sciences
Division of Social Work

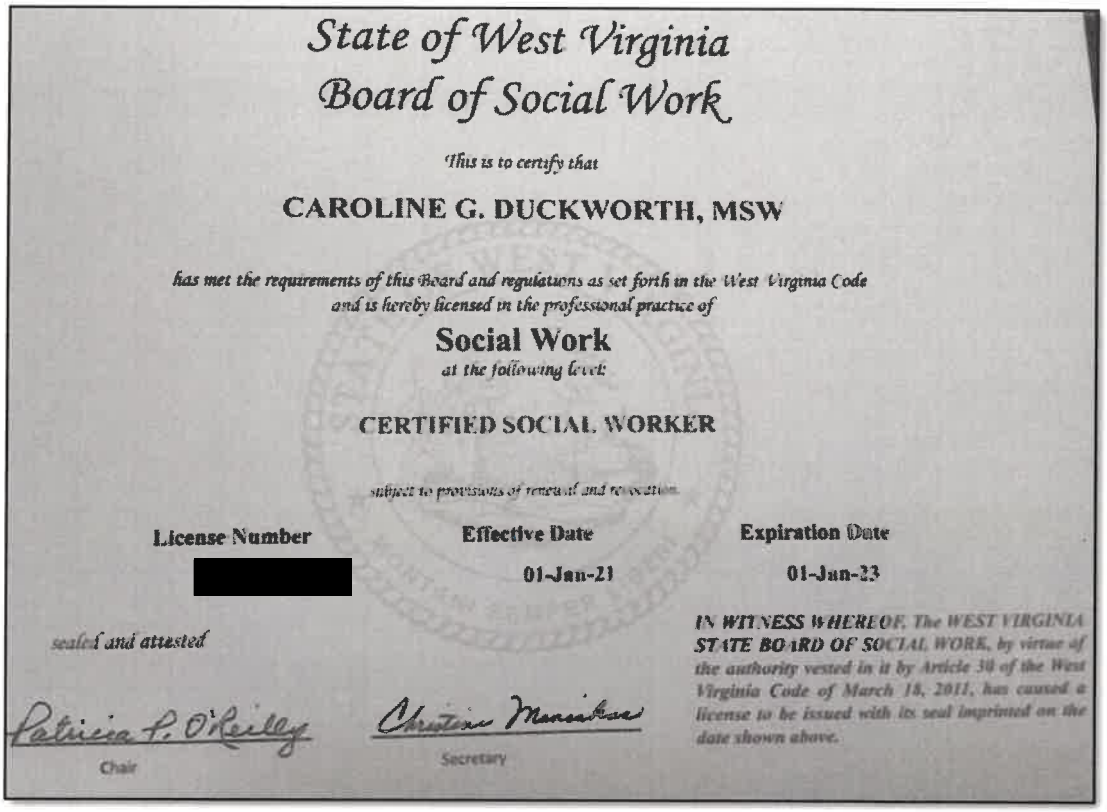
Know all persons by these presents
that the West Virginia University Board of Governors
upon the recommendation of the faculty
has conferred upon

REBECCA JAMNICK

The Degree of

MASTER OF SOCIAL WORK

With all the rights, honors, and privileges thereunto
appertaining. Witness the seal of the university and
the signatures of its duly authorized officers hereunto
affixed this eighteenth day of May,
two thousand eight.



State of West Virginia
Board of Social Work

This is to certify that

CAROLINE G. DUCKWORTH, MSW

has met the requirements of this Board and regulations as set forth in the West Virginia Code and is hereby licensed in the professional practice of

Social Work

at the following level:

CERTIFIED SOCIAL WORKER

subject to provisions of renewal and revocation.

License Number	Effective Date	Expiration Date
[redacted]	01-Jan-21	01-Jan-23

sealed and attested

Patricia P. O'Reilly
Chair

Christina Mancinelli
Secretary

***IN WITNESS WHEREOF,** The WEST VIRGINIA **STATE BOARD OF SOCIAL WORK,** by virtue of the authority vested in it by Article 30 of the West Virginia Code of March 18, 2011, has caused a license to be issued with its seal imprinted on the date shown above.*

West Virginia Board of Medicine

Search: Details

Name	Title	Specialty	Certified	Primary Practice Location	Licensed Or Has Been Licensed In
Paul Timothy Kuryla	MD	Family Practice	Verify Specialty Certification	Thomas Memorial Hospital Primary Care 400 Division Street, Suite 6 South Charleston, WV (Kanawha)	No other states on file

License History

License Type	License Number	Status	License Date	Expiration Date
Medical Doctor	[redacted]	Active	07/11/1988	6/30/2022
Controlled Substance Dispensing	[redacted]	Expired	08/14/1991	06/30/2013

Education History

School	Date Completed	Nature of Training
Marshall University School Of Medicine	05/09/1987	Medical or Podiatric School
West Virginia University Charleston Division	6/30/1988	Post-Graduate Training

Physician Assistant(s) Collaboration

Name

Discipline/Board Action History

No Discipline Cases On Record

Malpractice History

Settlements in malpractice claims occur for a number of reasons, and are often made without any admission, inference or finding of fault on the part of the practitioner. Some medical specialties have a higher rate of malpractice claims because of higher risks associated with certain specialty practices. The malpractice information reported below should not be construed as creating a presumption that medical malpractice has occurred.

Action	Loss Date	Action Date	Insurance Company	Adjudicating Body/Case #
Settlement	03/16/1999	11/28/2000	[redacted]	[redacted]

This data was retrieved on 12/9/2021.

ABMS® Board Certification Credentials Profile

A service provided by the American Board of Medical Specialties

New Search | Search Results | Email For Feedback | Save Physician | Print Profile

To become Board Certified, a physician must achieve expertise in a medical specialty or subspecialty that meets the profession-driven standards and requirements of one (or more) of the 24 ABMS certifying boards. To maintain Board Certification, the certifying boards may require physicians, depending on their date of initial certification, to participate in on-going programs of continuing learning and assessment (Maintenance of Certification) designed to help them remain current in an increasingly complex practice environment.

Paul Timothy Kuryla (ABMSUID - 73780) Viewed:12/9/2021 2:29:12 PM UTC

DOB: Private

Education: 1987 MD (Doctor of Medicine)

Address: Hurricane, WV 25526 (United States)

Individual NPI [1] : [redacted]

Show Active Medical License(s) [2] :

American Board of Medical Specialties
Higher standards. Better care.®

Board Certification(s):

American Board of Family Medicine

Family Medicine - General **Status: Certified**

Status	Duration	Occurrence	Start Date - End Date	Reverification Date	Participating in MOC
Active	MOC	Recertification	01/01/2019 -	02/15/2022	Yes
Expired	Time-Limited	Recertification	07/13/2009 - 12/31/2018		
Expired	Time-Limited	Recertification	07/12/2002 - 12/31/2009		
Expired	Time-Limited	Recertification	07/12/1996 - 12/31/2003		
Expired	Time-Limited	Initial Certification	07/13/1990 - 12/31/1997		

Learn more about Family Medicine MOC program

[1] NPI: Not for Primary Source Verification (PSV).

[2] State of Licensure provided by Federation of State Medical Boards (FSMB): Not for Primary Source Verification (PSV).

OFFICIAL DISPLAY AGENT ABMS

Notice: It is up to the user to determine if the physician record obtained from this service is that of the physician being sought.

With the exception of our Medical Specialists Online (MSO) product, all information as presented by ABMS Solutions products are approved for business use and are considered Primary Source Verified (PSV) and meet the primary source verification requirements as set by The Joint Commission, NCQA, URAC and other key accrediting agencies.

Paul Kuryla
ptk@suddenlink.net

Level User

E-mail ptk@suddenlink.net

Groups Peer Reviewers - Non Employees, NON-SUPERVISORY TEAM MEMBERS

7/9/2020 10:40:27 am	12/3/2021 12:02:08 am	1h 31m	4
Subscription date	Last Access Date	Total time	Active courses

Project Management Institute

THIS IS TO CERTIFY THAT

Lori McGurty

HAS BEEN FORMALLY EVALUATED FOR DEMONSTRATED EXPERIENCE, KNOWLEDGE AND PERFORMANCE IN ACHIEVING AN ORGANIZATIONAL OBJECTIVE THROUGH DEFINING AND OVERSEEING PROJECTS AND RESOURCES AND IS HEREBY BESTOWED THE GLOBAL CREDENTIAL

Project Management Professional (PMP)®

IN TESTIMONY WHEREOF, WE HAVE SUBSCRIBED OUR SIGNATURES UNDER THE SEAL OF THE INSTITUTE

Tony Appleby
Chair, Board of Directors

Sunil Prashara
President and Chief Executive Officer

PROJECT MANAGEMENT INSTITUTE CORPORATE SEAL 1969

PMP® Number: [redacted]
PMP® Original Grant Date: 27 August 2018
PMP® Expiration Date: 26 August 2024

Project Management Institute.

3.2 Other Staff

The following pages includes copies of other staff certifications or degrees applicable to this project.

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

BETHANY FRAME

Monday, August 01 2022 07:01:36 PM

- For a more broad search, select Search by License Number or Search by NCSBN ID above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification service to request the required verification of licensure.

Contact the board of nursing for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
FRAME, BETHANY JO	RN	[redacted]	Active	07/16/2014	10/31/2024	Multistate	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

BRENDA MICHELE MYERS

Monday, October 10 2022 04:56:46 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
MYERS, BRENDA MICHELE	RN	[redacted]	Active	07/02/1996	10/31/2024	Multistate	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home s provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

DAWN MARIE MEEKS

Wednesday, October 12 2022 02:56:21 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
MEEKS, DAWN MARIE	RN	[redacted]	Active	08/29/2007	10/31/2024	Multistate	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home s provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

JAMESA MYCHOL THOMAS

Monday, October 10 2022 05:21:02 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
THOMAS, JAMESA MYCHOL	RN	[redacted]	Inactive	01/16/2020	03/11/2020	N/A	NO

Primary Source Board of Nursing Messages & Notifications

- This temporary license is issued until the applicant meets all of the licensure requirements for a permanent license.

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
THOMAS, JAMESA MYCHOL	RN	[redacted]	Active	03/11/2020	10/31/2024	Multistate	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home s provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

JENNY CRAFT

Thursday, August 04 2022 07:27:48 AM

- For a more broad search, select Search by License Number or Search by NCSBN ID above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification service to request the required verification of licensure.

Contact the board of nursing for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
CRAFT, JENNY SUE	RN	[redacted]	Active	07/07/1977	10/31/2024	Multistate	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

KAREN S HALOSZKA

Monday, October 10 2022 05:00:21 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above. Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
HALOSZKA, KAREN S	RN	[redacted]	Active	06/21/1974	10/31/2024	Single State	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home s provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
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- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

nursys E-NOTIFY

Nursys e-Notify Report

Your licenses from Nursys e-Notify participating boards of nursing

Primary Source Boards of Nursing Report Summary for

KAREN SUE WILKINSON [NCSBN ID: [redacted]

As of Tuesday August 02 2022 08:06:00 AM US Central Time

Disclaimer of Representations and Warranties
Through a written agreement, participating individual state boards of nursing designate Nursys as a primary source equivalent database. NCSBN posts the information in Nursys when, and as, submitted by the individual state boards of nursing. NCSBN may not make any changes to the submitted information and disclaims any responsibility to update or verify such information as it is received from the individual state boards of nursing. Nursys displays the dates on which a board of nursing updated its information in Nursys.

This report is not sufficient when applying to another board of nursing for licensure. Use the "Nurse License Verification for Endorsement" service to request the required verification of licensure.

Contact the board of nursing for details about the Nurse Practice Act, which includes nurse scope of practice and privileges and information about advanced nursing practice roles (practice privileges, prescription authority, dispensing privileges & independent practice privileges).

UNENCUMBERED *means that the nurse has a full and unrestricted license to practice by the state board of nursing.*

Name on License	Type	License State	License	Active	License Status	License Original Issue Date	License Expiration Date	Compact Status
WILKINSON, KAREN SUE	RN	OHIO	[redacted]	YES	UNENCUMBERED	10/29/1993	10/31/2023	N/A

Name on License	Type	License State	License	Active	License Status	License Original Issue Date	License Expiration Date	Compact Status
WILKINSON, KAREN SUE	RN	WEST VIRGINIA-RN	[redacted]	YES	UNENCUMBERED	09/16/1993	10/31/2024	MULTISTATE

Where can the nurse practice as an RN and/or PN?

Authorized to Practice in

ALABAMA (RN)	LOUISIANA (RN)	OKLAHOMA (RN)
ARIZONA (RN)	MAINE (RN)	SOUTH CAROLINA (RN)
ARKANSAS (RN)	MARYLAND (RN)	SOUTH DAKOTA (RN)
COLORADO (RN)	MISSISSIPPI (RN)	TENNESSEE (RN)
DELAWARE (RN)	MISSOURI (RN)	TEXAS (RN)
FLORIDA (RN)	MONTANA (RN)	UTAH (RN)
GEORGIA (RN)	NEBRASKA (RN)	VERMONT (RN)
GUAM (RN)	NEW HAMPSHIRE (RN)	VIRGINIA (RN)
IDAHO (RN)	NEW JERSEY (RN)	WEST VIRGINIA (RN)
INDIANA (RN)	NEW MEXICO (RN)	WISCONSIN (RN)
IOWA (RN)	NORTH CAROLINA (RN)	WYOMING (RN)
KANSAS (RN)	NORTH DAKOTA (RN)	
KENTUCKY (RN)	OHIO (RN)	

Non-participating: MI. Non-participating boards of nursing do not allow licenses to be enrolled in the Nursys e-Notify service. Please contact them for authorization to practice details.
APRN authorization to practice details are not available.

UNENCUMBERED *means that the nurse has a full and unrestricted license to practice by the state board of nursing.*

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

License status information

- Unencumbered (full unrestricted license to practice)
- Cease & Desist
- Denial of License
- Expired
- Other license action
- Probation
- Reprimand
- Restriction
- Revoked
- Suspension
- Voluntary agreement to refrain from practice
- Voluntary Surrender

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact (NLC) and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- **Privilege to Practice (PTP):** Multistate licensure privilege is the authority under the Nurse Licensure Compact (NLC) to practice nursing in any compact party state that is not the state of licensure. All party states have the authority in accordance with existing state due process law to take actions against the nurse's privilege such as: revocation, suspension, probation or any other action which affects a nurse's authorization to practice.

NCSBN

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

KARI KATHERINE LEROSE

Monday, October 10 2022 04:39:36 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above. Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
LEROSE, KARI KATHERINE	RN	[redacted]	Active	07/01/1999	10/31/2024	Multistate	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home s provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

KATHERYN E CASE

Monday, October 10 2022 04:48:03 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above. Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
CASE, KATHERYN E	RN	[redacted]	Active	07/14/1982	10/31/2024	Single State	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home s provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

KIMBERLY SINGLETON

Tuesday, October 25 2022 08:44:13 PM

- For a more broad search, select Search by License Number or Search by NCSBN ID above. Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification service to request the required verification of licensure.

Contact the board of nursing for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
SINGLETON, KIMBERLY DIANE	RN	[redacted]	Active	06/30/1995	10/31/2024	Single State	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

KRISTEN LEIGH BRYAN

Monday, October 10 2022 05:03:05 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above. Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
BRYAN, KRISTEN LEIGH	RN	[redacted]	Active	07/02/2009	10/31/2024	Multistate	NO

License type information
- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information
- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home s provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

MARLENE REED

Tuesday, October 25 2022 08:37:27 PM

- For a more broad search, select Search by License Number or Search by NCSBN ID above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification service to request the required verification of licensure.

Contact the board of nursing for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
REED, MARLENE RENE	RN	[redacted]	Active	06/02/2005	10/31/2024	Single State	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

MARY E PODUNAVAC

Wednesday, October 12 2022 02:44:05 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above. Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
PODUNAVAC, MARY E	RN	[redacted]	Active	06/15/2013	10/31/2024	Single State	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home s provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

SARA CAMPBELL

Tuesday, October 25 2022 08:39:41 PM

- For a more broad search, select Search by License Number or Search by NCSBN ID above. Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification service to request the required verification of licensure.

Contact the board of nursing for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
CAMPBELL, SARA JANE	RN	[redacted]	Active	06/16/2006	10/31/2024	Single State	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home state provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

MONICA EVETTE KIRBY

Wednesday, October 12 2022 02:49:06 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSea service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
KIRBY, MONICA EVETTE	RN	[redacted]	Active	07/19/2006	10/31/2024	Single State	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

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West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

MELISSA RANETTE BELL

Wednesday, October 12 2022 02:46:25 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
BELL, MELISSA RANETTE	RN	[redacted]	Active	08/27/1992	10/31/2024	Multistate	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
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- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

SHARLA ANN CRAIG

Monday, October 10 2022 04:07:14 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
CRAIG, SHARLA ANN	RN	[redacted]	Active	06/28/1995	10/31/2024	Single State	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

- **Multistate licensure privilege:** Authority to practice as a licensed nurse in a remote state under the current license issued by the individual's home s provided both states are party to the Nurse Licensure Compact and the privilege is not otherwise restricted.
- **Single state license:** A license issued by a state board of nursing that authorizes practice only in the state of issuance.
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

SUZANNE MARIE COOK

Monday, October 10 2022 04:12:06 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above.Partial name searches are accepted

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Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
COOK, SUZANNE MARIE	RN	[redacted]	Active	06/30/1998	10/31/2024	Multistate	NO

License type information
- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
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- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

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West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

TEDDY RAY CRUICKSHANKS

Wednesday, October 12 2022 03:01:11 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above. Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
CRUICKSHANKS, TEDDY RAY	RN	[redacted]	Active	03/02/2012	10/31/2024	Multistate	NO

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
CRUICKSHANKS, TEDDY RAY	RN	[redacted]	Lapsed	07/07/2010	07/31/2010	N/A	NO

Primary Source Board of Nursing Messages & Notifications
- This temporary license is issued until the applicant meets all of the licensure requirements for a permanent license.

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
CRUICKSHANKS, TEDDY RAY	RN	[redacted]	Lapsed	01/04/2012	03/02/2012	N/A	NO

Primary Source Board of Nursing Messages & Notifications
- This temporary license is issued until the applicant meets all of the licensure requirements for a permanent license.

License type information
- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) Information
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West Virginia
Board of Registered Nurses
Primary Source License Verification

Verification Report

Primary Source Board of Nursing Report Summary for

WENDY Michele LITTRELL

Wednesday, October 12 2022 02:58:53 PM

- For a more broad search, select "Search by License Number" or "Search by NCSBN ID" above.Partial name searches are accepted

This report is not sufficient when applying to another board of nursing for licensure. Use the Nurse License Verification (http://www.nursys.com/NLV/NLVSe service to request the required verification of licensure.

Contact the board of nursing (https://www.ncsbn.org/contact-bon.htm) for details about the Nurse Practice Act.

Temporary and Permanent Licenses/Certificate

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
LITTRELL, WENDY Michele	RN	[redacted]	Inactive	08/29/2019	09/17/2019	N/A	NO

Primary Source Board of Nursing Messages & Notifications

- This temporary license is issued until the applicant meets all of the licensure requirements for a permanent license.

Name on License	License /Certificate Type	License/Certificate Number	License Status	Original Issue Date	Current Expiration Date	Compact Status	Discipline
LITTRELL, WENDY Michele	RN	[redacted]	Active	09/17/2019	10/31/2024	Multistate	NO

License type information

- **RN:** Registered Nurse
- **PN:** Practical Nurse (aka Licensed Practical Nurse (LPN), Vocational Nurse (VN), Licensed Vocational Nurse (LVN))
- **CNP:** Certified Nurse Practitioner
- **CNS:** Clinical Nurse Specialist
- **CNM:** Certified Nurse Midwife
- **CRNA:** Certified Registered Nurse Anesthetist

Nurse Licensure Compact (NLC) information

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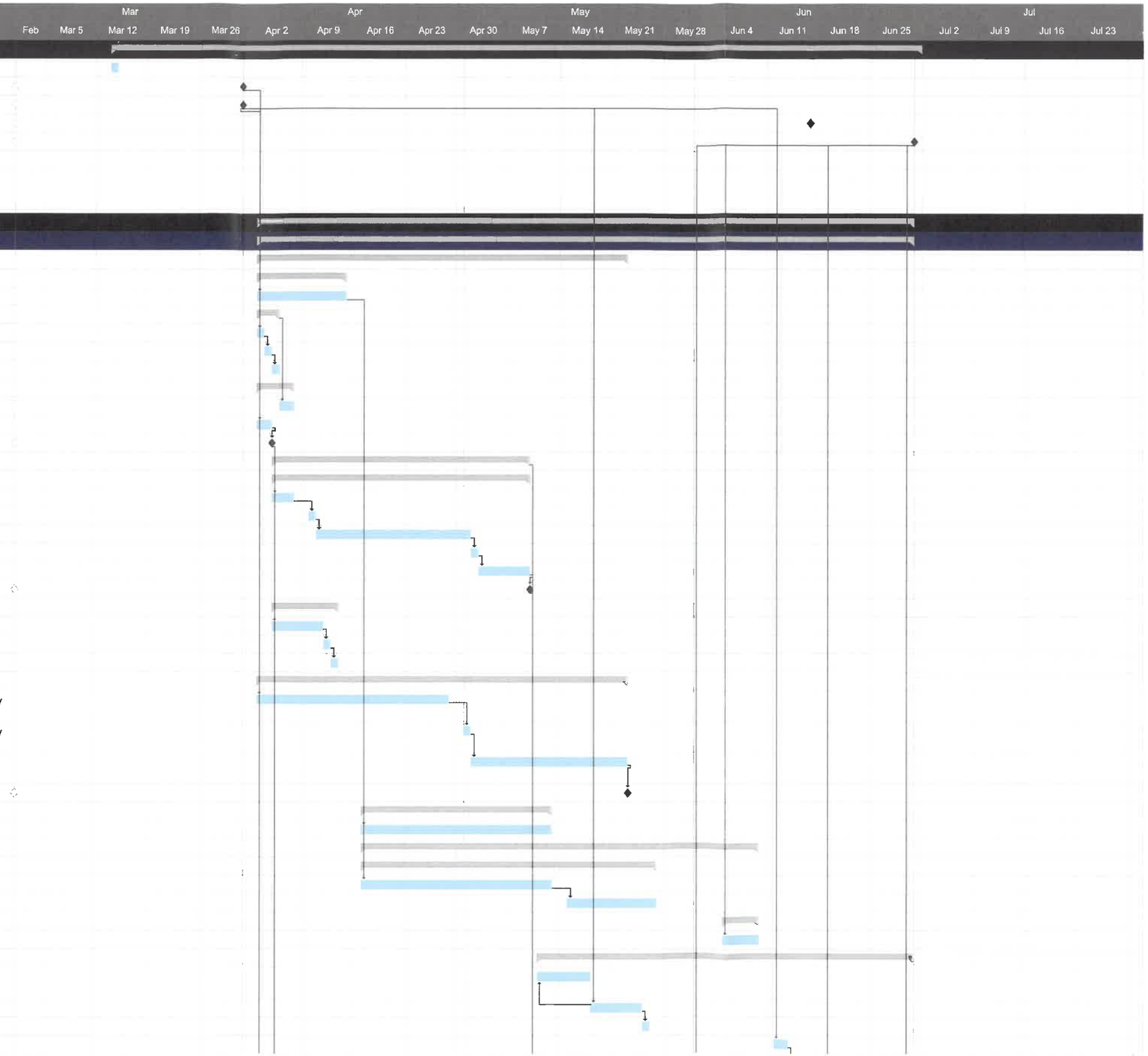
- More information about the Nurse Licensure Compact (NLC) (https://www.ncsbn.org/nurse-licensure-compact.htm)

Attachment 4 Implementation Work Plan

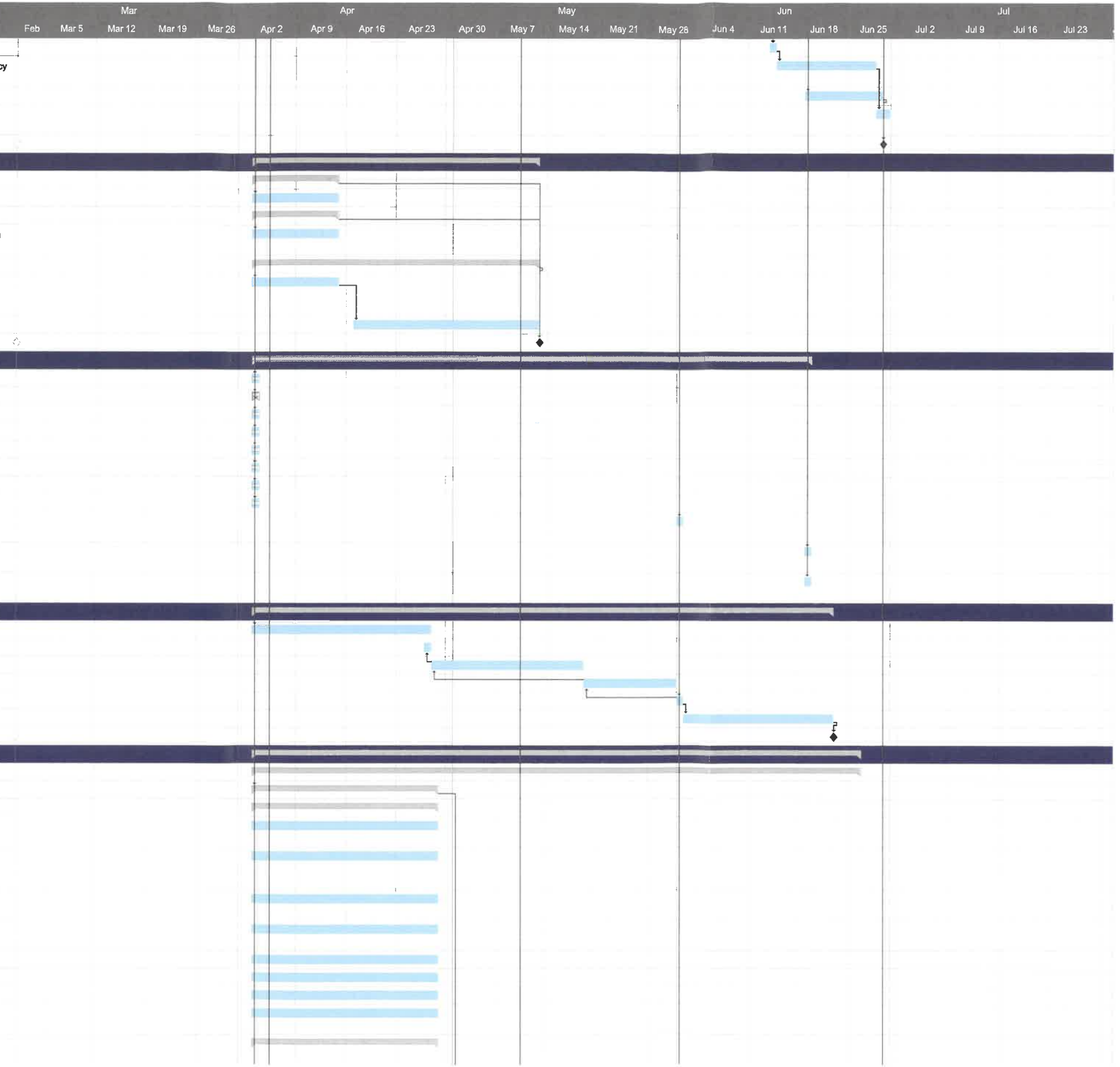
The following pages include our detailed work plan and schedule. This Gantt chart is broken down by tasks and subtasks and includes a schedule for the performance of each task.

WV Implementation Schedule

	Task Name	Start	Finish	Assigned To
1	Key Dates & Assumptions	03/14/23	07/01/23	
2	Solicitation # 0511 BMS 2300000002 due 003/14/2023 1:30PM EST	03/14/23	03/14/23	–
3	Notice of award (est)	04/01/23	04/01/23	–
4	Implementation start (est)	04/01/23	04/01/23	–
5	2 wk Lead- Begin Receiving Requests	06/17/23	06/17/23	–
6	Go Live-Ops Start Date (est)	07/01/23	07/01/23	–
7	Contract Term: 5 years with option for 3 1-year periods	07/01/23	–	–
8	Customer: West Virginia Department of Health and Human Resources (DHHR) Bureau for Medical Services (BMS), Bureau for Social Services (BSS), Bureau for Behavioral Health (BBH)	–	–	–
9	Implementation	04/03/23	06/30/23	
10	Admin	04/03/23	06/30/23	–
11	Project Initiation	04/03/23	05/22/23	–
12	Contracting Requirements	04/03/23	04/14/23	–
13	Review and execute contract with customer	04/03/23	04/14/23	Michelle Marks
14	Establish Kepro Implementation Project Team	04/03/23	04/05/23	–
15	Prep internal kickoff deck	04/03/23	04/03/23	Lori McGurty
16	Prepare Project Team with knowledge share- internal kick off	04/04/23	04/04/23	Lori McGurty
17	Assign responsibilities to Project Team members	04/05/23	04/05/23	Lori McGurty
18	Kick-Off Meeting	04/03/23	04/07/23	–
19	Prepare external kick-off meeting deck	04/06/23	04/07/23	Nancy Sullivan
20	Conduct kick-off meeting	04/03/23	04/04/23	Nancy Sullivan
21	Kick-Off	04/04/23	04/04/23	–
22	Align on Project Management Standards	04/05/23	05/09/23	–
23	Project Schedule	04/05/23	05/09/23	–
24	Develop Project Schedule	04/05/23	04/07/23	Lori McGurty
25	Submit Project Schedule	04/10/23	04/10/23	Lori McGurty
26	Review Project Schedule	04/11/23	05/01/23	WVDHHR
27	Revise Project Schedule - Final Submission	05/02/23	05/02/23	Lori McGurty
28	Accept Project Schedule	05/03/23	05/09/23	WVDHHR
29	Project schedule approved	05/09/23	05/09/23	–
30	Project Status Reporting	04/05/23	04/13/23	–
31	Develop Weekly Implementation Status Report	04/05/23	04/11/23	Lori McGurty
32	Kepro approval of status report template/method	04/12/23	04/12/23	Nancy Sullivan
33	Initiate weekly status reporting per communication plan	04/13/23	04/13/23	Lori McGurty
34	WV Certification for Utilization Review Resource	04/03/23	05/22/23	–
35	Complete application for Certification as a Utilization Review Resource in WV	04/03/23	04/28/23	Amber Murphy, Nancy Sullivan
36	Submit application for UR Resource	05/01/23	05/01/23	Amber Murphy, Nancy Sullivan
37	Review/approve application	05/02/23	05/22/23	WV Insurance Commission
38	Kepro certified as WV UR Resource	05/22/23	05/22/23	–
39	Post-award Submissions	04/17/23	05/12/23	–
40	Submit required insurance	04/17/23	05/12/23	Mark Erb
41	Kepro Quality & Compliance [Internal]	04/17/23	06/09/23	–
42	SharePoint Deliverables Assessment Grid	04/17/23	05/26/23	–
43	Update deliverable and assessments compliance grid	04/17/23	05/12/23	Amber Murphy
44	Enter edits to compliance grid into C360	05/15/23	05/26/23	Amber Murphy
45	Local Quality Improvement Council (LQIC)	06/05/23	06/09/23	–
46	Confirm LQIC Plan, activities, and members	06/05/23	06/09/23	Nancy Sullivan
47	Operational Readiness Review	05/11/23	06/30/23	–
48	Develop readiness evaluation matrix (people, process, technology, facility)	05/11/23	05/17/23	Lori McGurty
49	Conduct initial readiness evaluation (50%)	05/18/23	05/24/23	Lori McGurty
50	Review readiness evaluation results with leadership	05/25/23	05/25/23	Lori McGurty
51	Conduct 2nd readiness evaluation (75%)	06/12/23	06/13/23	Lori McGurty



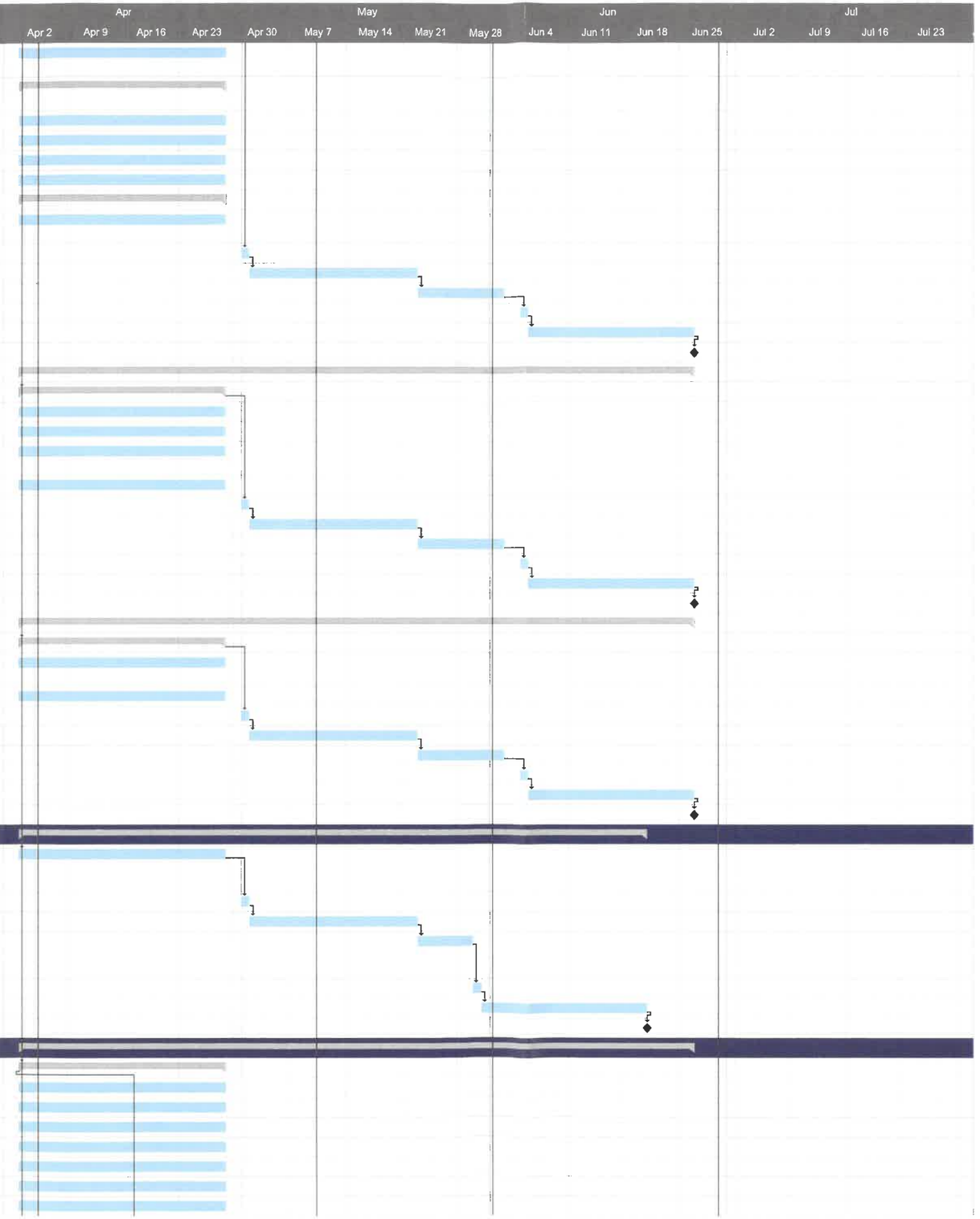
	Task Name	Start	Finish	Assigned To
52	Review 2nd readiness evaluation results with leadership	06/14/23	06/14/23	Lori McGurty
53	Determine and implement path to compliance for any deficient readiness items, risks or issues	06/15/23	06/28/23	Michelle Marks, Nancy Sullivan
54	Conduct Operational Readiness Review of vendor	06/19/23	06/29/23	WVDHHR
55	Conduct final readiness evaluation (90-99%) - resolve any remaining defects	06/29/23	06/30/23	Lori McGurty
56	Approve Vendor for Implementation	06/29/23	06/29/23	WVDHHR
57	Facility	04/03/23	05/12/23	–
58	Location	04/03/23	04/14/23	
59	Confirm/continue 1007 Bullitt Street location	04/03/23	04/14/23	Amber Murphy
60	IT/Infrastructure	04/03/23	04/14/23	–
61	Confirm facility has all required IT setup	04/03/23	04/14/23	Amber Murphy, Brian Kneeland
62	Furniture, Equipment & Supplies	04/03/23	05/12/23	–
63	Inventory any newly needed equipment and supplies (workstations, furniture, cabinets, storage, copier, water, postage, etc.)	04/03/23	04/14/23	Amber Murphy
64	Order/receive/install equipment and supplies	04/17/23	05/12/23	Amber Murphy
65	Facility confirmed compliant	05/12/23	05/12/23	–
66	Recruitment & Staffing	04/03/23	06/19/23	–
67	Existing Managers and Supervisors ON STAFF	04/03/23	04/03/23	–
68	Key Personnel ON STAFF	04/03/23	04/03/23	–
69	Executive Director, Nancy Sullivan	04/03/23	04/03/23	–
70	Long-Term Care PM. Melody Cottrell	04/03/23	04/03/23	–
71	Medical, SUD and BH PM, Emily Proctor	04/03/23	04/03/23	–
72	Administrative Services PM, Amber Murphy	04/03/23	04/03/23	–
73	Information Technology PM, Rebecca Jamnick	04/03/23	04/03/23	–
74	Health Homes, CSED, and TBI Waiver PM, Caroline Duckworth	04/03/23	04/03/23	–
75	New Supervisors and Manager start by	06/01/23	06/01/23	HR and Hiring Managers
76	New Clinical staff start by	06/19/23	06/19/23	HR and Hiring Managers
77	New Customer Support staff start by	06/19/23	06/19/23	HR and Hiring Managers
78	Quality Assurance (QA) Plan	04/03/23	06/22/23	–
79	Develop QA Plan	04/03/23	04/27/23	Amber Murphy
80	Submit QA Plan	04/27/23	04/27/23	Lori McGurty
81	Review QA Plan	04/28/23	05/18/23	WVDHHR
82	Revise/Resubmit QA Plan	05/19/23	05/31/23	Amber Murphy
83	Resubmit QA Plan	06/01/23	06/01/23	Lori McGurty
84	Final Review/approval QA Plan	06/02/23	06/22/23	WVDHHR
85	QA Plan accepted	06/22/23	06/22/23	–
86	Operations Procedure Manuals	04/03/23	06/26/23	–
87	Bureau for Medical Services (BMS) Operations Procedure Manual	04/03/23	06/26/23	–
88	Develop BMS Operations Procedure Manual	04/03/23	04/28/23	–
89	Medical Services	04/03/23	04/28/23	–
90	Confirm Procedure - Inpatient Medical/Surgical - Prior Authorization (PA)	04/03/23	04/28/23	Emily Proctor
91	Confirm Procedure - Organ Transplant - PA, DRG, CORE costs, vendor access to Medical Director, member selection criteria	04/03/23	04/28/23	Emily Proctor
92	Confirm Procedure - Hospice - PA, education & training, case management enrollment	04/03/23	04/28/23	Emily Proctor
93	Confirm Procedure - DME, Supplies and Orthotics and Prosthetics-PA	04/03/23	04/28/23	Emily Proctor
94	Confirm Procedure - Vision-PA	04/03/23	04/28/23	Emily Proctor
95	Confirm Procedure - Audiology-PA	04/03/23	04/28/23	Emily Proctor
96	Confirm Procedure - Outpatient PT, OT and ST-PA	04/03/23	04/28/23	Emily Proctor
97	Confirm Procedure - Physician and Non-Physician Practitioner-PA	04/03/23	04/28/23	Emily Proctor
98	Update Procedure - Home Health-Initial visit registration, PA, CSR, retro, education and training	04/03/23	04/28/23	–



	Task Name	Start	Finish	Assigned To
99	Update Policy to include Home Health-Case Management Enrollment and Weekly Notification for members receiving Home Health and Waiver or PC	04/03/23	04/28/23	Emily Proctor
100	Update Procedure - PDN - PA, education and training	04/03/23	04/28/23	--
101	Update Policy to include PDN -Weekly Notification for members receiving PDN and Waiver or PC	04/03/23	04/28/23	Emily Proctor
102	Confirm Procedure - Diagnostic Imaging/Radiology-PA, criteria use and development	04/03/23	04/28/23	Emily Proctor
103	Confirm Procedure - Nursing Home Eligibility and PASRR Eligibility-PA, Level 1, 1.5, Referral for Level II	04/03/23	04/28/23	Melody Cottrell
104	Confirm Procedures-TBI Waiver	04/03/23	04/28/23	--
105	Confirm - PA	04/03/23	04/28/23	Caroline Duckworth
106	Confirm - Member eligibility - Initial and annual assessments	04/03/23	04/28/23	Caroline Duckworth
107	Confirm - Education and training	04/03/23	04/28/23	Caroline Duckworth
108	Confirm - Managed enrollment and activation	04/03/23	04/28/23	Caroline Duckworth
109	Confirm - Assessment-based budgets	04/03/23	04/28/23	Caroline Duckworth
110	Confirm - Maintain electronic system for PA and eligibility	04/03/23	04/28/23	Caroline Duckworth
111	Confirm - Appeals and Hearings	04/03/23	04/28/23	Caroline Duckworth
112	Confirm - Quality assurance + reviews	04/03/23	04/28/23	Caroline Duckworth
113	Confirm - QIA Council management	04/03/23	04/28/23	Caroline Duckworth
114	Confirm - Complaints	04/03/23	04/28/23	Caroline Duckworth
115	Confirm - IMS monitoring and investigation	04/03/23	04/28/23	Caroline Duckworth
116	Confirm - CMS Quality Measures reporting and management	04/03/23	04/28/23	Caroline Duckworth
117	Confirm/Update Procedures - IDD Waiver	04/03/23	04/28/23	--
118	Update - PA (w/in 2 days)	04/03/23	04/28/23	Emily Proctor
119	Confirm - Member eligibility - initial and annual assessments	04/03/23	04/28/23	Emily Proctor
120	Confirm -Education and training	04/03/23	04/28/23	Emily Proctor
121	Confirm -Managed enrollment and activation	04/03/23	04/28/23	Emily Proctor
122	Confirm -Assessment-based budgets	04/03/23	04/28/23	Emily Proctor
123	Confirm -Maintain electronic system for PA and eligibility	04/03/23	04/28/23	Emily Proctor
124	Confirm -Quality assurance + reviews	04/03/23	04/28/23	Emily Proctor
125	Confirm -QIA Council management	04/03/23	04/28/23	Emily Proctor
126	Confirm -Complaints	04/03/23	04/28/23	Emily Proctor
127	Confirm -IMS monitoring and investigation	04/03/23	04/28/23	Emily Proctor
128	Confirm -CMS Quality measures reporting and management	04/03/23	04/28/23	Emily Proctor
129	Confirm Procedures - CSED Waiver	04/03/23	04/28/23	--
130	Confirm -PA	04/03/23	04/28/23	Caroline Duckworth
131	Update - Initial and Annual Assessments - update TAT	04/03/23	04/28/23	Caroline Duckworth
132	Confirm - Managed enrollment	04/03/23	04/28/23	Caroline Duckworth
133	Confirm - Maintain electronic system for PA and eligibility	04/03/23	04/28/23	Caroline Duckworth
134	Confirm - Education and training, stakeholder engagement	04/03/23	04/28/23	Caroline Duckworth
135	Confirm - SED Waiver Program service determinations	04/03/23	04/28/23	Caroline Duckworth
136	Confirm - Quality assurance + reviews	04/03/23	04/28/23	Caroline Duckworth
137	Confirm - Ongoing quality assurance & improvement (internal)	04/03/23	04/28/23	Caroline Duckworth
138	Confirm - Centralized Wraparound Hub	04/03/23	04/28/23	Caroline Duckworth
139	Confirm/Update Procedures - Personal Care	04/03/23	04/28/23	--
140	Confirm - PA	04/03/23	04/28/23	Melody Cottrell
141	Confirm - Maintain electronic system for PA and eligibility	04/03/23	04/28/23	Melody Cottrell
142	Update - Data analysis and reporting - add export to Online CM and Integrated IMS	04/03/23	04/28/23	Melody Cottrell
143	Update - Initial eligibility (7cd) and re-evaluation assessments + eligibility extensions	04/03/23	04/28/23	Melody Cottrell
144	Confirm - Education and training	04/03/23	04/28/23	Melody Cottrell
145	Confirm - Consultation on P&Ps	04/03/23	04/28/23	Melody Cottrell

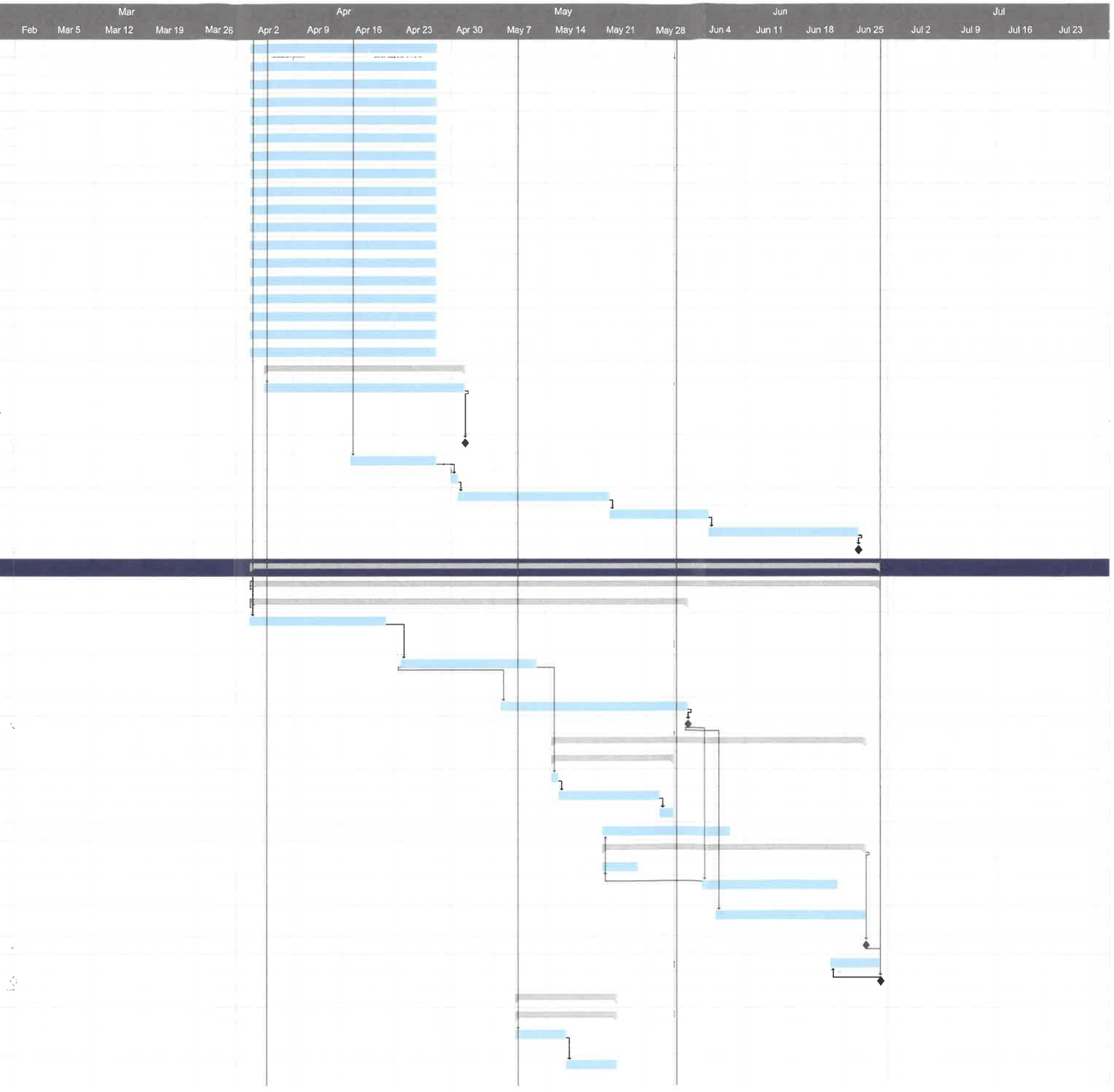
	Task Name	Start	Finish	Assigned To
146	Confirm - Quality measures	04/03/23	04/28/23	Melody Cottrell
147	Update - Letters inc. certified mail when requested	04/03/23	04/28/23	Melody Cottrell
148	Confirm/Update/Develop Procedures - AD Waiver	04/03/23	04/28/23	--
149	Confirm - PA	04/03/23	04/28/23	Melody Cottrell
150	Confirm - Member eligibility - Initial and annual assessments	04/03/23	04/28/23	Melody Cottrell
151	Update -Notifications inc. certified mail when requested	04/03/23	04/28/23	Melody Cottrell
152	Confirm - Managed enrollment, and activation	04/03/23	04/28/23	Melody Cottrell
153	Confirm - Service level assignment and updates	04/03/23	04/28/23	Melody Cottrell
154	Confirm - Maintain electronic review request system for PA and eligibility	04/03/23	04/28/23	Melody Cottrell
155	Update - Data analysis and reporting - add export to Online CM and Integrated IMS	04/03/23	04/28/23	Melody Cottrell
156	Confirm - Education and training	04/03/23	04/28/23	Melody Cottrell
157	Develop New - Evaluation of locations for Integrated Setting Rule	04/03/23	04/28/23	Melody Cottrell
158	Confirm Procedures - Take Me Home	04/03/23	04/28/23	--
159	Confirm - TMH status reporting, tracking	04/03/23	04/28/23	Caroline Duckworth, Emily Proctor, Melody Cottrell
160	Confirm - QA activities	04/03/23	04/28/23	Caroline Duckworth, Emily Proctor, Melody Cottrell
161	Confirm Procedure - Lab/Genetics	04/03/23	04/28/23	Emily Proctor
162	Confirm Procedure - OON Services	04/03/23	04/28/23	Emily Proctor
163	Confirm Procedure - Cardiac Rehab	04/03/23	04/28/23	Emily Proctor
164	Confirm Procedure - General and Acute Care Inpatient Hospital Admission and CSR	04/03/23	04/28/23	Emily Proctor
165	Confirm Procedure - Pulmonary Rehab	04/03/23	04/28/23	Emily Proctor
166	Confirm Procedure - Chiropractic	04/03/23	04/28/23	Emily Proctor
167	Confirm Procedure - Podiatry	04/03/23	04/28/23	Emily Proctor
168	Update Procedure - Case Management + high risk pregnancy & CM summary to MCO	04/03/23	04/28/23	Emily Proctor
169	Confirm Procedure - EPSDT and Criteria Development	04/03/23	04/28/23	Emily Proctor
170	Confirm/Update Procedures - Health Home	04/03/23	04/28/23	--
171	Confirm - MedNec and PA	04/03/23	04/28/23	Caroline Duckworth
172	Confirm - Form development	04/03/23	04/28/23	Caroline Duckworth
173	Confirm - Data analysis and reporting	04/03/23	04/28/23	Caroline Duckworth
174	Confirm - HH for Bipolar & At Risk for Hepatitis	04/03/23	04/28/23	Caroline Duckworth
175	Update - HH for Pre-Diabetes, Diabetes, Obesity & At Risk for Anxiety and/or Depression to include statewide	04/03/23	04/28/23	Caroline Duckworth
176	Confirm - ASO services	04/03/23	04/28/23	Caroline Duckworth
177	Confirm Procedure - Long-Term Acute Care	04/03/23	04/28/23	Emily Proctor
178	Confirm Procedure - School Based Health	04/03/23	04/28/23	Caroline Duckworth
179	Confirm Procedure - Inpatient Rehab	04/03/23	04/28/23	Emily Proctor
180	Update Procedure - Specialty Medications/Physician Administered Drugs to include WVCHIP	04/03/23	04/28/23	Emily Proctor
181	Confirm Procedure - Applied Behavior Analysis	04/03/23	04/28/23	Emily Proctor
182	Update Procedure - General Auth for all Programs - add notice to hospitals when certification expires w/in 48 hrs	04/03/23	04/28/23	Emily Proctor
183	Licensed BH Services UM - Operational Procedures	04/03/23	04/28/23	--
184	Confirm Procedure - Inpatient Psychiatric Services	04/03/23	04/28/23	Emily Proctor
185	Confirm Procedure - Targeted Case Management	04/03/23	04/28/23	Emily Proctor
186	Confirm Procedure - Licensed Behavioral Health Center Services	04/03/23	04/28/23	Emily Proctor
187	Update Procedure - Behavioral Health Outpatient Services - update TAT for investigations	04/03/23	04/28/23	Emily Proctor
188	Confirm/Develop Procedures - Psychiatric Residential Treatment Facility Services	04/03/23	04/28/23	--
189	Confirm - PA	04/03/23	04/28/23	Emily Proctor
190	Develop - Retrospective provider reviews	04/03/23	04/28/23	Emily Proctor
191	Confirm Procedure - Inpatient Psychiatric Services for Individuals under 21 years of age	04/03/23	04/28/23	Emily Proctor

	Task Name	Start	Finish	Assigned To
192	Confirm Procedure - Behavioral Health Services Criteria Development	04/03/23	04/28/23	Emily Proctor
193	Dental and Oral Health Services UM - Operational Procedures	04/03/23	04/28/23	--
194	Confirm Procedure - Dental Services	04/03/23	04/28/23	Emily Proctor
195	Confirm Procedure - Oral and Maxillofacial Surgery	04/03/23	04/28/23	Emily Proctor
196	Confirm Procedure - Orthodontia	04/03/23	04/28/23	Emily Proctor
197	Confirm Procedure - Dental Services Criteria Development	04/03/23	04/28/23	Emily Proctor
198	WVCHIP - Operational Procedures	04/03/23	04/28/23	--
199	Include WVCHIP Operational requirements with comparable BMS procedures	04/03/23	04/28/23	Emily Proctor
200	Submit BMS Operations Procedure Manual	05/01/23	05/01/23	Lori McGurty
201	Review BMS Operations Procedure Manual	05/02/23	05/22/23	WVDHHR BMS
202	Revise BMS Operations Procedure Manual	05/23/23	06/02/23	Kepro Ops Leaders
203	Resubmit BMS Operations Procedure Manual	06/05/23	06/05/23	Lori McGurty
204	Final Review/approval BMS Operations Procedure Manual	06/06/23	06/26/23	WVDHHR
205	BMS Operations Procedure Manual accepted	06/26/23	06/26/23	--
206	Bureau for Social Services (BSS) Operations Procedure Manual	04/03/23	06/26/23	--
207	Develop BSS Operations Procedure Manual	04/03/23	04/28/23	--
208	Confirm Procedure - Non-Medical Services	04/03/23	04/28/23	Caroline Duckworth
209	Confirm Procedure - Qualified Residential Treatment	04/03/23	04/28/23	Caroline Duckworth
210	Update Procedure - Children's Out of State Residential Program to include "at risk" children	04/03/23	04/28/23	Caroline Duckworth
211	Confirm Procedure - Psychological Evaluations	04/03/23	04/28/23	Caroline Duckworth
212	Submit BSS Operations Procedure Manual	05/01/23	05/01/23	Lori McGurty
213	Review BSS Operations Procedure Manual	05/02/23	05/22/23	WVDHHR BSS
214	Revise BSS Operations Procedure Manual	05/23/23	06/02/23	Kepro Ops Leaders
215	Resubmit BSS Operations Procedure Manual	06/05/23	06/05/23	Lori McGurty
216	Final Review/approval BSS Operations Procedure Manual	06/06/23	06/26/23	WVDHHR BSS
217	BSS Operations Procedure Manual accepted	06/26/23	06/26/23	--
218	Bureau for Behavioral Health (BBH) Operations Procedure Manual	04/03/23	06/26/23	--
219	Develop BBH Operations Procedure Manual	04/03/23	04/28/23	--
220	Confirm Procedures - Comprehensive Data Set - Data Collection	04/03/23	04/28/23	Becky Jamnick
221	Confirm Procedures - Satisfaction Surveys	04/03/23	04/28/23	Becky Jamnick
222	Submit BBH Operations Procedure Manual	05/01/23	05/01/23	Lori McGurty
223	Review BBH Operations Procedure Manual	05/02/23	05/22/23	WVDHHR BBH
224	Revise BBH Operations Procedure Manual	05/23/23	06/02/23	Becky Jamnick
225	Resubmit BBH Operations Procedure Manual	06/05/23	06/05/23	Lori McGurty
226	Final Review/approval BBH Operations Procedure Manual	06/06/23	06/26/23	WVDHHR BBH
227	BBH Operations Procedure Manual accepted	06/26/23	06/26/23	--
228	Provider Manual	04/03/23	06/20/23	--
229	Develop Provider Manual (inc. Utilization Data Submission Procedures)	04/03/23	04/28/23	Caroline Duckworth, Emily Proctor, Melody Cottrell
230	Submit Provider Manual	05/01/23	05/01/23	Lori McGurty
231	Review Provider Manual	05/02/23	05/22/23	WVDHHR
232	Revise Provider Manual	05/23/23	05/29/23	Caroline Duckworth, Emily Proctor, Melody Cottrell
233	Resubmit Provider Manual	05/30/23	05/30/23	Lori McGurty
234	Final Review/approval Provider Manual	05/31/23	06/20/23	WVDHHR
235	Provider Manual accepted	06/20/23	06/20/23	--
236	Health Analytics - Reporting	04/03/23	06/26/23	--
237	Confirm continuation of current reports	04/03/23	04/28/23	--
238	Monthly Administrative Project Summary	04/03/23	04/28/23	Emily Proctor
239	Monthly Report Card	04/03/23	04/28/23	Emily Proctor
240	Monthly Retrospective Report Card	04/03/23	04/28/23	Emily Proctor
241	Monthly Reconsideration Report Card	04/03/23	04/28/23	Emily Proctor
242	Monthly Member Hearing Report Card	04/03/23	04/28/23	Emily Proctor
243	Monthly Out-of-Network (OON) Report	04/03/23	04/28/23	Emily Proctor
244	Utilization/Prior Authorization Summary Report	04/03/23	04/28/23	Emily Proctor

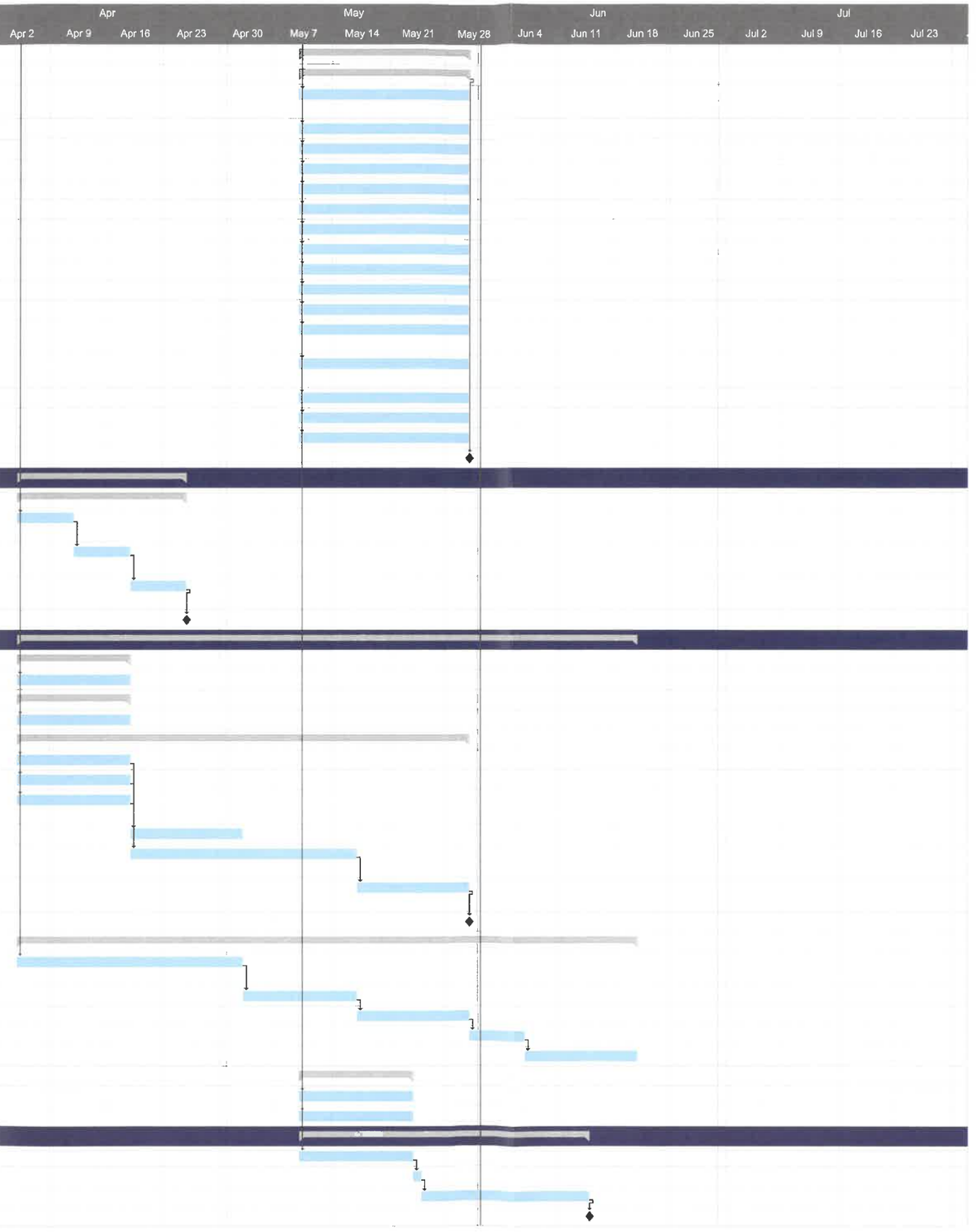


	Task Name	Start	Finish	Assigned To
245	Unduplicated Riders by Ambulance Transportation Level of Service Report	04/03/23	04/28/23	Emily Proctor
246	Monthly Complaint Summary Report	04/03/23	04/28/23	Emily Proctor
247	Monthly IDD and TBI Waiver Complaint Detail Report	04/03/23	04/28/23	Caroline Duckworth, Emily Proctor
248	Monthly Denial Summary Report	04/03/23	04/28/23	Emily Proctor
249	Utilization/Prior Authorization Services Requests Ad Hoc Report	04/03/23	04/28/23	Emily Proctor
250	Provider Training Schedule	04/03/23	04/28/23	Emily Proctor
251	Annual Stakeholder Satisfaction Survey Report	04/03/23	04/28/23	Emily Proctor
252	Quarterly Suspected Fraud, Abuse and/or Misuse	04/03/23	04/28/23	Emily Proctor
253	Annual Report	04/03/23	04/28/23	Nancy Sullivan
254	Quarterly Behavioral Health (BH) Investigations Report	04/03/23	04/28/23	Emily Proctor
255	Monthly EPSDT Request by Environment And Category of Service Request	04/03/23	04/28/23	Emily Proctor
256	Monthly EPSDT Services Request Status and Tracking Report	04/03/23	04/28/23	Emily Proctor
257	Quarterly EPSDT numbers and Cost Data	04/03/23	04/28/23	Emily Proctor
258	Therapeutic Foster Care Retrospective Review	04/03/23	04/28/23	Caroline Duckworth
259	Therapeutic Foster Care Utilization Reports	04/03/23	04/28/23	Caroline Duckworth
260	Therapeutic Foster Care Data Analysis	04/03/23	04/28/23	Caroline Duckworth
261	Therapeutic Foster Care Focus Group Summary	04/03/23	04/28/23	Caroline Duckworth
262	Non-medical Services Review Committee Report to Providers	04/03/23	04/28/23	Caroline Duckworth
263	Diagnostic Reports for Children in Custody of DHHR	04/03/23	04/28/23	Caroline Duckworth
264	Out-of-state Residential Data Analysis	04/03/23	04/28/23	Caroline Duckworth
265	Out-of-state Residential Focus Group Summary	04/03/23	04/28/23	Caroline Duckworth
266	Younger Children Clinical Summaries	04/03/23	04/28/23	Caroline Duckworth
267	Older Children Clinical Summaries	04/03/23	04/28/23	Caroline Duckworth
268	Tracking Reports-Parentally Placed Children in Out-of-state PRTF care	04/03/23	04/28/23	Caroline Duckworth
269	TMH Access to Services	04/03/23	04/28/23	Emily Proctor
270	TMH Quality Review	04/03/23	04/28/23	Emily Proctor
271	Weekly Hospice Report	04/03/23	04/28/23	Emily Proctor
272	Weekly ADW Managed Enrollment Wait List	04/03/23	04/28/23	Melody Cottrell
273	ADW Discovery and Remediation Reports	04/03/23	04/28/23	Melody Cottrell
274	ADW Integrated Settings Report	04/03/23	04/28/23	Melody Cottrell
275	Personal Care Monthly Activity Report	04/03/23	04/28/23	Melody Cottrell
276	ADW Monthly Activity Report	04/03/23	04/28/23	Melody Cottrell
277	Monthly Personal Care Prior Authorizations	04/03/23	04/28/23	Melody Cottrell
278	I/DD Monthly FBDH/SE Report	04/03/23	04/28/23	Emily Proctor
279	I/DD Monthly Member Activity Report	04/03/23	04/28/23	Emily Proctor
280	I/DD Monthly Managed Enrollment List Activity Report	04/03/23	04/28/23	Emily Proctor
281	I/DO Monthly Report on CMS Quality Performance Indicators	04/03/23	04/28/23	Emily Proctor
282	I/DD Monthly Provider Report	04/03/23	04/28/23	Emily Proctor
283	I/DD Annual Report	04/03/23	04/28/23	Emily Proctor
284	I/DD 24 Hour Residential Settings Report	04/03/23	04/28/23	Emily Proctor
285	I/DD Integrated Settings Report	04/03/23	04/28/23	Emily Proctor
286	BBH Indigent Care Monthly Report Card	04/03/23	04/28/23	Becky Jamnick
287	BBH Statewide Demographic and Clinical Data	04/03/23	04/28/23	Becky Jamnick
288	BBH Data Quality Report	04/03/23	04/28/23	Becky Jamnick
289	Community Mental Health Services Block Grant Reporting	04/03/23	04/28/23	Becky Jamnick
290	Substance Abuse Prevention and Treatment Block Grant Reporting	04/03/23	04/28/23	Becky Jamnick
291	Traumatic Brain Injury (TBI) Monthly Activity Report	04/03/23	04/28/23	Caroline Duckworth
292	TBI Monthly Report on CMS Quality Performance Indicators	04/03/23	04/28/23	Caroline Duckworth
293	Monthly Integrated Settings Report	04/03/23	04/28/23	Caroline Duckworth
294	ICF-IID Monthly Report	04/03/23	04/28/23	Emily Proctor
295	ICF-IID Ad Hoc Report	04/03/23	04/28/23	Emily Proctor
296	ICF-IID Quarterly Report	04/03/23	04/28/23	Emily Proctor
297	ICF-IID Hearings Report	04/03/23	04/28/23	Emily Proctor
298	Nursing Facility Eligibility - PASRR Level II Monthly Report	04/03/23	04/28/23	Melody Cottrell
299	Nursing Facility Eligibility- PASRR Level II Ad Hoc Report	04/03/23	04/28/23	Melody Cottrell
300	Nursing Facility Eligibility- PASRR Level II Quarterly Report	04/03/23	04/28/23	Melody Cottrell

	Task Name	Start	Finish	Assigned To
301	Nursing Facility Eligibility. PASRR Level II Hearings Report	04/03/23	04/28/23	Melody Cottrell
302	Nursing Facility Eligibility— PASRR Level II Evaluator Report	04/03/23	04/28/23	Melody Cottrell
303	BBHHF Consumer Satisfaction Survey Results	04/03/23	04/28/23	Emily Proctor
304	Weekly ADW Managed Enrollment Wait List Report	04/03/23	04/28/23	Melody Cottrell
305	ADW Monthly Discovery and Remediation Report	04/03/23	04/28/23	Melody Cottrell
306	ADW Monthly Activity Report	04/03/23	04/28/23	Melody Cottrell
307	Annual ADW Provider Audit Report	04/03/23	04/28/23	Melody Cottrell
308	Monthly Personal Care Prior Authorizations	04/03/23	04/28/23	Melody Cottrell
309	Monthly Personal Care Determination Time Frames Report	04/03/23	04/28/23	Melody Cottrell
310	Monthly Personal Care Redetermination Time Frames Report	04/03/23	04/28/23	Melody Cottrell
311	Monthly CDCSP Determination Time Frames Report	04/03/23	04/28/23	Emily Proctor
312	Monthly Personal Care Medical Eligibility Determinations Report	04/03/23	04/28/23	Emily Proctor
313	Monthly CDCSP Redetermination Time Frames Report	04/03/23	04/28/23	Emily Proctor
314	Monthly Health Homes Member Report	04/03/23	04/28/23	Caroline Duckworth
315	Monthly Health Homes Provider Report	04/03/23	04/28/23	Caroline Duckworth
316	Monthly Adult Preventative Dental Report	04/03/23	04/28/23	Emily Proctor
317	Quarterly Transplants Report	04/03/23	04/28/23	Emily Proctor
318	Quarterly UDS Report	04/03/23	04/28/23	Emily Proctor
319	Letters	04/05/23	05/02/23	--
320	Confirm existing notifications/letters to continue for each program	04/05/23	05/02/23	Becky Jarnnick, Caroline Duckworth, Emily Proctor, Melody Cottrell
321	Letters ready	05/02/23	05/02/23	--
322	Develop Report Templates Package - for any new/changed reports	04/17/23	04/28/23	Kepro Ops Leader
323	Submit Reports Package - for any new/changed reports	05/01/23	05/01/23	Lori McGurty
324	Review Reports Package (new/changes)	05/02/23	05/22/23	WVDHHR
325	Revise Reports Package (new/changes)	05/23/23	06/05/23	Kepro Ops Leader
326	Final review/accept Reports Package (new/changes)	06/06/23	06/26/23	WVDHHR
327	Reports Package approved (new/changes)	06/26/23	06/26/23	--
328	Information Technology/Systems	04/03/23	06/30/23	--
329	Atrezzo	04/03/23	06/30/23	--
330	Configuration	04/03/23	06/02/23	--
331	Assess for any new system configuration needs, per program	04/03/23	04/21/23	Caroline Duckworth, Emily Proctor, Melody Cottrell
332	Gather requirements for any new system config needs, per program	04/24/23	05/12/23	Caroline Duckworth, Emily Proctor, Melody Cottrell
333	Configure software	05/08/23	06/02/23	Wayne Bolton
334	Atrezzo changes configured	06/02/23	06/02/23	--
335	Testing	05/15/23	06/27/23	--
336	UAT Access	05/15/23	05/31/23	--
337	Submit ticket requesting access for UAT users	05/15/23	05/15/23	Amber Murphy
338	Create login and password for any new users	05/16/23	05/29/23	Kepro Service Desk
339	Supply credentials to UAT users	05/30/23	05/31/23	Kepro Service Desk
340	Prepare User Acceptance Testing Plan	05/22/23	06/08/23	Prashanth Krishnan
341	Configuration UAT	05/22/23	06/27/23	--
342	Train UAT team	05/22/23	05/26/23	Sierra Hall
343	Conduct UAT	06/05/23	06/23/23	WV Operational Leaders
344	Resolve defects or add defect(s) to Defect Resolution Plan	06/06/23	06/27/23	Wayne Bolton
345	Atrezzo tested successfully	06/27/23	06/27/23	--
346	Deploy Atrezzo config changes to Prod	06/23/23	06/29/23	Wayne Bolton
347	Atrezzo deployed to Prod	06/30/23	06/30/23	--
348	Access to State Systems	05/10/23	05/23/23	--
349	Access to MMIS	05/10/23	05/23/23	--
350	Confirm process for requesting access to MMIS for Kepro staff requiring access	05/10/23	05/16/23	Becky Jarnnick
351	Document/update business processes for requesting access to and deactivating access to MMIS	05/17/23	05/23/23	Becky Jarnnick



	Task Name	Start	Finish	Assigned To
352	File and Data Exchange	05/10/23	05/30/23	--
353	Confirm continuation of current file and data exchanges	05/10/23	05/30/23	--
354	Confirm continuation of existing trading partner cadence, location of file transfer, key contacts, etc.	05/10/23	05/30/23	Becky Jamnick
355	Medicaid Provider file to Kepro	05/10/23	05/30/23	Becky Jamnick
356	Member eligibility file to Kepro	05/10/23	05/30/23	Becky Jamnick
357	Prior Authorization Extract File to MMIS (all programs)	05/10/23	05/30/23	Becky Jamnick
358	Prior Auth Response file to Kepro	05/10/23	05/30/23	Becky Jamnick
359	TBIW Attribute	05/10/23	05/30/23	Becky Jamnick
360	IDDW Attribute	05/10/23	05/30/23	Becky Jamnick
361	ADW Attribute	05/10/23	05/30/23	Becky Jamnick
362	CSED Attribute	05/10/23	05/30/23	Becky Jamnick
363	(BBH) BH-ML - Military File - from provider	05/10/23	05/30/23	Becky Jamnick
364	(BBH) BH-PA-Request for auth-from provider	05/10/23	05/30/23	Becky Jamnick
365	(BBH) BH-FE-Federal supplemental report (Data Segment)-from provider	05/10/23	05/30/23	Becky Jamnick
366	(BBH) BH-CSDR97-Consumer Service Detail Report-from provider	05/10/23	05/30/23	Becky Jamnick
367	(BBH) BH-Header File-Demo and Clinical Data-from provider	05/10/23	05/30/23	Becky Jamnick
368	(BBH) BH Export to MMIS	05/10/23	05/30/23	Becky Jamnick
369	(BBH) 5 Provider files pass-through	05/10/23	05/30/23	Becky Jamnick
370	File transfers confirmed	05/30/23	05/30/23	--
371	Stakeholder Engagement (inc. Member & Provider Training)	04/05/23	04/25/23	--
372	Stakeholder Engagement Plan	04/05/23	04/25/23	--
373	Identify key stakeholders	04/05/23	04/11/23	Nancy Sullivan, WVDHHR
374	Conduct Stakeholder Analysis/needs	04/12/23	04/18/23	Nancy Sullivan, WVDHHR
375	Develop Stakeholder Engagement Plan/Activities and Communications with WV	04/19/23	04/25/23	Nancy Sullivan, WVDHHR
376	Stakeholder engagement initiated	04/25/23	04/25/23	--
377	Customer Support	04/05/23	06/20/23	--
378	Group email boxes	04/05/23	04/18/23	--
379	Confirm continuation of currently utilized group email boxes	04/05/23	04/18/23	Amber Murphy
380	E-Fax	04/05/23	04/18/23	--
381	Confirm continuation of currently utilized fax lines	04/05/23	04/18/23	Amber Murphy
382	Call Center	04/05/23	05/30/23	--
383	Assess need for any new TF#s, software or hardware	04/05/23	04/18/23	Amber Murphy
384	Confirm current TF#s should be continued	04/05/23	04/18/23	Amber Murphy
385	Confirm continuation of system/agent call routing/workflow, voicemail, scripts, user profile requirements	04/05/23	04/18/23	Amber Murphy
386	Procure any needed items, as identified	04/19/23	05/02/23	Amber Murphy
387	[If needed] Update system configuration, agent call routing, workflow, voicemail, scripts or user profiles	04/19/23	05/16/23	Amber Murphy
388	[If needed] Test updates to system configuration, agent call routing, workflow, voicemail, scripts or user profiles	05/17/23	05/30/23	Amber Murphy
389	Call center changes [if needed] operational	05/30/23	05/30/23	--
390	Public Website	04/05/23	06/20/23	--
391	Assess for needed changes to existing Kepro public website	04/05/23	05/02/23	Nancy Sullivan, WVDHHR
392	Develop public website requirements and materials	05/03/23	05/16/23	Amber Murphy
393	Update website - sandbox	05/17/23	05/30/23	Harry Cook
394	UAT website	05/31/23	06/06/23	Amber Murphy
395	Update website, per UAT; post website content	06/07/23	06/20/23	Harry Cook
396	Mail-Paper	05/10/23	05/23/23	--
397	Assess use of Print vendor (BFC Print) for snail mail processing	05/10/23	05/23/23	Amber Murphy
398	Confirm help center snail mail address, process with WVDHHR	05/10/23	05/23/23	Amber Murphy
399	Business Continuity/Disaster Recovery Plan	05/10/23	06/14/23	--
400	Prepare for delivery- Kepro BC/DR Plan	05/10/23	05/23/23	Perry Coleman
401	Submit BC/DR Plan	05/24/23	05/24/23	Lori McGurty
402	Review/approval of BC/DR Plan	05/25/23	06/14/23	WVDHHR
403	BC/DR accepted	06/14/23	06/14/23	--



	Task Name	Start	Finish	Assigned To
404	Keprō Staff Training	05/04/23	06/30/23	--
405	Develop training content and materials (aligns with applicable Standard Operating Procedures, user guides, job aids)	05/04/23	05/31/23	WV Ops Leaders, per program
406	Conduct systems and operational training (as applicable to position)	06/01/23	06/30/23	WV Ops Leaders, per program

Attachment 5 Business Continuity and Disaster Recovery Procedure

The following pages include our companywide Business Continuity and Disaster Recovery Plan (BCDR). The BDCR will continue to ensure continuity of service to critical business systems and safeguard State data during any emergency. The principles of our BCDR are based on guidance from the National Institute of Standards and Technology (NIST) Contingency Planning Guide for Federal Information Systems, Special Publication 800-34 Rev 1. We will submit a final Business Continuity and Disaster Recovery Plan to the Agency at least 30 calendar days prior to Operations Start date for review and approval.

Procedure Title: **Business Continuity and Disaster Recovery Procedure**	
Procedure Number: ISEC.PRC.0016	Effective Date: 10/01/2022
Owner/Department: Perry Coleman, Compliance	Last Revision Date: 2/2/2023
Approver: Perry Coleman, Compliance	Last Review Date: 2/2/2023
Related Policies: ISEC.016 Business Continuity Planning Policy	Next Scheduled Review Date: 10/1/2023

Business Continuity and Disaster Recovery Procedure

SCOPE

This procedure applies Company-wide.

PROCEDURE

1.0 The Tier 3 Infrastructure Team performs routine backups of information and software, and regularly tests the media and backup restoration procedures.
[BUID: 1616.09l1Organizational.16 | CVID: 0901.0]

2.0 The Tier 3 Infrastructure Team defines and documents a formal definition of the level of backup required for each system, including how each system will be restored, the scope of data to be imaged, frequency of imaging, and retention duration based on relevant contractual, legal, regulatory, and business requirements.
[BUID: 1617.09l1Organizational.23 | CVID: 0902.0]

3.0 The backups are stored in a physically secure remote location, at a sufficient distance to make them reasonably immune from damage to data at the primary site, and reasonable physical and environmental controls are in place to ensure their protection at the remote location.
[BUID: 1618.09l1Organizational.45 | CVID: 0903.0]
[BUID: 1604.12c2Organizational.16789 | CVID: 1516.0]

4.0 The Tier 3 Infrastructure Team configures and maintains the backup schedule (incorporating both incrementation and differential backup methodologies) and automation configuration settings using a backup and recovery engine, which performs integrity checks after each backup. Servers are backed up every night and every production server is stored offsite in Azure Site Recovery every night with at least three generations of stored backups. Inventory records, including name, date, time, and action, are maintained in the data management solution. The service level agreement includes specific protections to control confidentiality, integrity, and availability of the backup information.
[BUID: 1619.09l1Organizational.7 | CVID: 0904.0]
[BUID: 1620.09l1Organizational.8 | CVID: 0905.0]
[BUID: 1621.09l2Organizational.1 | CVID: 0907.0]
[BUID: 1622.09l2Organizational.23 | CVID: 0908.0]
[BUID: 1624.09l3Organizational.12 | CVID: 0910.0]
[BUID: 1625.09l3Organizational.34 | CVID: 0911.0]
[BUID: 1627.09l3Organizational.6 | CVID: 0913.0]

5.0 The Tier 3 Infrastructure Team ensures that backups containing covered information are stored in an encrypted format to ensure confidentiality.
[BUID: 1623.09l2Organizational.4 | CVID: 0909.0]

6.0 Before moving any servers, the Tier 3 Infrastructure Team ensures that a current, retrievable copy of covered information is available, and documented as part of the change management process ticket.
[BUID: 1626.09l3Organizational.5 | CVID: 0912.0]
[BUID: 1689.09lHIXOrganizational.1 | CVID: 0923.0]

7.0 System users submit backup restoration requests in the ticketing system, which is assigned to the Tier 3 Infrastructure Team to fulfill the request.

8.0 The Tier 3 Infrastructure Team conducts disaster recovery simulations twice a year. The test consists of the entire application and environment. The Team schedules the test, provides evidence that the test occurred, documents findings and recommendations from the test, and any remediations performed. They store documentation in a designated folder in SharePoint.
[BUID: 1638.12b2Organizational.345 | CVID: 1512.0]
BUID: 1601.12c1Organizational.1238 | CVID: 1513.0]

9.0 The Risk Advisory Board identifies critical business processes requiring business continuity and formally defines and reviews the level of backup required for each system is defined and documented including how each system will be restored, the scope of data to be imaged, frequency of imaging, and duration of retention based on relevant contractual, legal, regulatory and business requirements.
[BUID: 1690.09lHIXOrganizational.2 | CVID: 0924.0]
[BUID: 1634.12b1Organizational.1 | CVID: 1508.0]

10.0 The Risk Advisory Board ensures the business continuity planning framework addresses the identified set of information security requirements as well as temporary operational procedures to follow pending completion of recovery and restoration. They also ensure plans include a Business Impact Analysis, identify critical missions and business functions, define recovery objectives and priorities, and identify roles and responsibilities assigned to individuals, describing who is responsible for executing which component of the plan (alternatives are nominated as required). The Business Continuity Plans specify the conditions for activating the plans describing the process to be followed (e.g., how to assess the situation, who is to be involved) before each plan is activated; emergency procedures describing the actions to be taken following an incident that jeopardizes business operations; fallback procedures describing the actions to be taken to move essential business activities or support services to alternative temporary locations, and to bring business processes back into operation in the required time-scales; resumption procedures describing the actions to be taken to return to normal business operations; a maintenance schedule specifying how and when the plan will be tested, and the process for maintaining the plan; awareness, education, and training activities designed to create understanding of the business continuity processes and ensure that the processes continue to be effective; and, the critical assets and resources needed to be able to perform the emergency, fallback and resumption procedures.
[BUID: 1635.12b1Organizational.2 | CVID: 1509.0]
[BUID: 1636.12b2Organizational.1 | CVID: 1510.0]
[BUID: 1637.12b2Organizational.2 | CVID: 1511]
[BUID: 1602.12c1Organizational.4567 | CVID: 1514.0]

[BUID: 1607.12c2Organizational.4 | CVID: 1519.0]
[BUID: 1666.12d1Organizational.1235 | CVID: 1542.0]
[BUID: 1668.12d1Organizational.67 | CVID: 1544.0]
[BUID: 1669.12d1Organizational.8 | CVID: 1545.0]
[BUID: 1672.12d2Organizational.3 | CVID: 1548.0]

11.0 The Risk Advisory Board annually reviews the Business Continuity Plans for each business unit, which are stored, modified and published in the policy management system (a secured cloud-hosted vendor solution). When new requirements are identified, any existing emergency procedures (e.g., evacuation plans or fallback arrangements) are amended to meet the requirements.
[BUID: 1603.12c1Organizational.9 | CVID: 1515.0]
[BUID: 1608.12c2Organizational.5 | CVID: 1520.0]
[BUID: 1667.12d1Organizational.4 | CVID: 1543.0]
[BUID: 1670.12d2Organizational.1 | CVID: 1546.0]

12.0 For the sites hosting the information system, the Tier 3 Infrastructure Team selects and contracts with data centers that have emergency power and backup telecommunications.
[BUID: 1605.12c2Organizational.2 | CVID: 1517.0]

13.0 The Tier 3 Infrastructure Team establishes alternate telecommunications services that are sufficiently separated from the primary service provider with priority-of-service provisions, including necessary agreements to permit the resumption of information system operations for essential missions and business functions within a business-defined time period, when the primary telecommunications capabilities are unavailable at either the primary or alternate processing or storage sites. The organization develops primary and alternate telecommunications service agreements that contain priority-of-service provisions in accordance with organizational availability requirements (including recovery time objectives); and requests telecommunications service priority for all telecommunications services used for national security emergency preparedness in the event that the primary and/or alternate telecommunications services are provided by a common carrier.
[BUID: 1609.12c3Organizational.12 | CVID: 1521.0]

14.0 The Tier 3 Infrastructure Team ensures all equipment and supplies required for resuming system operations at the alternate processing site are available, or contracts are in place to support delivery to the site to permit resumption of essential missions and business functions within one week of contingency plan activation.
[BUID: 1663.12cHIXOrganizational.1 | CVID: 1539.0]

15.0 The Tier 3 Infrastructure Team ensures alternate telecommunications Service Level Agreements (SLAs) are in place to permit resumption of information system operations for essential missions and business functions within a system owner-defined, business owner-approved time period consistent with the Recovery Time Objectives, Maximum Tolerable Downtimes (MTDs), and business impact analysis for the system when primary telecommunications capabilities are unavailable.
[BUID: 1664.12cHIXOrganizational.2 | CVID: 1540.0]

16.0 The Information Security Team determines the appropriate compensating security controls to address vulnerabilities and risks in situations where it is not possible to fully recover and return to a known and secure state. These controls may include backup and disaster recovery plans,

redundant systems and processes, or other measures.
[BUID: 1665.12cHIXOrganizational.3 | CVID: 1541.0]

17.0 The CIO ensures that the change management process formally addresses business continuity matters (e.g., changes to continuity systems, alternative process sites, availability requirements).
[BUID: 1671.12d2Organizational.2 | CVID: 1547.0]

RELEVANT DOCUMENTS

REVISION HISTORY

Date	Revision	Approved By
10/01/2022	Initial publication	Perry Coleman, Compliance
1/19/2023	Reviewed/Updated per HITRUST guidance	Perry Coleman, Compliance

Attachment 6 Required Signed Forms

The following pages include the forms that require our signature.

Addendum 1

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

State of West Virginia
Centralized Request for Proposals
Info Technology

Proc Folder: 876562	**Reason for Modification:**
Doc Description: UTILIZATION MANAGEMENT AND PRIOR AUTHORIZATION	ADDENDUM 1 TO EXTEND PROPOSAL OPENING DATE
Proc Type: Central Master Agreement	

Date Issued	Solicitation Closes	Solicitation No	Version
2023-02-21	2023-03-07 13:30	CRFP 0511 BMS2300000002	2

BID RECEIVING LOCATION

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

VENDOR

Vendor Customer Code: 000000125086
Vendor Name : Keystone Peer Review Organ ization, LLC (Kepro)
Address :
Street : 777 East Park Drive
City : Harrisburg
State : Pennsylvania **Country :** United States **Zip :** 17111
Principal Contact : Meghan Harris, President and COO
Vendor Contact Phone: (216) 392-2833 **Extension:**

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X **FEIN#** 23-2348176 **DATE** March 8, 2023

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

Date Printed: Feb 21, 2023 Page: 1 FORM ID: WV-PRC-CRFP-002 2020/05

ADDITIONAL INFORMATION

THE STATE OF WEST VIRGINIA PURCHASING DIVISION FOR THE AGENCY, DEPARTMENT OF HEALTH AND HUMAN RESOURCES (DHHR), BUREAU FOR MEDICAL SERVICES (BMS), IS SOLICITING PROPOSALS TO ESTABLISH AN OPEN-END CONTRACT TO PROVIDE UTILIZATION MANAGEMENT (UM) AND PRIOR AUTHORIZATION (PA) SERVICES PER THE ATTACHED DOCUMENTS.

QUESTIONS REGARDING THE SOLICITATION MUST BE SUBMITTED IN WRITING TO CRYSTAL.G.HUSTEAD@WV.GOV PRIOR TO THE QUESTION PERIOD DEADLINE CONTAINED IN THE INSTRUCTIONS TO VENDORS SUBMITTING BIDS

ONLINE RESPONSES ARE PROHIBITED FOR THIS SOLICITATION

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

Line	Comm Ln Desc	Qty	Unit of Measure	Unit Price	Total Price
1	Utilization Management and Prior Authorization Services	0.00000			

Comm Code	Manufacturer	Specification	Model #
80000000			

Extended Description:
Utilization Management and Prior Authorization Services

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2023-02-10

SOLICITATION NUMBER: CRFP 0511 BMS2300000002
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

[ ] Correction of error

[ ] Other

Description of Modification to Solicitation:

1. To extend the proposal opening date to 03/07/2023 at 1:30 PM ET

Answers to vendor questions will be addressed in a forthcoming addendum

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.

Revised 6/8/2012

ATTACHMENT A

Revised 6/8/2012

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS2300000002

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
[ ]	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 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.

Keystone Peer Review Organization, LLC (Kepro)
Company

Authorized Signature

February 27, 2023
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

Addendum 2

Department of Administration Purchasing Division 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	State of West Virginia Centralized Request for Proposals Info Technology

Proc Folder: 876562 **Doc Description:** UTILIZATION MANAGEMENT AND PRIOR AUTHORIZATION **Proc Type:** Central Master Agreement			**Reason for Modification:** ADDENDUM 2 TO PROVIDE ANSWERS TO VENDOR QUESTIONS AND EXTEND OPENING DATE
Date Issued	**Solicitation Closes**	**Solicitation No**	**Version**
2023-02-28	2023-03-14 13:30	CRFP 0511 BMS2300000002	3

BID RECEIVING LOCATION

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

VENDOR

Vendor Customer Code: 000000125086
Vendor Name : Keystone Peer Review Organization, LLC
Address :
Street : 777 East Park Drive
City : Harrisburg
State : Pennsylvania **Country :** United States **Zip :** 17111
Principal Contact : Meghan Harris
Vendor Contact Phone: (216) 392-2833 **Extension:** (717) 564-3862

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X **FEIN#** 23-2348176 **DATE** March 8, 2023

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

Date Printed: Feb 28, 2023 Page: 1 FORM ID: WV-PRC-CRFP-002 2020/05

ADDITIONAL INFORMATION

THE STATE OF WEST VIRGINIA PURCHASING DIVISION FOR THE AGENCY, DEPARTMENT OF HEALTH AND HUMAN RESOURCES (DHHR), BUREAU FOR MEDICAL SERVICES (BMS), IS SOLICITING PROPOSALS TO ESTABLISH AN OPEN-END CONTRACT TO PROVIDE UTILIZATION MANAGEMENT (UM) AND PRIOR AUTHORIZATION (PA) SERVICES PER THE ATTACHED DOCUMENTS.

QUESTIONS REGARDING THE SOLICITATION MUST BE SUBMITTED IN WRITING TO CRYSTAL.G.HUSTEAD@WV.GOV PRIOR TO THE QUESTION PERIOD DEADLINE CONTAINED IN THE INSTRUCTIONS TO VENDORS SUBMITTING BIDS

ONLINE RESPONSES ARE PROHIBITED FOR THIS SOLICITATION

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

Line	Comm Ln Desc	Qty	Unit of Measure	Unit Price	Total Price
1	Utilization Management and Prior Authorization Services	0.00000			

Comm Code	Manufacturer	Specification	Model #
80000000			

Extended Description:
Utilization Management and Prior Authorization Services

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2023-02-10

Date Printed: Feb 28, 2023 Page: 2 FORM ID: WV-PRC-CRFP-002 2020/05

SOLICITATION NUMBER: CRFP BMS2300000002
Addendum Number: 2

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

[ ] Correction of error

[ ] Other

Description of Modification to Solicitation:

1. To provide answers to vendor questions
2. To extend proposal opening date to 03/14/2023 at 1:30 PM ET

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.

Revised 6/8/2012

ATTACHMENT A

Revised 6/8/2012

Questions and Answers for Addendum Two:
BMS Request for Proposal: BMS2300000002

Question #	Section	Question	Answer:
1	4.2.1.22	Does BSS have a preference regarding evidence based criteria?	Yes, BSS prefers evidence based criteria, but not necessarily a preference on a specific curriculum.
2	Attachment A / Cost Bid Sheet	Will volumes be provided to help vendors provide competitive pricing?	The cost for each service line is a fixed cost. Pricing is not transactional. Please see Attachment 1 for enrollment numbers for the Medicaid and CHIP program (Pre-Covid-February 2020, and Current-February 2023). Population(s) from the total enrollment may be associated with individual services. Volumes for BBH and BSS are varied based on other factors, so no volume is available.
3	Attachment A / Cost Bid Sheet	Section A and Section C, where applicable for each tab, clarifies Year 1 as providing 9 months of pricing, however Section B and Section D, again where applicable for each tab, does not make this distinction. Will we be providing a full 12 months of pricing in Year 1, unless stated otherwise?	A corrected pricing page has been included with Addendum 2.
4	6.7 / Cost Evaluation Formula	Will cost scores be rounded to a specific decimal number?	Cost score will be rounded to 4th decimal place.
5	Attachment A / Cost Bid Sheet	On the Summary tab, the Grand Total for BMS only includes Sections A, B, C. Should this also include Section D?	A corrected pricing page has been included with Addendum 2.
6	Attachment A / Cost Bid Sheet	On the Summary tab, the Grand Total for BSS includes a Section C, however there is no Section C in the BSS tab. Should the BSS tab include an additional Section C?	A corrected pricing page has been included with Addendum 2.
7	Attachment A / Cost Bid Sheet	On the Summary tab, the Grand Total for BBHHF includes a Section B, however there is no Section B in the BSS tab. Should the BBHHF tab include an additional Section B?	A corrected pricing page has been included with Addendum 2.
8	4.2.2.6.1	Can you provide the current formats that must be used for data transfers?	Common formats are JSON, XML, and CSV. The vendor should propose its data transfer format.
9	4.2.2.3	As WV transitions to modernize your MES environment, should new interfaces with a system integrator or other modules be accounted for in the scope of this contract?	Yes.
10	Appendix 4: Implementation Work Plan	Our work plan will include specific communication and training tasks to transition providers to a new portal. Is the Agency willing to accept the Work Plan sooner than 14 calendar days for contract award, and will you approve the work plan sooner than the planned for 15 working days, so that we can start provider communications as soon as possible in the 3 month implementation period?	Yes, the work plan can be submitted earlier. The Agency will approve the work plan within fifteen (15) days of receipt.
11	Appendix 4: Implementation Work Plan	Should a data migration from the current vendor system be included in our implementation plan?	Yes.
12	General	Will IDD ISS/GH Health and Welfare check assessments services be included in the contract?	Yes.
13	General	Will authorizations, retro reviews and on-site program certifications for the SUD Waiver be included in the contract?	Yes.
14	General	Will Behavioral Health Outpatient Retrospective Documentation Review services be included in the contract?	Yes.
15	Appendix 1.1.q.4.p ADW	"p. Export authorization and member eligibility data to the Online Case Management and Integrated Incident Reporting/Management System (IMS)." How often will this need exported? Is the export to the IMS expected via file transfer or other mode?	Export will be daily. The mode will be file transfer.
16	Appendix 5 - Reporting Requirement I/DD 24 Hour Residential Settings Report	How does the I/DD 24 Hour Residential Settings Report data requirements relate to Appendix 1.1.n	It is addressed in Appendix 1 under N.7.t.
17	Appendix 1.2.c	Does BMS foresee additional provider groups/service types to be included that are not covered in Appendix 1.2.c and 1.2.d?	Yes. Possibly Certified Community Behavioral Health Clinics (CCBHC), Mobile Crisis Teams and Center of Excellence (COE's).

Questions and Answers for Addendum Two:
BMS Request for Proposal: BMS2300000002

Question #	Section	Question	Answer:
18	General	Please verify quality reviews are expected for only programs identified in RFP.	All programs identified in RFP are subject to quality review request. Quality review for services not identified in the RFP will be processed with an approved Statement of Work (SOW) using the additional services hourly rate.
19	Appendix 1.4.c.4.b	"b. Conduct initial and annual certification reviews of new and existing IDDW providers to include on-site and desk review as requested by the Agency." Please provide the anticipated volume of initial and annual certification reviews for ADW providers.	No estimate is a available. There has been an average of two (2) new agencies in recent years. There are currently 81 ADW Case Management agencies, 135 ADW Personal Attendant agencies, and 73 Personal Care agencies.
20	Appendix 1.4.c.4.c	"c. Conduct quality reviews of all ADW providers at to verify compliance with current policies, appropriate utilization management and documentation of authorized services. This includes, but is not limited to, notifying the provider agencies of reviews based upon timelines established by the Agency, identifying issues that potentially result in disallowances of provider agency claims payments and calculating the disallowance amounts. This review shall include providers with active/enrolled ADW members at the time of the specified review period. The findings of the quality reviews shall be verbally presented to the agency at the time of the review and provided in writing to the agency at the completion of the review. The Vendor will track the agency's Plan of Correction (when applicable)." Please provide the anticipated volume of quality reviews for ADW providers.	The annual quality reviews of ADW providers is performed at the same time as their annual agency certification. The volume of current providers is provided in Question 19.
21	Appendix 1.4.c.5	"5. Conduct interviews of members annually using a mutually agreed upon sample of enrolled members. The Agency will determine the interview tool and whether the interviews will be face-to-face or by telephone." Please provide the anticipated volume/sample methodology for conducting ADW member interviews.	The survey sample size is approximately 10% of active program members.
22	Appendix 1.4.c.6	"6. Receive, track, triage or investigate complaints submitted by providers, members, or other stakeholders. Complaints will be reported to the Agency each month." Please provide the anticipated number of ADW complaints to be investigated.	The number of written complaints received in SFY22 averaged less than one per month.
23	Appendix 1.4.d.4.b	"b. Conduct initial and annual certification reviews of new and existing Personal Care agencies to include on-site and desk review as requested by the Agency." Please provide the anticipated volume of initial and annual certification reviews for PC agencies.	There are currently 73 Personal Care agencies that require annual recertifications. In FY21 and FY22, no new Personal Care agencies were enrolled therefore no initial certifications were completed.
24	Appendix 1.4.d.4.c	"c. Conduct quality reviews of all Personal Care agencies to verify compliance with current policies, appropriate utilization management and documentation of authorized services. This includes, but is not limited to, notifying the provider agencies of reviews based upon timelines established by the Agency, identifying issues that potentially result in disallowances of provider agency claims payments and calculating the disallowance amounts. This review shall include providers with active/enrolled members at the time of the specified review period. The findings of the quality reviews shall be verbally presented to the agency at the time of the review and provided in writing to the agency at the completion of the review. The Vendor will track the agency's Plan of Correction (when applicable)." Please provide the anticipated volume of quality reviews for PC agencies.	The annual quality reviews of Personal Care providers is performed at the same time as their annual agency certification. There are currently 73 Personal Care agencies.
25	Appendix 1.4.d.5	"5. Conduct interviews of members annually using a mutually agreed upon sample of enrolled members. The Agency will determine the interview tool and whether the interviews will be face-to-face or by telephone." Please provide the anticipated volume/sample methodology for conducting PC member interviews.	There are currently 6,200 active Personal Care members and the sample size for the survey is approximately 10%.
26	Appendix 1.4.d.6	"6. Receive, track, triage or investigate complaints submitted by providers, members, or other stakeholders. Complaints will be reported to the Agency each month." Please provide the anticipated number of PC complaints to be investigated.	In SFY 22 the average number of written complaints for the Personal Care program was less than one per month.
27	Appendix 1.4.e.2	"2. The Vendor shall ensure the Ambulance provider meets all Agency requirements and utilizes the appropriate mode of transport for the requested trip type. Trip Types: Specific authorization standards unique to specific trip types are defined as follows:" Please provide the anticipated number of ambulance transports, by trip type.	The cost for each service line is a fixed cost. Pricing is not transactional. Please see Attachment 1 for enrollment numbers for the Medicaid and CHIP program (Pre-Covid-February 2020, and Current-February 2023). Population(s) from the total enrollment may be associated with individual services.

Questions and Answers for Addendum Two:
BMS Request for Proposal: BMS2300000002

Question #	Section	Question	Answer:
28	Appendix 1.7.b.4.b	"b. Conduct initial and annual certification reviews of new and existing Personal Care agencies to include on-site and desk review as requested by the Agency." Please provide the anticipated volume of initial and annual certification reviews for CHIP PC agencies.	There is no data or information to share about the anticipated volume of initial and annual certification reviews for CHIP PC agencies. Volume is expected to be low."
29	Appendix 1.7.b.4.c	"c. Conduct quality reviews of all Personal Care agencies to verify compliance with current policies, appropriate utilization management and documentation of authorized services. This includes, but is not limited to, notifying the provider agencies of reviews based upon timelines established by the Agency, identifying issues that potentially result in disallowances of provider agency claims payments and calculating the disallowance amounts. This review shall include providers with active/enrolled members at the time of the specified review period. The findings of the quality reviews shall be verbally presented to the agency at the time of the review and provided in writing to the agency at the completion of the review. The Vendor will track the agency's Plan of Correction (when applicable)." Please provide the anticipated volume of quality reviews for CHIP PC agencies.	There is no data or information to share about the anticipated volume of quality reviews for CHIP PC agencies. Volume is expected to be low.
30	Appendix 1.7.b.5	"5. Conduct interviews of members annually using a mutually agreed upon sample of enrolled members. The Agency will determine the interview tool and whether the interviews will be face-to-face or by telephone." Please provide the anticipated volume/sample methodology for conducting CHIP PC member interviews.	There is no data or information to share about the anticipated volume/sample methodology for conducting CHIP PC member interviews. Volume is expected to be low.
31	Appendix 1.7.b.6	"6. Receive, track, triage or investigate complaints submitted by providers, members, or other stakeholders. Complaints will be reported to the Agency each month." Please provide the anticipated number of CHIP PC complaints to be investigated.	There is no data or information to share about the anticipated number of CHIP PC complaints to be investigated. Volume is expected to be low.
32	Appendix 1.7.c.2	"2. The Vendor shall ensure the Ambulance provider meets all Agency requirements and utilizes the appropriate mode of transport for the requested trip type. Trip Types: Specific authorization standards unique to specific trip types are defined as follows:" Please provide the anticipated number of CHIP ambulance transports, by trip type.	The cost for each service line is a fixed cost. Pricing is not transactional. Please see Attachment 1 for enrollment numbers for the Medicaid and CHIP program (Pre-Covid-February 2020, and Current-February 2023). Population(s) from the total enrollment may be associated with individual services.
33	Additional Information ***ONLINE RESPONSES ARE PROHIBITED FOR THIS SOLICITATION***	Please clarify if bidders are to submit proposals through wvOASIS or in paper form delivered to the Purchasing Division.	Submission of a response to a Request for Proposal is not permitted in wvOASIS. In the event that Vendor is responding to a request for proposal, the Vendor shall submit one original technical and one original cost proposal prior to the bid opening date and time identified in Section 7 below, plus N/A convenience copies of each to the Purchasing Division at the address shown below. Additionally, the Vendor should clearly identify and segregate the cost proposal from the technical proposal in a separately sealed envelope. Bid Delivery Address: Department of Administration, Purchasing Division 2019 Washington Street East Charleston, WV 25305-0130
34	4.2.1.5	Does the State require denial notices be sent by trackable mail to the provider, member, and/or member's representative?	Yes, denial notices are to be mailed using certified mail that required recipient's signature.

Questions and Answers for Addendum Two:
BMS Request for Proposal: BMS2300000002

Question #	Section	Question	Answer:
35	4.2.1.11	To support accurate scoping by all vendors, please provide the historic annual volumes for each method that requests are received.	BSS does not have a mechanism to track the method of request. The following reflects the volume of social necessary referrals sent through BSS: CY2020 57,477 CY2021 71,323 CY2022 68,960 Total Authorizations: 197,760 Average Overall: 65,920
36	4.2.1.16	Is training required to be in person or are remote/online trainings acceptable?	Online Virtual Training is acceptable.
37	4.2.1.26	Does the State require a minimum sample size by provider for retrospective reviews?	Retrospective Reviews take place once every 18 months for agencies currently providing services for the department's families. The reviews can vary in size based on the number of services being reviewed.
38	4.2.2.5.3	Please verify if all professional staff listed are required to be licensed in West Virginia.	Yes. A compact license will be also acceptable for the Registered Nurse.
39	4.2.2.6.1	Can the state support SFTP (FTP over SSH) for secure data transmission?	Yes.
40	4.2.2.11	Please verify if the Registered Nurse is required to be licensed in West Virginia or is a nursing compact license acceptable?	For Registered Nurse position only either would be acceptable.
41	Appendix 1: BMS/ WVCHIP Detailed Specifications – o. Children with Serious Emotional Disorder (SED) Waiver Services 8.	To support accurate scoping by all vendors, please provide the historic annual volumes of quality assurance activities requested over the past three years.	The cost for each service line is a fixed cost. Pricing is not transactional. Please see Attachment 1 for enrollment numbers for the Medicaid and CHIP program (Pre-Covid-February 2020, and Current-February 2023). Population(s) from the total enrollment may be associated with individual services. Volumes for BBH are varied based on other factors, so no volume is available.
42	Appendix 1: BMS/ WVCHIP Detailed Specifications – 11	To support accurate scoping by all vendors, please provide the historic volumes of provider trainings and technical assistance requested over the past three years.	The cost for each service line is a fixed cost. Pricing is not transactional. Please see Attachment 1 for enrollment numbers for the Medicaid and CHIP program (Pre-Covid-February 2020, and Current-February 2023). Population(s) from the total enrollment may be associated with individual services. Volumes for BBH are varied based on other factors, so no volume is available.
43	4.2.2.7 Appendix 6: Service Level Agreements (SLAs)	Please provide a listing of contract activities that are considered deliverables in relation to this Service Level Agreement.	Any activity with a deliverable in the contract relate to the Service Level Agreement.
44	Attachment A: Cost Sheet	To support accurate scoping by all vendors, please provide the historic annual volumes for each of the last 3 contract years for each of the Review services listed in the Cost Sheet.	The cost for each service line is a fixed cost. Pricing is not transactional. Please see Attachment 1 for enrollment numbers for the Medicaid and CHIP program (Pre-Covid-February 2020, and Current-February 2023). Population(s) from the total enrollment may be associated with individual services. Volumes for BBH and BSS are varied based on other factors, so no volume is available.

BUREAU FOR MEDICAL SERVICES (BMS)

Section A: Mandatory Services

RFP Ref.	Reviewed Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (1.a.)	Inpatient Medical/Surgical Services									
Appendix 1, (1.b.)	Organ Transplant Services									
Appendix 1, (1.c.)	Hospice Services									
Appendix 1, (1.d.)	Durable Medical Equipment and Supplies/Orthotics and Prosthetics Services									
Appendix 1, (1.e.)	Vision Services									
Appendix 1, (1.f.)	Audiology Services									
Appendix 1, (1.g.)	Outpatient Physical Therapy, Occupational Therapy and Speech Therapy Services									
Appendix 1, (1.h.)	Physician and Non-Physician Practioner Services									
Appendix 1, (1.i.)	Home Health Services									
Appendix 1, (1.j.)	Private Duty Nursing Services									
Appendix 1, (1.k.)	Diagnostic Imaging/Radiology Services									
Appendix 1, (1.l.)	Nursing Home Eligibility and Pre-Admission Screening and Resident Review (PASRR) Eligibility Services									
Appendix 1, (1.m.)	Traumatic Brain Injury (TBI) Waiver Services									
Appendix 1, (1.n.)	Intellectual/Developmental Disabilities Waiver (IDDW) Services									
Appendix 1, (1.o.)	Children with Serious Emotional Disorder (CSED) Waiver Services									
Appendix 1, (1.p.)	Personal Care Services									
Appendix 1, (1.q.)	Aged and Disabled Waiver (ADW) Services									
Appendix 1, (1.r.)	Take Me Home (TMH) Services									
Appendix 1, (1.s.)	Lab/Genetics Services									
Appendix 1, (1.t.)	Out-of-Network (OON) Services									
Appendix 1, (1.u.)	Cardiac Rehabilitation Services									
Appendix 1, (1.v.)	General and Acute Care Inpatient Hospital Admission and Continued Stay Review Services									
Appendix 1, (1.w.)	Pulmonary Rehabilitation Services									
Appendix 1, (1.x.)	Chiropractic Services									
Appendix 1, (1.y.)	Podiatry Services									
Appendix 1, (1.z.)	Case Management Services									
Appendix 1, (1.aa.)	Expanded EPSDT Services and Criteria Development Services									
Appendix 1, (1.bb.)	Health Home Services									
Appendix 1, (1.cc.)	Long-Term Acute Care (LTAC) Services									
Appendix 1, (1.dd.)	School-Based Health Services									
Appendix 1, (1.ee.)	Inpatient Rehabilitation Services									
Appendix 1, (1.ff.)	Specialty Medications/Physician Administered Drug Services									
Appendix 1, (1.gg.)	Applied Behavioral Analysis (ABA) Services									
Appendix 1, (2.a.)	Inpatient Psychiatric Services									

Appendix 1, (2.b.)	Targeted Case Management Services									
Appendix 1, (2.c.)	Licensed Behavioral Health Center Services									
Appendix 1, (2.d.)	Behavioral Health Outpatient Services									
Appendix 1, (2.e.)	Psychiatric Residential Treatment Facility Services									
Appendix 1, (2.f.)	Inpatient Psychiatric Services for Individuals under 21 years of age									
Appendix 1, (2.g.)	Behavioral Health Services Criteria Development									
Appendix 1, (3.a.)	Dental Services									
Appendix 1, (3.b.)	Oral and Maxillofacial Dental Surgery Services									
Appendix 1, (3.c.)	Orthodontia Services									
Appendix 1, (3.d.)	Dental Services Criteria Development									
Section A: Total Mandatory Services										
Total Mandatory Services Year 1 Start Up Costs (3 Months)										
Section A: Total Mandatory Services (Operational + Start Up)										

Section B: Optional Services

Optional Program Services:

RFP Section	Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (4.a.)	Clinical/Medical Consulting Services									
	Start Up 3 (3 Months)									
Total Optional Clinical/Medical Consulting Services Program (Operational + Start Up)										

RFP Section	Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (4.b.)	Intermediate Care Facility for individuals with Intellectual Disabilities (ICF/IID) Eligibility Services									
	Start Up (3 Months)									
Total Optional Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) Eligibility (Operational + Start Up)										

RFP Section	Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (4.c.)	Aged and Disabled Waiver (ADW) Functions									
	Start Up (3 Months)									
Total Optional Aged and Disabled Waiver (ADW) Functions (Operational + Start Up)										

RFP Section	Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (4.d.)	Personal Care Functions									
	Start Up (3 Months)									
Total Personal Care Functions (Operational + Start Up)										

RFP Section	Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (4.e.)	Ambulance Transportation Sevices									
	Start Up (3 Months)									
Total Optional Ambulance Transportation Program (Operational + Start Up)										

RFP Section	Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (4.f.)	Online Case Management System with Integrated Incident Reporting/Management (IMS) for Home and Community-Based Services (HCBS)									
	Start Up (3 Months)									
Total Optional Online Case Management System with Integrated Incident Reporting/Management (IMS) for Home and Community-Based Services (HCBS) (Operational + Start Up)										

Section B: Total Optional Services (Operational + Start Up)										

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Grand Total BMS (Section A + B)									

WEST VIRGINIA CHILDREN'S HEALTH INSURANCE PROGRAM (WVCHIP)

Section C: Mandatory Services

RFP Ref.	Reviewed Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (5.a.)	Inpatient Medical/Surgical Services									
Appendix 1, (5.b.)	Organ Transplant Services									
Appendix 1, (5.c.)	Hospice Services									
Appendix 1, (5.d.)	Durable Medical Equipment, Supplies, and Orthotics and Prosthetics Services									
Appendix 1, (5.e.)	Vision Services									
Appendix 1, (5.f.)	Audiology Services									
Appendix 1, (5.g.)	Outpatient Physical Therapy, Occupational Therapy and Speech Therapy Services									
Appendix 1, (5.h.)	Physician and Non-Physician Practitioner Services									
Appendix 1, (5.i.)	Home Health Services									
Appendix 1, (5.j.)	Diagnostic Imaging/Radiology Services									
Appendix 1, (5.k.)	Lab/Genetics Services									
Appendix 1, (5.l.)	Out-of-Network (OON) Services									
Appendix 1, (5.m.)	Cardiac Rehabilitation Services									
Appendix 1, (5.n.)	Pulmonary Rehabilitation Services									
Appendix 1, (5.o.)	Chiropractic Services									
Appendix 1, (5.p.)	Podiatry Services									
Appendix 1, (5.q.)	Case Management Services									
Appendix 1, (5.r.)	Specialty Medications/Physician Administered Drugs Services									
Appendix 1, (5.s.)	Applied Behavior Analysis (ABA) Services									
Appendix 1, (6.a.)	Dental Services									
Appendix 1, (6.b.)	Orthodontia Services									
Section A: Total Mandatory Services										

Total Mandatory Services Year 1 Start Up Costs (3 Months)									
Section C: Total Mandatory Services (Operational + Start Up)									

Section D: Optional Services

Optional Program Services:

RFP Section	Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (7.a.)	Clinical/Medical Consulting Services									
	Start Up (3 Months)									
Total Optional Clinical/Medical Consulting Services Program (Operational + Start Up)										

RFP Section	Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (7.b.)	Personal Care Functions									
	Start Up (3 Months)									
Total Personal Care Functions (Operational + Start Up)										

RFP Section	Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 1, (7.c.)	Ambulance Transportation Services									
	Start Up (3 Months)									
Total Optional Ambulance Transportation Program (Operational + Start Up)										

Section D: Total Optional Services (Operational + Start Up)									

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Grand Total WVCHIP (Section C + D)									

TOTAL BMS and WVCHIP

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Grand Total BMS and WVCHIP (Section A + B)+ (Section C+D)									

Notes:

1.) The Vendors Grand Total will include all costs necessary to perform these services.
2.) The cost bid will be evaluated on the Total Not to Exceed Cost of Contract for BMS/WVCHIP, BSS and BBH for the eight (8) year period.
3.) Vendor will not be eligible to invoice any operational or programmatic costs while invoicing for start-up costs.
4.) Program services shall be invoiced monthly in arrears.
5.) Any decrease in benefit or membership as a result of transferring to managed care or otherwise will result in a net reduction in payment for each applicable service/review category listed above in which the benefit is included in the capitated agreement.
The reduction will be based on the following formula:
(1 – (FFS Members – Transitioning MCO members) / (FFS Members)) = Percent reduction
6.) Any increase in benefit or membership as a result of transferring from managed care to FFS or otherwise will result in a net increase in payment for each applicable service/review category listed above in which the benefit is included in the capitated agreement.
The increase will be based on the following formula:
(1 - (FFS Members + Transitioning MCO members) / (FFS Members)) = Percent Increase

_____
(Company)

_____
(Representative Name, Title)

_____
(Contact Phone/Fax Number)

_____
(Date)

_____
Remit To Address

Attachment A COST BID SHEET
BUREAU FOR SOCIAL SERVICES (BSS)

Section A: Mandatory Services:

RFP Section	Reviewed Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 2 (A)	General Requirements									
Appendix 2 (B)	Non-Medical Services									
Appendix 2 (C)	Qualified Residential Treatment Program Independent Assessments									
Appendix 2 (D)	Behavioral Health Services Children's Out-of-State Residential Programs									
Appendix 2 (E)	Psychological Evaluations									
Section A-E: Total Mandatory Services										

Total Mandatory Services Year 1 Start Up Costs (3 Months)										
Section A-E: Total Mandatory Services (Operational + Start Up)										

Section B: Optional Services

RFP Section	Reviewed Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 2 (F)	CANS-based Necessity Establishment System									
	Start Up (3 Months)									
Total Optional Research and Consultation on Service Provisions										

Section B: Total Optional Services (Operational + Start Up)										

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Grand Total BSS (Section A+B)									

Notes:
1.) The Vendors Grand Total will include all costs necessary to perform these services.
2.) The cost bid will be evaluated on the Total Not to Exceed Cost of Contract for BMS/WVCHIP, BSS and BBH for the eight (8) year period .
3.) Vendor will not be eligible to invoice any operational or programmatic costs while invoicing for start-up costs.
4.) Program services shall be invoiced monthly in arrears.

Keystone Peer Review Organization, LLC
(Company)

Meghan Harris, President and COO
(Representative Name, Title)

(216) 392-2833 / (717) 564-3862
(Contact Phone/Fax Number)

March 3, 2023
(Date)

777 East Park Drive, Harrisburg, PA, 17111
Remit To Address

ATTACHMENT A COST BID SHEET
BUREAU FOR BEHAVIORAL HEALTH (BBH)

Section A: Mandatory Services

RFP Section	Reviewed Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Appendix 3 (a.)	BBH Comprehensive Service Data Collection									
Appendix 3 (b.)	Satisfaction Surveys									
Total Mandatory Service Operational Costs										
Total Mandatory Services Year 1 Start Up Costs (3 Months)										
Section A: Total Mandatory Services (Operational + Start Up)										

Notes:
1.) The Vendors Grand Total will include all costs necessary to perform these services.
2.) The cost bid will be evaluated on the Total Not to Exceed Cost of Contract for BMSAWVCHIP, BSS and BBH for the eight (8) year period.
3.) Vendor will not be eligible to invoice any operational or programmatic costs while invoicing for start-up costs.
4.) Program services shall be invoiced monthly in arrears.

_____
(Company)

_____
(Representative Name, Title)

_____
(Contact Phone/Fax Number)

_____
(Date)

_____
Remit To Address

Attachment A COST BID SHEET
ALL BUREAUS

Section A: Additional Services

RFP Ref.	Reviewed Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
RFP 4.2.2.12	a. Hourly Rate									
	b.. Assumed Hours									
	Total Hourly Services (a*b)									
Section A: Total Additional Services										

Section B: Ad Hoc Reporting

RFP Ref.	Reviewed Service/Program	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
4.2.2.13	a. Rate per report									
	b.. Assumed Estimated Quantity (10 Per Year)									
	Total Ad Hoc Report Cost (a*b)									
Section B: Ad Hoc Reporting										

	Year 1 (9 Months)	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Grand Total All Bureaus Additional Services and Ad									

Notes:
1.) The Vendors Grand Total will include all costs necessary to perform these services.
2.) The cost bid will be evaluated on the Total Not to Exceed Cost of Contract for BMS/WVCHIP, BSS and BBH for the eight (8) year period .
3.) Vendor will not be eligible to invoice any operational or programmatic costs while invoicing for start-up costs.
4.) Program services shall be invoiced monthly in arrears.
5.) All hours and reports included in the pricing calculation are for bid purposes only, and are not considered to be an annual project cap.

_____
(Company)

_____
(Representative Name, Title)

_____
(Contact Phone/Fax Number)

_____
(Date)

Attachment A COST BID SHEET-SUMMARY

	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	TOTAL
Grand Total BMS (Section A + B + C + D)									
Grand Total BSS (Section A + B)									
Grand Total BBH (Section A)									
Grand Total All Bureaus Additional Services and Ad Hoc Reporting (Section A + B)									
Grand Total									

Notes:
1.) The Vendors Grand Total will include all costs necessary to perform these services.
2.) The cost bid will be evaluated on the Total Not to Exceed Cost of Contract for BMS/WVCHIP, BSS and BBH for the eight (8) year period .
3.) Vendor will not be eligible to invoice any operational or programmatic costs while invoicing for start-up costs.
4.) Program services shall be invoiced monthly in arrears.

Addendum 2, Attachment 1

	Pre-Covid (February 2020)	Current (February 2023)
Medicaid Total	**518,044**	**666,700**
Fee For Service Only	**130,607**	**127,056**
WVCHIP Total	**23,448**	**18,989**
Fee For Service Only	*	**2,595**

*** WVCHIP Moved to MCO 1/1/21.**

ADDENDUM ACKNOWLEDGEMENT FORM
SOLICITATION NO.: BMS2300000002

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
[ ]	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 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.

Keystone Peer Review Organization, LLC.
Company

Authorized Signature

March 6, 2023
Date

NOTE: This addendum acknowledgement should be submitted with the bid to expedite document processing.
Revised 6/8/2012

West Virginia CRFP Form

Department of Administration Purchasing Division 2019 Washington Street East Post Office Box 50130 Charleston, WV 25305-0130	**State of West Virginia** **Centralized Request for Proposals** **Info Technology**	

Proc Folder: 876562 **Doc Description:** UTILIZATION MANAGEMENT AND PRIOR AUTHORIZATION **Proc Type:** Central Master Agreement			**Reason for Modification:** ADDENDUM 1 TO EXTEND PROPOSAL OPENING DATE
Date Issued	**Solicitation Closes**	**Solicitation No**	**Version**
2023-02-21	2023-03-07 13:30	CRFP 0511 BMS2300000002	2

BID RECEIVING LOCATION

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

VENDOR

Vendor Customer Code: 000000125086

Vendor Name : Keystone Peer Review Organization, LLC (Kepro)

Address :

Street : 777 East Park Drive

City : Harrisburg

State : Pennsylvania **Country :** United States **Zip :** 17111

Principal Contact : Meghan Harris, President and COO

Vendor Contact Phone: (216) 392-2833 **Extension:**

FOR INFORMATION CONTACT THE BUYER
Crystal G Hustead
(304) 558-2402
crystal.g.hustead@wv.gov

Vendor Signature X **FEIN#** 23-2348176 **DATE** March 8, 2023

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

Date Printed: Feb 21, 2023 Page: 1 FORM ID: WV-PRC-CRFP-002 2020/05

ADDITIONAL INFORMATION

THE STATE OF WEST VIRGINIA PURCHASING DIVISION FOR THE AGENCY, DEPARTMENT OF HEALTH AND HUMAN RESOURCES (DHHR), BUREAU FOR MEDICAL SERVICES (BMS), IS SOLICITING PROPOSALS TO ESTABLISH AN OPEN-END CONTRACT TO PROVIDE UTILIZATION MANAGEMENT (UM) AND PRIOR AUTHORIZATION (PA) SERVICES PER THE ATTACHED DOCUMENTS.

QUESTIONS REGARDING THE SOLICITATION MUST BE SUBMITTED IN WRITING TO CRYSTAL.G.HUSTEAD@WV.GOV PRIOR TO THE QUESTION PERIOD DEADLINE CONTAINED IN THE INSTRUCTIONS TO VENDORS SUBMITTING BIDS

ONLINE RESPONSES ARE PROHIBITED FOR THIS SOLICITATION

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

Line	Comm Ln Desc	Qty	Unit of Measure	Unit Price	Total Price
1	Utilization Management and Prior Authorization Services	0.00000			

Comm Code	Manufacturer	Specification	Model #
80000000			

Extended Description:
Utilization Management and Prior Authorization Services

SCHEDULE OF EVENTS

Line	Event	Event Date
1	VENDOR QUESTION DEADLINE	2023-02-10

Date Printed: Feb 21, 2023 Page: 2 FORM ID: WV-PRC-CRFP-002 2020/05

	Document Phase	Document Description	Page 3
BMS2300000002	Final	UTILIZATION MANAGEMENT AND PRIOR AUTHORIZATION	

ADDITIONAL TERMS AND CONDITIONS

See attached document(s) for additional Terms and Conditions

Terms and Conditions

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

(Printed Name and Title) Meghan Harris, President and COO

(Address) 424 Church Street, Suite 2200

(Phone Number) / (Fax Number) (216) 392-2833 / (717) 564-3862

(Email address) mharris@kepro.cpm

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

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

Keystone Peer Review Organization, LLC. (Kepro)
(Company)

(Signature of Authorized Representative)
Meghan Harris, President and COO / March 3, 2023
(Printed Name and Title of Authorized Representative) (Date)
(216) 392-2833 / (717) 564-3862
(Phone Number) (Fax Number)
mharris@kepro.com
(Email Address)

Revised 11/1/2022

CRFP Vendor Certification

REQUEST FOR PROPOSAL
CRFP BMS2300000002
Utilization Management and Prior Authorization

Proposal 1: Step 1 – $1,000,000 / $1,000,000 = Cost Score Percentage of 1 (100%)
Step 2 – 1 X 300 = Total Cost Score of 300

Proposal 2: Step 1– $1,000,000 / $1,100,000 = Cost Score Percentage of 0.909091 (90.9091%)
Step 2 – 0.909091 X 300 = Total Cost Score of 272.7273

6.8. **Availability of Information:** Proposal submissions become public and are available for review immediately after opening pursuant to West Virginia Code §5A-3-11(h). All other information associated with the RFP, including but not limited to, technical scores and reasons for disqualification, will not be available until after the contract has been awarded pursuant to West Virginia Code of State Rules §148-1-6.3.d.

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

Keystone Peer Review Organization, LLC (Kepro)
(Company)

Meghan Harris, President and COO
(Representative Name, Title)

Phone: (216) 392-2833 Fax: (717) 564-3862
(Contact Phone/Fax Number)

February 27, 2023
(Date)

Revised 07/01/2021

Federal Funds Addendum

Attachment 1

FEDERAL FUNDS ADDENDUM
2 C.F.R. §§ 200.317 – 200.327

Purpose: This addendum is intended to modify the solicitation in an attempt to make the contract compliant with the requirements of 2 C.F.R. §§ 200.317 through 200.327 relating to the expenditure of certain federal funds. This solicitation will allow the State to obtain one or more contracts that satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

Instructions: Vendors who are willing to extend their contract to procurements with federal funds and the requirements that go along with doing so, should sign the attached document identified as: "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)"

Should the awarded vendor be unwilling to extend the contract to federal funds procurement, the State reserves the right to award additional contracts to vendors that can and are willing to meet federal funds procurement requirements.

Changes to Specifications: Vendors should consider this solicitation as containing two separate solicitations, one for state level procurement and one for county/local procurement.

State Level: In the first solicitation, bid responses will be evaluated with applicable preferences identified in sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" to establish a contract for both standard state procurements and state federal funds procurements.

County Level: In the second solicitation, bid responses will be evaluated with applicable preferences identified in Sections 15, 15A, and 16 of the "Instructions to Vendors Submitting Bids" omitted to establish a contract for County/Local federal funds procurement.

Award: If the two evaluations result in the same vendor being identified as the winning bidder, the two solicitations will be combined into a single contract award. If the evaluations result in a different bidder being identified as the winning bidder, multiple contracts may be awarded. The State reserves the right to award to multiple different entities should it be required to satisfy standard state procurement, state federal funds procurement, and county/local federal funds procurement requirements.

State Government Use Caution: State agencies planning to utilize this contract for procurements subject to the above identified federal regulations should first consult with the federal agency providing the applicable funding to ensure the contract is complaint.

County/Local Government Use Caution: County and Local government entities planning to utilize this contract for procurements subject to the above identified federal regulation should first consult with the federal agency providing the applicable funding to ensure the contract is complaint. For purposes of County/Local government use, the solicitation resulting in this contract was conducted in accordance with the procurement laws, rules, and procedures governing the West Virginia Department of Administration, Purchasing Division, except that vendor preference has been omitted for County/Local use purposes and the contract terms contained in the document entitled "REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317)" have been added.

FEDERAL FUNDS ADDENDUM

REQUIRED CONTRACT PROVISIONS FOR NON-FEDERAL ENTITY CONTRACTS UNDER FEDERAL AWARDS (2 C.F.R. § 200.317):

The State of West Virginia Department of Administration, Purchasing Division, and the Vendor awarded this Contract intend that this Contract be compliant with the requirements of the Procurement Standards contained in the Uniform Administrative Requirements, Cost Principles, and Audit Requirements found in 2 C.F.R. § 200.317, et seq. for procurements conducted by a Non-Federal Entity. Accordingly, the Parties agree that the following provisions are included in the Contract.

1. **MINORITY BUSINESSES, WOMEN'S BUSINESS ENTERPRISES, AND LABOR SURPLUS AREA FIRMS:** (2 C.F.R. § 200.321)

   a. The State confirms that it has taken all necessary affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible. Those affirmative steps include:

      (1) Placing qualified small and minority businesses and women's business enterprises on solicitation lists;
      (2) Assuring that small and minority businesses, and women's business enterprises are solicited whenever they are potential sources;
      (3) Dividing total requirements, when economically feasible, into smaller tasks or quantities to permit maximum participation by small and minority businesses, and women's business enterprises;
      (4) Establishing delivery schedules, where the requirement permits, which encourage participation by small and minority businesses, and women's business enterprises;
      (5) Using the services and assistance, as appropriate, of such organizations as the Small Business Administration and the Minority Business Development Agency of the Department of Commerce; and
      (6) Requiring the prime contractor, if subcontracts are to be let, to take the affirmative steps listed in paragraphs (1) through (5) above.

   b. Vendor confirms that if it utilizes subcontractors, it will take the same affirmative steps to assure that minority businesses, women's business enterprises, and labor surplus area firms are used when possible.

2. **DOMESTIC PREFERENCES:** (2 C.F.R. § 200.322)

   a. The State confirms that as appropriate and to the extent consistent with law, it has, to the greatest extent practicable under a Federal award, provided a preference for the purchase, acquisition, or use of goods, products, or materials produced in the United

States (including but not limited to iron, aluminum, steel, cement, and other manufactured products).

b. Vendor confirms that will include the requirements of this Section 2. Domestic Preference in all subawards including all contracts and purchase orders for work or products under this award.

c. Definitions: For purposes of this section:

(1) "Produced in the United States" means, for iron and steel products, that all manufacturing processes, from the initial melting stage through the application of coatings, occurred in the United States.
(2) "Manufactured products" means items and construction materials composed in whole or in part of non-ferrous metals such as aluminum; plastics and polymer-based products such as polyvinyl chloride pipe; aggregates such as concrete; glass, including optical fiber; and lumber.

3. **BREACH OF CONTRACT REMEDIES AND PENALTIES:**
(2 C.F.R. § 200.327 and Appendix II)

(a) The provisions of West Virginia Code of State Rules § 148-1-5 provide for breach of contract remedies, and penalties. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

4. **TERMINATION FOR CAUSE AND CONVENIENCE:**
(2 C.F.R. § 200.327 and Appendix II)

(a) The provisions of West Virginia Code of State Rules § 148-1-5 govern Contract termination. A copy of that rule is attached hereto as Exhibit A and expressly incorporated herein by reference.

5. **EQUAL EMPLOYMENT OPPORTUNITY:**
(2 C.F.R. § 200.327 and Appendix II)

Except as otherwise provided under 41 CFR Part 60, and if this contract meets the definition of "federally assisted construction contract" in 41 CFR Part 60–1.3, this contract includes the equal opportunity clause provided under 41 CFR 60–1.4(b), in accordance with Executive Order 11246, "Equal Employment Opportunity" (30 FR 12319, 12935, 3 CFR Part, 1964–1965 Comp., p. 339), as amended by Executive Order 11375, "Amending Executive Order 11246 Relating to Equal Employment Opportunity," and implementing regulations at 41 CFR part 60, "Office of Federal Contract Compliance Programs, Equal Employment Opportunity, Department of Labor."

6. **DAVIS-BACON WAGE RATES:**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that if this Contract includes construction, all construction work in excess of $2,000 will be completed and paid for in compliance with the Davis–Bacon Act (40 U.S.C. 3141–3144, and 3146–3148) as supplemented by Department of Labor regulations (29 CFR Part 5, "Labor Standards Provisions Applicable to Contracts Covering Federally Financed and Assisted Construction"). In accordance with the statute, contractors must:

(a) pay wages to laborers and mechanics at a rate not less than the prevailing wages specified in a wage determination made by the Secretary of Labor.
(b) pay wages not less than once a week.

A copy of the current prevailing wage determination issued by the Department of Labor is attached hereto as Exhibit B. The decision to award a contract or subcontract is conditioned upon the acceptance of the wage determination. The State will report all suspected or reported violations to the Federal awarding agency.

7. **ANTI-KICKBACK ACT:**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that it will comply with the Copeland Anti-KickBack Act (40 U.S.C. 3145), as supplemented by Department of Labor regulations (29 CFR Part 3, "Contractors and Subcontractors on Public Building or Public Work Financed in Whole or in Part by Loans or Grants from the United States"). Accordingly, Vendor, Subcontractors, and anyone performing under this contract are prohibited from inducing, by any means, any person employed in the construction, completion, or repair of public work, to give up any part of the compensation to which he or she is otherwise entitled. The State must report all suspected or reported violations to the Federal awarding agency.

8. **CONTRACT WORK HOURS AND SAFETY STANDARDS ACT**
(2 C.F.R. § 200.327 and Appendix II)

Where applicable, and only for contracts awarded by the State in excess of $100,000 that involve the employment of mechanics or laborers, Vendor agrees to comply with 40 U.S.C. 3702 and 3704, as supplemented by Department of Labor regulations (29 CFR Part 5). Under 40 U.S.C. 3702 of the Act, Vendor is required to compute the wages of every mechanic and laborer on the basis of a standard work week of 40 hours. Work in excess of the standard work week is permissible provided that the worker is compensated at a rate of not less than one and a half times the basic rate of pay for all hours worked in excess of 40 hours in the work week. The requirements of 40 U.S.C. 3704 are applicable to construction work and provide that no laborer or mechanic must be required to work in surroundings or under working conditions which are unsanitary, hazardous or dangerous. These requirements do not apply to the purchases of supplies or materials or articles ordinarily available on the open market, or contracts for transportation or transmission of intelligence.

9. **RIGHTS TO INVENTIONS MADE UNDER A CONTRACT OR AGREEMENT.**
(2 C.F.R. § 200.327 and Appendix II)

If the Federal award meets the definition of "funding agreement" under 37 CFR § 401.2 (a) and the recipient or subrecipient wishes to enter into a contract with a small business firm or nonprofit organization regarding the substitution of parties, assignment or performance of experimental, developmental, or research work under that "funding agreement," the recipient or subrecipient must comply with the requirements of 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements," and any implementing regulations issued by the awarding agency.

10. **CLEAN AIR ACT**
(2 C.F.R. § 200.327 and Appendix II)

Vendor agrees that if this contract exceeds $150,000, Vendor is to comply with all applicable standards, orders or regulations issued pursuant to the Clean Air Act (42 U.S.C. 7401–7671q) and the Federal Water Pollution Control Act as amended (33 U.S.C. 1251–1387). Violations must be reported to the Federal awarding agency and the Regional Office of the Environmental Protection Agency (EPA).

11. **DEBARMENT AND SUSPENSION**
(2 C.F.R. § 200.327 and Appendix II)

The State will not award to any vendor that is listed on the governmentwide exclusions in the System for Award Management (SAM), in accordance with the OMB guidelines at 2 CFR 180 that implement Executive Orders 12549 (3 CFR part 1986 Comp., p. 189) and 12689 (3 CFR part 1989 Comp., p. 235), "Debarment and Suspension." SAM Exclusions contains the names of parties debarred, suspended, or otherwise excluded by agencies, as well as parties declared ineligible under statutory or regulatory authority other than Executive Order 12549.

12. **BYRD ANTI-LOBBYING AMENDMENT**
(2 C.F.R. § 200.327 and Appendix II)

Vendors that apply or bid for an award exceeding $100,000 must file the required certification. Each tier certifies to the tier above that it will not and has not used Federal appropriated funds to pay any person or organization for influencing or attempting to influence an officer or employee of any agency, a member of Congress, officer or employee of Congress, or an employee of a member of Congress in connection with obtaining any Federal contract, grant or any other award covered by 31 U.S.C. 1352. Each tier must also disclose any lobbying with non–Federal funds that takes place in connection with obtaining any Federal award. Such disclosures are forwarded from tier to tier up to the non–Federal award.

13. **PROCUREMENT OF RECOVERED MATERIALS**
(2 C.F.R. § 200.327 and Appendix II; 2 C.F.R. § 200.323)

Vendor agrees that it and the State must comply with section 6002 of the Solid Waste Disposal Act, as amended by the Resource Conservation and Recovery Act. The requirements of Section 6002 include procuring only items designated in guidelines of the

Environmental Protection Agency (EPA) at 40 CFR part 247 that contain the highest percentage of recovered materials practicable, consistent with maintaining a satisfactory level of competition, where the purchase price of the item exceeds $10,000 or the value of the quantity acquired during the preceding fiscal year exceeded $10,000; procuring solid waste management services in a manner that maximizes energy and resource recovery; and establishing an affirmative procurement program for procurement of recovered materials identified in the EPA guidelines.

14. **PROHIBITION ON CERTAIN TELECOMMUNICATIONS AND VIDEO SURVEILLANCE SERVICES OR EQUIPMENT.**
(2 C.F.R. § 200.327 and Appendix II; 2 CFR § 200.216)

Vendor and State agree that both are prohibited from obligating or expending funds under this Contract to:

(1) Procure or obtain;
(2) Extend or renew a contract to procure or obtain; or
(3) Enter into a contract (or extend or renew a contract) to procure or obtain equipment, services, or systems that uses covered telecommunications equipment or services as a substantial or essential component of any system, or as critical technology as part of any system. As described in Public Law 115–232, section 889, covered telecommunications equipment is telecommunications equipment produced by Huawei Technologies Company or ZTE Corporation (or any subsidiary or affiliate of such entities).

(i) For the purpose of public safety, security of government facilities, physical security surveillance of critical infrastructure, and other national security purposes, video surveillance and telecommunications equipment produced by Hytera Communications Corporation, Hangzhou Hikvision Digital Technology Company, or Dahua Technology Company (or any subsidiary or affiliate of such entities).
(ii) Telecommunications or video surveillance services provided by such entities or using such equipment.
(iii) Telecommunications or video surveillance equipment or services produced or provided by an entity that the Secretary of Defense, in consultation with the Director of the National Intelligence or the Director of the Federal Bureau of Investigation, reasonably believes to be an entity owned or controlled by, or otherwise connected to, the government of a covered foreign country.

In implementing the prohibition under Public Law 115–232, section 889, subsection (f), paragraph (1), heads of executive agencies administering loan, grant, or subsidy programs shall prioritize available funding and technical support to assist affected businesses, institutions and organizations as is reasonably necessary for those affected entities to transition from covered communications equipment and services, to procure replacement equipment and services, and to ensure that communications service to users and customers is sustained.

State of West Virginia	**Vendor Name:** Keystone Peer Review Organization, LLC.
By: _____	**By:** _____
Printed Name: _____	**Printed Name:** Meghan Harris
Title: _____	**Title:** President and COO
Date: _____	**Date:** March 8, 2023